THE MAKING OF A 'CRISIS':

Syrian Refugees and the Politics of Health in Jordan

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Abstract

The Making of a 'Crisis': Syrian Refugees and the Politics of Health in Jordan

Sigrid Lupieri

In recent years, the pace at which apparent refugee and health 'crises' – and their humanitarian responses – are being subsumed within foreign policy agendas appears to be accelerating. From the Syrian 'refugee crisis' in Europe in 2015, to the outbreak of Ebola, the Zika virus and, more recently, Covid-19, attempts at tackling these 'crises' have not only conflated cross-border mobility with illness and disease, but have also served as a justification for sealing national borders. Yet there has been surprisingly little research on the intersection between forced migration, global health, and humanitarian assistance, particularly in the context of refugee hosting countries in the Global South. Building on scholarship on refugee and forced migration studies, global health security, and international relations, this thesis provides a new perspective on how the politics of health care undertaken by donors, host states, and non-governmental organizations affects the priorities of refugee health responses.

This thesis considers the case study of Jordan, a country in the Middle East which hosts one of the largest refugee populations relative to its national population in the world. Based on six months of fieldwork, I investigate the ways in which the arrival of an estimated 650,000 Syrian refugees between 2012 and 2019 transformed Jordan into an arena in which large-scale national and international interests, foreign policy objectives, and power dynamics collide. Findings show that health policies affecting refugees have been increasingly co-opted within the foreign policy agendas of both donor and refugee receiving states, with wide-ranging effects on the allocation of humanitarian assistance. Such effects include a disproportionate focus on infectious diseases at the expense of more prevalent chronic diseases, and gendered and racialized constructions of 'vulnerable' refugees. As a result, I contend that some refugee groups – mainly women and children – are championed by certain powerful actors, while other groups within the same refugee population – such as older people and young men – are consistently overlooked.

Preface

The arguments in Chapter 5 are based in part on an article, of which I am the sole author, published in Third World Quarterly. Furthermore, a section of Chapter 6 is based on an article published in Global Social Policy which was co-authored with Lorraine Frisina Doetter (University of Bremen).

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List of Acronyms

Abbreviation	*Full term*
DFID	UK Department for International Development
ECC	Exceptional Care Committee
HHC	High Health Council
JHAS	Jordan Health Aid Society
JRP	Jordan Response Plan for the Syria Crisis
MOH	Jordanian Ministry of Health
MOSD	Jordanian Ministry of Social Development
MOPIC	Jordanian Ministry of Planning and International Cooperation
NCD	Non-communicable disease
NGO	Non-governmental organisation
UHC	Universal Health Coverage
UNDP	UN Development Programme
UNHCR	UN High Commissioner for Refugees
UN OCHA	UN Office for the Coordination of Humanitarian Affairs
UNRWA	UN Relief and Works Agency for Palestine
USAID	US Agency for International Development
WHO	World Health Organisation

Chapter 1 | INTRODUCTION

In the months since the WHO declared the novel coronavirus a Public Health Emergency of International Concern, attempts at tackling the crisis have not only conflated migration and cross-border mobility with illness and disease, but have also served as a justification for sealing national borders. In some cases, refugees arriving to the EU by sea have been refused assistance or have been pushed back in violation of international refugee and maritime law. In the Global South, which hosts the vast majority of the world's displaced persons, reports have emerged of deportations and human rights violations exacerbated by the COVID-19 response. While the conflation of cross-border mobility with the threat of new infections follows 'a playbook centuries old, dating back to at least the Black Death of the 14th century', it is one of history's more sobering lessons that border controls tend to outlast the crises they were meant to prevent (Kenny, 2020, para 3).

The politicization of perceived existential threats – whether they be refugee movements or health crises – is hardly a new phenomenon. Nor is the politicization of the responses to such threats in the form of humanitarian assistance (Curtis, 2001; Donini, 2010; Panebianco, 2016). Yet in recent years, the pace at which apparent crises and their humanitarian responses are being subsumed within foreign policy agendas appears to be accelerating. In 2015, the arrival in Europe of significant numbers of Syrian refugees, in what was called the 'greatest refugee crisis' since World War II (Henley, 2018; McKirdy, 2016), linked refugee movements to national security concerns and justified more restrictive migration policies. Recent securitized responses to infectious diseases such as Ebola and the Zika virus sanctioned the use of the military to deliver medical humanitarian relief (Wenham, 2019). At the time of writing, the UK government was in the process of merging its Department for International Development (DFID) with the Foreign and Commonwealth Office, a move widely condemned as merging international development concerns with political self-interest (Gulrajani, et al., 2020; McVeigh, 2020).

In this thesis I tackle an issue that has so far eluded closer scrutiny within international relations and refugee scholarship: how security concerns, foreign policy agendas and diplomacy fundamentally shape the priorities of refugee health responses. Whereas scholars have acknowledged the effects of power and politics on humanitarian assistance, medical humanitarianism has often been viewed as a benevolent force, rising above the 'dirty business of power politics' (Khakee, 2018, p. 19). Yet to what extent – and to whom – limited health resources are allocated is not only one of the most pressing concerns for many refugees dependent on humanitarian aid, but also one of the most politicized factors in refugee responses.

How do international politics and security issues affect spending priorities for health in refugee settings? Over the past few decades, there has been growing acknowledgement of the role and strategic importance of forced migration within world politics, and within bilateral and multilateral diplomatic relations (Castles, 2003; Chimni, 1998; Collinson, 2003; Duffield, 2014). Scholarship on 'migration diplomacy' highlights how the 'remote control' of migration has successfully transferred the responsibility of border control and migration management from migrant receiving to migrant sending states (Adamson & Tsourapas, 2018; Greenhill, 2010). Recently, scholars have begun to emphasise the ways in which refugee host states in the Global South are able to leverage the presence of refugees on their territories as 'bargaining chips' for material gain (Adamson & Tsourapas, 2018; Tsourapas, 2019). To date, however, the ways in which parallel policy fields such as health in refugee settings are implicated within the politics of migration control and diplomacy have been largely overlooked.

I argue that health policies affecting refugees have been increasingly co-opted within the foreign policy agendas of both donor and refugee receiving states. In this thesis, I consider the case study of Jordan, a relatively small country in the Middle East that hosts one of the world's largest refugee populations compared to its national population. This thesis investigates the ways in which the arrival of Syrian refugees between 2012 and 2019 not only affected the delivery of health care resources, but also transformed Jordan into an arena in

which large-scale national and international interests, foreign policy objectives, and power dynamics collide.

Amid rising numbers of refugees in need of assistance and declining popular and political support for humanitarian action worldwide, this research provides new theoretical and empirical perspectives on how international politics, security and 'migration diplomacy' fundamentally influence spending priorities for health in refugee settings and on the inequalities they (re)produce. From a policy standpoint, this research expands our understanding of the impact of refugee movements and crises on the health care systems of host countries, and of the intended and unintended effects of international aid on refugee welfare.

1.1 The case study

Since the 1950s the Middle East has hosted one of the largest refugee populations in the world, predominantly comprised of Palestinian and Iraqi refugees (Thiollet, 2011). Yet despite the magnitude of the migratory phenomenon, there has been a dearth of research on the politics of migration and, in particular, the politics of health in such a highly strategic region. In Jordan, where refugees now make up an estimated 10% of the population (UNHCR, 2018), historic colonial ties to the UK and, more recently, its support for the US-led 'war against terror' have made the country one of the largest recipients of overseas development assistance in the world (OECD, 2019). Considered by its allies to be a beacon of stability in a volatile region, Jordan boasts a 'special relationship' with the United States.[1] Since 2012, the country has further risen to prominence – in the eyes of its donors – when it began to host an estimated 650,000 refugees from neighbouring war-torn Syria.

While I explore the particularities of Jordan's political and economic backdrop in more detail in Chapter 4, it is important to situate the case study within the context of national health and social policymaking. In particular, in the wake of the 'Arab uprisings' beginning

[1] Interview with USAID, Amman, November 2017

in 2011, calls for political and economic reform across the Middle East brought about limited reforms and an expansion of social services in Jordan (Ceyhun, 2017; Coutts, et al., 2013; Devarajan & Ianchovichina, 2017). In most cases, however, reforms undertaken to appease protesters have been considered marginal and largely failed to live up to popular expectations (Abbott, et al., 2016; Martínez, 2016; Salameh, 2018). Enduring social and economic woes in Jordan include growing social inequality (Atamanov, et al., 2015) and limited access to basic services such as health care (Batniji, et al., 2014).

When it comes to national health and health care policies, reforms to the health sector have attempted to address the impact of rising rates of non-communicable diseases as a major cause of morbidity and mortality among the Jordanian population (Al-Makhamreh, et al., 2011; Brixi, et al., 2015). In recent years, government policies have increasingly emphasised the importance of universal health coverage and the value of health as a human right (Government of Jordan, 2006; Government of Jordan, 2011; Government of Jordan, 2015). At the same time, however, many challenges remain to the implementation of successful reforms. In particular, scholarship has highlighted the limited accessibility and quality of cancer services, and the challenges posed by behavioural determinants of health – including high levels of smoking and obesity – which affect rates of chronic diseases (Nazer & Tuffaha, 2017; Rabie, et al., 2017).

Recently, an overwhelming national and international focus on the Syrian refugee crisis has overshadowed attempts at national policy reform. In particular, large-scale studies have highlighted the barriers to access to health care for Syrian refugees (Doocy, et al., 2015; Doocy, et al., 2012; Spiegel, et al., 2014), including a lack of services for chronic conditions such as cancer (Akik, et al., 2019; Mansour-Ille, et al., 2018; Rehr, et al., 2018), for mental health, and maternal and child health (Groenveld & Abu-Taleb, 2016). Interestingly, reports published by international NGOs on access to health care for Syrian refugees tend to highlight the vulnerabilities of certain refugee populations – such as older refugees and refugees with disabilities or chronic diseases – and the lack of accessible health care (Amnesty International, 2016; Ay, et al., 2016; Dunmore & Sakkab, 2018; HI and iMMAP , 2018; Röth, et al., 2017). Nationally conducted studies, however, tend to highlight the

economic impact of the presence of Syrian refugees on already limited and overstretched public health services (Arab & Sagbakken, 2018; Gharaibeh, 2015; Murshidi, et al., 2013).

1.2 The research agenda

Though not a signatory of the 1951 Refugee Convention and its 1967 Protocol, Jordan's position as a refugee host country in the Middle East region has in many ways tested the limits of the international refugee regime. Indeed, one of the most contentious issues to have emerged from the Refugee Convention – which laid the foundation for the current refugee system – is the contrast between a strong obligation to respect the right of refugees to asylum and a weak commitment to 'responsibility-sharing'. On the one hand, refugees arriving in the territory of a state have the right to claim asylum and may not be forcibly repatriated. On the other hand, there is no binding framework to compel states to support refugees residing in the territories of other states (Achiume, 2015; Aleinikoff & Poellot, 2014; Panebianco & Fontana, 2018). With an estimated 85% of the world's refugees residing in the Global South, wealthier states in the Global North often have few incentives to share responsibility for global refugee movements (Aleinikoff & Poellot, 2014; Loescher & Milner, 2005; Thielemann, 2003).

In a context in which countries in the Global South are frequently left to shoulder refugee crises with little international support, the case of Syrian refugees in Jordan provides an example of the stark asymmetries which permeate North-South relations. On the one hand, the arrival of Syrian refugees, widely referred to as a 'crisis' by political elites, became the catalyst for the rapid proliferation of international humanitarian and development organizations in the country, and a dramatic increase in overseas development assistance. On the other hand, the sudden humanitarian concern for Jordan and its refugees should be viewed as a central strategy of western states aimed at reducing refugee movements to the Global North. In other words, the conflation of refugees with national security concerns in the west, particularly after the European 'refugee crisis' in 2015, became a catalyst for border policies aimed at containing refugees in their host countries. Despite a lack of evidence that increased development assistance in host countries reduces the onward

mobility of refugees, donors I interviewed frequently emphasized Jordan's role as a gatekeeper in stemming the tide of successive refugee flows to Europe and beyond.

In what is inevitably a contested and politically charged environment, my research investigates the underexplored intersection between refugee movements, politics, and humanitarian health. This thesis asks: **how has the increasing politicization of both refugee movements and global health influenced the priorities of the Syrian refugee health response in Jordan?** I employ a Critical Discourse Analysis-based approach to examine the priorities and interests of three main groups of political actors engaged in the refugee response: (1) bilateral and multilateral donor organizations, (2) the Government of Jordan, and (3) international humanitarian and development organizations.

Using a combination of qualitative research methods, I conducted six months of fieldwork in Jordan in 2017-2019, including four months of participant observation at an international NGO and 61 semi-structured interviews with elite decision-makers in Jordan and Lebanon. This thesis examines (a) the ways in which 'migration diplomacy' and relations between international donors and national government authorities affect policymaking for health; (b) how the politicization of health policies affects the behaviour and strategies employed by international organizations to negotiate access to the humanitarian space; and (c) how this politicization affects the spending priorities of humanitarian actors and their methods for selecting recipients of humanitarian assistance.

This research builds upon three main bodies of scholarship: international relations (IR), global health, and refugee and migration studies. IR and refugee studies research has recently begun to address the transnational dimensions of global policymaking and the commodification of refugee populations as 'bargaining chips' (Adamson & Tsourapas, 2018; Thielemann, 2003; Tsourapas, 2019). In what has been referred to as 'migration diplomacy', studies show that refugees and refugee movements are frequently instrumentalized by refugee host states in the Global South to increase their bargaining power vis-à-vis powerful western states. So far little attention has been paid to the strategic use of social policies towards refugees – including health care – as a form of diplomacy. In this thesis I demonstrate how health policies affecting Syrian refugees have been largely co-opted

within the foreign policy agendas of donor governments and refugee host states. Building on the concept of 'migration diplomacy', I contribute a new perspective on how donors and host states instrumentalize refugee mobility and health financing as bargaining tools to implicitly renegotiate their respective positions in the global policymaking sphere.

I then examine the effects of such bargaining on the distributional politics of the humanitarian health response. While international organizations select recipients of humanitarian assistance based on supposedly objective criteria such as 'vulnerability' and 'need', I find that the security interests of powerful states have a significant influence on the values and spending priorities of humanitarian health programmes. Overall, this research expands our understanding of how the increasing politicization of refugees and health care has not only affected the 'life chances' of some refugee groups, but has also altered the political significance of Jordan in the international relations landscape.

Underlying this research is a critical reflection on the dominant discursive and political framing of 'crises'. Scholars have highlighted how politicized crisis discourses have proliferated in recent years. Since the terrorist attacks on the US on September 11, 2001, US policies on the 'war on terror' have largely ushered in an era characterized by a global state of emergency (Bigo & Tsoukala, 2008; De Genova, et al., 2018). Such crisis discourse has legitimized political repression, state surveillance, and military invasions around the world. In 2008, the global economic recession set the stage for a new 'crisis' narrative, that of a crisis of the capitalist economic system. More recently, the 2015 'migrant crisis' and 'refugee crisis' provided further fuel for nationalist projects and authoritarian responses to protect 'the people' and 'nations' from transnational mobility (De Genova et al., 2018). In this context, it is important to question the politics that underpin the framing of a 'crisis'. Who defines what is or what is not a crisis? And who benefits from such discourses? As this thesis will show, crisis discourses cannot be divorced from the securitization processes from which they stem. In a world which increasingly sees refugees as threats to the security of – predominantly – western populations, constructions of 'crises' not only conceal a wide range of political interests, but also portray western states as disconnected from the causes of suffering from which populations flee (De Genova, et al., 2018).

In Jordan the term 'crisis', often used interchangeably with 'emergency' within reports and interviews, appears as an ambiguous concept with strong political implications. Several representatives from NGOs and donor organizations questioned whether the presence of Syrian refugees in Jordan constituted a crisis at all or, rather, should be considered 'business as usual'. The concept of a *protracted refugee situation,* which, according to UNHCR's definition, refers to refugees trapped in a condition of exile 'for 5 years or more after their initial displacement, without immediate prospects for implementation of durable solutions' (UNHCR ExCom, 2009, p. 198) became particularly relevant in 2017, when many Syrian refugees had been residing in Jordan for at least five years.

The timing of my fieldwork provided the opportunity to observe a shift in the crisis narratives of the refugee health response. From the perspective of humanitarian and development actors, the protracted nature of the 'crisis' generated deliberations on long-term planning and, alternatively, 'exit strategies'. Donors, in particular, revealed tensions between their desire to extricate themselves from a 'crisis' with no apparent end in sight, and the need to maintain strong diplomatic relations with Jordan. From the point of view of the Government of Jordan, the framing of refugees as a 'security crisis' sent a clear message that Syrian refugees had overstayed their welcome. Underpinning such national and international discourses were concerns about dwindling international interest in what was now considered to be a 'protracted crisis' along with long-standing fears that refugees – and international agencies – would become permanent fixtures within the Jordanian policy landscape.

Indeed, such fears cannot be analysed in isolation from the historical context of the Palestinian refugee crisis, which is a poignant example of how acute crises become chronic without the political will for change. In Jordan, an estimated 2 million Palestinian refugees and their descendants reside in the country under the protection of UNRWA, which has long exceeded its initial temporary mandate of three years. 'UNRWA was established in 1950 and is now almost 70 years old, and the organization is still thinking of people on the move without suggesting an alternative,' explained an academic focusing on the health

response to the Syrian refugee crisis. 'Many UN organizations and academics are stuck in the model of emergency. But what if we have a chronic emergency?'[2]

The focus of this research is actor-centred and my analysis focuses on humanitarianism as a *system* that encompasses a plurality of actors and motivations. As such, I view humanitarianism not as a neutral and impartial mechanism for providing aid, but as a system of competing interests, power dynamics, and agendas. More specifically, I include three main sets of state and non-state actors that dominate the humanitarian space in Jordan: bilateral donors, host government authorities, and international organizations. While this thesis does, in many ways, present a critique of the humanitarian system, my intention is not to be unduly critical of humanitarianism per se. Rather, I view critique as a necessary lens through which to maintain vigilance and self-reflexivity when assessing the impact and implications of the political realities that permeate the humanitarian system (Kennedy, 2004).

At the heart of this thesis lies the highly contested and fractured concept of humanitarianism. With no agreed upon definition, humanitarianism is, among other things, a cause, an ideology, and a profession. But humanitarianism is also a business that attracts billions of dollars in investments, hires and mobilizes hundreds of thousands of professionals, and is subject to market forces. Increasingly, humanitarianism is a political endeavour and an expression of global governance processes, subsumed within world-ordering and securitization objectives. As I will show in this thesis, humanitarianism is also a form of containment. As Donini writes, containment can take two forms: 'the provision of a minimum of assistance to ensure that crises do not spin out of control (and threaten the citadels of the north) and the deliberate incorporation of humanitarian action in the world-ordering and security strategies of the north' (Donini, 2010, p. 4). In other words, humanitarianism can be seen as a system of governance – and an expression of power – that largely protects the economic and security interests of the Global North (Duffield, 2008; Fassin, 2012).

[2] Interview with academic, Beirut, September 2017

1.3 Chapter outline and structure

In **Chapter 2**, I address the theoretical underpinnings that informed my research. To better understand how elite decision-makers formulate policies within the refugee health response in Jordan, I draw upon the disciplines of refugee and forced migration studies, IR, and global health security. In particular, I situate refugee movements within the broader political context of North-South relations. I argue that the fundamentally asymmetrical nature of the modern refugee system exacerbates power struggles and attempts at instrumentalizing refugee flows for political gain within inter-state relations. More specifically to health care, I contend that the presence of international organizations and external financing for health not only reinforces an overarching securitization of refugees and health, but also leads to the retreat of the state as the main provider of services. I then consider how often-conflicting definitions and conceptualizations of 'vulnerability' have emerged and developed over time, and how these have become one of the central organizing principles of refugee responses worldwide. Lastly, I discuss my research questions and outline the conceptual framework used to analyse my data.

In **Chapter 3** I discuss the practicalities of my fieldwork, interview selection, and overall research design. In **Chapter 4** I provide an historical overview of the political and economic factors in the development of a modern nation-state since Jordan's declaration of independence in 1946. Within a context of recurring regional instability, political crises, and refugee movements, I argue that Jordan's ambivalent policies towards refugees and migrants have been part of a larger strategy to capitalize on foreign assistance, and leverage the country's strategic position on the international stage. In regard to health care, I contend that Jordan has progressively shifted from universalistic aspirations of health as a human right to that of a privilege awarded to certain citizens and to the exclusion of refugees and migrants. More recently, the arrival of Syrian refugees, which was accompanied by a large-scale humanitarian response, has had far-reaching consequences for national health care policies, including a further fragmentation of the national health care system and the retrenchment of the state in providing services to refugees.

Chapter 5 analyses how transnational and national state interests have affected policy decisions on health care resources for Syrian refugees in Jordan. Drawing from elements of securitization theory, especially in regard to health, I examine how discourses and practices undertaken by the government and international donors have affected health policy development for refugees and the allocation of health care resources to some vulnerable refugee groups and health causes over others. I analyse funding flows into Jordan over the past two decades to show how the politics of 'migration diplomacy' and 'global health diplomacy' have led to a heightened presence of donors, UN aid agencies, and international financial institutions providing means-tested health care services to refugees and Jordanians.

In a context that both expands and limits the scope for cooperation among international organizations, national NGOs, and the Jordanian state, I argue in **Chapter 6** that the retrenchment of the state as the main service provider has left a vacuum filled in part by non-state actors increasingly involved in determining inclusion and exclusion criteria for beneficiaries. Differently from other health actors, NGOs are bound by temporal constraints, by mandates circumscribed by the presence of a 'crisis', and the need to maintain legitimacy in a crowded humanitarian space. In the absence of a single authority regulating the health response, I argue that health governance has become a contested space in which international non-governmental actors have to overcome 'collective action problems', while also contending with divergent and competing interests. Struggles over authority, legitimacy and power come to the fore and have a significant impact over which causes are spotlighted and which categories of beneficiaries are considered a priority.

Across this thesis, findings show the central importance of notions of 'vulnerability' in guiding the allocation of resources to Syrian refugees. **Chapter 7** analyses how the Vulnerability Assessment Framework in Jordan obfuscates the interests and preferences of health actors based on their respective positions in the humanitarian system. I argue that the concept of 'vulnerability' remains elusive and ill-defined within refugee response efforts. As a result, I contend that some groups – mainly women and children – are championed by certain powerful actors, while other groups within the same refugee

population – such as older people – are consistently overlooked. This chapter examines whose interests are represented and whose are not among the priorities of powerful health actors.

In **Chapter 8** I examine the analytical and theoretical implications of the research questions introduced in Chapter 2. More specifically, I draw on the evidence laid out in Chapters 5, 6, and 7 to situate my findings within the wider political context of the international refugee regime and the humanitarian system. First, I contend that the Syrian refugee health response exposes some of the fundamental limitations of the international refugee regime, including an overwhelming focus on national security, unequal power dynamics among states, and a fragile commitment to international responsibility-sharing. Second, I investigate the ways in which the increased politicization of the humanitarian system affects the behaviour of non-state actors involved in the health response. Third, my research uncovers the political constructions that underpin the selection and ordering of refugees based on their 'vulnerability'. In a context where resources are scarce, findings show that constructions of who is 'vulnerable' and who is not are strongly influenced by the principle of 'value for money' and a reliance on gendered and stereotyped notions of vulnerability. In the last section I address the implications of my research and outline some recommendations for further research.

Chapter 9 concludes this thesis with some reflections on the implications of this research in light of the ongoing COVID-19 pandemic.

Chapter 2 | HUMANITARIANISM, DEVELOPMENT, AND THE POLITICS OF HEALTH IN REFUGEE SETTINGS

To better understand the political dynamics which underpin humanitarian assistance to refugees, I draw upon an existing body of work from refugee and forced migration studies, international relations, and global health. This chapter is divided into several thematic sections. First, I address the role of forced migration in world politics and situate refugee movements within the context of the international refugee system. I argue that, within a fundamentally asymmetrical regime, relations between refugee host states, donor states, and international organizations are strongly affected by power struggles and attempts at 'migration diplomacy'. Second, more specifically to health care, I argue that at times the significant presence of international organizations and external financing for health not only reinforces an overarching securitization of refugees and health, but also leads to the retreat of the state as the main provider of services.

Third, I consider the centrality of the notion of 'vulnerability' in guiding the allocation of resources in humanitarian and development responses. I contend that the concept has so far eschewed a more critical analysis of the political processes which make up its often-conflicting definitions and conceptualizations. Finally, I highlight the gaps in knowledge and understanding of the intersections between the politics of refugee responses and the politics of global health. I argue that limited collaboration between forced migration and global health studies has hampered a more nuanced understanding of the implicit power dynamics involved in the formulation of health policies affecting refugees. More specifically, I contend that the politicization of health policies in refugee responses has been largely overlooked within IR scholarship. I then provide an overview of my research questions.

2.1 Refugees in world politics

To date, close to 26 million people are officially recognized as 'refugees' and under the protection of UNHCR's mandate (UNHCR, 2020). The considerable increase in the number of displaced persons has attracted growing scholarly attention, in particular in regard to the politics underlying refugee responses and protection (Duffield, 2014; Huysmans, 2006; Pittaway, et al., 2010), and the impact of forced migration on world politics (Betts & Collier, 2017; Betts & Loescher, 2011; Castles, 2003; Thiollet, 2011). There has been increasing recognition of how the movement of people and the resulting migration policies are both a cause and a result of power asymmetries among countries (Paoletti, 2011). By situating responses to refugee movements within the context of North-South relations, what emerges are the asymmetrical power dynamics between supposedly more powerful actors, such as states in the Global North, and allegedly 'weaker' actors, such as refugee host states in the Global South (Betts, 2014; Cronin, 2003; Suhrke, 1998; Thielemann, 2003).

Based on the 1951 Refugee Convention, which provides the foundation of the current refugee regime, first states of asylum are obligated to provide protection to refugees arriving within their borders. Moreover, the principle of *non-refoulement* stipulates that host states may not return refugees to a country in which they may face persecution (Achiume, 2015; Aleinikoff & Poellot, 2014; Loescher & Milner, 2005; Panebianco & Fontana, 2018). At the same time, however, there is no binding international commitment for responsibility-sharing. In other words, states are under no obligation to support other host states which are frequently overwhelmed by the arrival of refugees due to their geographic proximity to a crisis (Achiume, 2015; Thielemann, 2003). In this thesis, the role of refugee movements within the international refugee system emerges as a central theme within the broader context of North-South relations. In other words, how do state actors, such as international donors and refugee host states, engage with refugees on the international stage?

Refugees, security and border control

In recent decades, refugee movements and the nature of refugee protection have become one of the most fiercely debated issues on national and international agendas, particularly

in countries in the Global North (Appleby, 2017; Baldwin-Edwards, et al., 2019; Gibney, 2015; Goodwin-Gill, 2019; Menjívar, 2014). While the political element of international migration has long been recognized (Teitelbaum, 1984; Zolberg, 1989), only in more recent years has increasing attention been paid to migration in relation to a state's capacity and authority to control the entry and exit of persons on its territory (Menjívar, 2014; Paoletti, 2011). As Haddad argues, refugee protection is not only a human rights issue, but also an inherent aspect of international politics in that it represents a breakdown of the state-citizen-territory relationship assumed by the state system (Haddad, 2008). In other words, migration and refugee movements have increasingly become conflated with discourses surrounding state power, security, and border control (Bigo & Tsoukala, 2008; Duffield, 2014; Huysmans, 2006).

In this thesis, policy decisions affecting refugees are seen as an expression not only of global governance processes theorized by IR and global health scholarship, but also of political and securitization processes emphasized by international politics of forced displacement and security studies discourses. Scholars have argued that state actors and, in particular, the U.S. have engaged in a progressive process of securitization in regard to forced migration (Hammerstad, 2011). Initially described as a 'politics of unease' which saw migration as an ill-defined threat towards social identity (Bigo, 2002) this culminated in a renewed concern for border security in the wake of 9/11. In particular, the US administration raised the possibility of terrorists abusing the asylum system and cemented the link between terrorism, foreignness and asylum (Guild, 2003). More recently, a rise in populist movements around the world along with an increased visibility of refugees, asylum seekers, and irregular migrants, has seen the conflation of nationalist rhetoric with concerns over immigration (Gray & Franck, 2019; Holzberg, et al., 2018).

In order to examine the meaning of securitization and its application to this thesis, I begin by defining some of its core concepts. Based on a framework of analysis developed by the Copenhagen School, securitization is described as a speech act in which a securitizing actor articulates an already politicized issue as an existential threat to a referent object, and declares the need for extraordinary measures (Buzan, et al., 1998). Based on this framework,

the 'security actors' who engage in securitizing speech acts are generally understood to be decision-making elites such as political leaders, governments, lobbyists, and bureaucracies. What is perceived to be existentially threatened, on the other hand, constitutes the 'referent object'. A referent object can be a state, an ideology, the economy, national sovereignty, the environment, or even a collective social identity (Buzan, et al., 1998). According to this model, securitization occurs as a three-step process. In the first step, an issue which was previously not politicized becomes politicized and is considered to be a matter for state action (Balzacq, 2005). In a subsequent step the issue becomes securitized when its resolution requires actions that call for extraordinary measures beyond 'standard procedures' (Emmers, 2019; Watson, 2011). At the core of this process is the portrayal of certain issues, persons or phenomena as *existential threats* (Emmers, 2019; Wæver, 2011).

Simply portraying an issue as a security threat, however, is not sufficient for the issue to become securitized (Watson, 2011). In order for the process to be considered complete, a relevant audience such as politicians, military officers and the general public must accept and legitimize the discursive representation of the existential threat (Balzacq, 2005). Securitization, as initially conceptualized by the Copenhagen School, is primarily a *discursive act* which does not necessarily involve its implementation or the adoption of emergency measures as a necessary outcome. More recently, however, critical voices have specified the need for both a discursive speech act and a non-discursive act for an issue to become securitized (Emmers, 2019; McDonald, 2008; Watson, 2011). Such non-discursive acts might include the implementation of emergency measures, including new policies or bureaucratic processes that are tasked with managing persistent threats (Bigo, 2002; Huysmans, 2006).

Within this framework, security emerges as a socially constructed and subjective concept which can be applied to a variety of perceived threats, including a focus on migration and refugee movements (Bigo, 2002; Duffield, 2008; Duffield, 2014). In particular, Bigo's Bordieau-inspired work has stressed the perceived threat that migration poses to the integrity of the state and its national boundaries which manifests itself as a 'governmentality of unease'. In Bigo's words: 'Securitization of the immigrant as a risk is

based on our conception of the state as a body or a container for the polity. It is anchored in the fears of politicians about losing their symbolic control over the territorial boundaries' (Bigo, 2002, p. 65).

Overall, securitized discourses in the Global North have not only raised the visibility of migration and forced displacement, but have also increased the relevance of such issues in the international arena. In particular, recent scholarship has begun to analyse the ways in which the growing focus on migration issues has begun to affect mainstream understandings of interdependence among states and the balance of power within North-South relations (Menjívar, 2014; Norman, 2020; Paoletti, 2011). In particular, the 'migration crisis' in 2014 and 2015, which saw large numbers of asylum seekers and refugees arriving in Europe, was met with increased concern over national security and the tightening of borders (Arar, 2017; Baldwin-Edwards, et al., 2019). In what follows, I situate the Syrian 'refugee crisis' in 2014 and 2015 within the ongoing discussions on forced migration and the broader context of the international refugee system.

Refugees and border externalization policies in the Global North

Scholars have noted how an increased attention to national security among states in the Global North has led to strategies of 'containment' as a means of managing and restricting the movement of refugees towards the Global North (Greussing & Boomgaarden, 2017; Panebianco & Fontana, 2018). More specifically, an increased policing of migration as a state of exception means that many industrialized countries spend more on immigration and asylum control than they do on development assistance in countries of origin (Bigo, 2002; Duffield, 2008). The arrival of Syrian refugees in Europe in the wake of the conflict in Syria in 2011 is a case in point. Scholars argue that the widespread paralysis of the EU in managing the arrival of refugees was determined in part by the competing and often conflicting priorities of 'border control' and the 'duty to protect' (De Genova, et al., 2018; Panebianco & Fontana, 2018).

When faced with the responsibility to offer protection to refugees arriving in their territories, EU member states find themselves struggling with what Hollifield calls a 'liberal

paradox' (Hollifield, 2004). On the one hand, liberal states which are signatories of the 1951 Refugee Convention and its 1967 Protocol, have an obligation to honour the rights of refugees arriving in their territories. On the other hand, liberal democracies have increasingly restricted the arrival of forced migrants out of concerns over security and national identity (Baldwin-Edwards, et al., 2019; Faist, 2018). Similarly, such countries have been grappling with a 'welfare paradox' which juxtaposes the rights of refugees to access basic services such as health care with the retrenchment of the state as the main provider of services to both citizens and non-citizens. As Faist (2018, p. 414) puts it:

> This paradox points to the tension between social rights of citizens in national welfare states which are opposed by the drive for liberalized trade and exchange and a deregulation of labour regulations. It is a tension between the national state as a welfare state and as a capitalist competition state.

In the face of competing priorities during the 2015 'migration crisis', a majority of EU countries embarked upon a trajectory of progressive securitization and containment of migrant and refugee flows (Crawley, 2016; Heisbourg, 2015). European attempts at containing migration and refugee movements have come under increased scrutiny as scholars have begun to emphasize the human rights costs associated with policies which privilege the 'externalization' of European borders to sending and transit countries in the Global South (Gross-Wyrtzen & Gazzotti, 2020; Stock, et al., 2019). Here, 'externalization' has been defined as 'the extension of border and migration controls beyond the so-called "migrant receiving nations" in the Global North and into neighbouring countries or sending states in the Global South' (Stock, et al., 2019, p. 1). In other words, externalization involves 'policing at a distance', in which border control is exercised outside the territory of the state (Bigo & Guild, 2005).

Policies of externalization are not a new phenomenon. In particular, EU countries have a long history of exporting the management of migration to neighbouring states in exchange for visa access, trade deals, and development assistance (Gazzotti, 2019; Haddad, 2008; Menjívar, 2014). Examples include agreements between Italy and Libya in the late 1990s,

which on the one hand sought to compensate Libya for its colonial suffering, while on the other hand strengthened informal agreements on how to deal with unauthorized migration. Simply put, Italy agreed to compensate its former colony while at the same time requiring a stronger commitment to curtailing the arrival of irregular migrants on Italian shores (Paoletti, 2011).

Refugee movements not only represent a fundamental challenge to the implicit state-citizen-territory relationship of the current world order, but also bring the structural limitations of the refugee system to the fore. From the perspective of wealthier states in the Global North, which are less frequently affected by refugee movements than their counterparts in the Global South, there is often little incentive to support refugees residing in the territories of other states. More generally, as Keohane sums it up in an essay: 'There is general acceptance that both differential state and non-state power, and multilateral institutions, are important factors affecting policy outcomes. Under different conditions, states may seek to promote other states' interests, hinder them, or be indifferent to their fate' (Keohane, 2009, p. 37).

Within a context of migration policies largely based on self-interest, contentious instances of 'policing at a distance' (Bigo & Guild, 2005) have been seen to have successfully transferred the responsibility of border control and migration management from migrant receiving to migrant sending countries (Greenhill, 2010; Thiollet, 2011). A growing number of scholars, however, have begun to question the assumption that migration policies based on border externalization necessarily weaken the position of countries in the Global South (Adamson & Tsourapas, 2018; Cassarino, 2010; Natter, 2020). In this context, countries in the Global South, which host the majority of the world's migrants and refugees, have frequently engaged in instances of 'migration diplomacy' which have at times strengthened their negotiating power vis-à-vis Northern states.

Refugee host states in the Global South: the rise of migration diplomacy

From the perspective of refugee host states, often located in geographic proximity to conflict areas in the Global South, only recently have scholars begun to address the policy

strategies employed by these states to improve their standing and negotiating power in the international arena. In this context, early theorists such as Keohane and Nye described the role of 'issue-linkages' which allow 'weaker' states to bargain for concessions from more powerful states on multiple issues for a joint settlement (Keohane & Nye, 1987). Oye, Haas, and Stein developed more detailed typologies of linkages which can be employed by supposedly weaker states to strengthen their respective bargaining positions (Haas, 1980; Oye, 1985; Stein, 1980). These include Oye's distinction between 'blackmailing' – making a threat one does not wish to carry out — and 'back-scratching' – offering a quid pro quo bargain (Oye, 1985).

More recently, such distinctions have been applied to studies on forced migration (Thiollet, 2011). Scholars argue that refugee host states in the Global South are at times able to leverage the presence of refugees for material gain through various forms of 'engineered migration flows' (Greenhill, 2010). In the words of Greenhill, 'coercive engineered migrations' are defined as: 'those cross-border population movements that are deliberately created or manipulated in order to induce political, military, and/or economic concessions from a target state or states' (Greenhill, 2010, p. 116). More broadly, 'strategic engineered migration' involves the exploitation of a crisis for political and military ends (ibid.). According to Greenhill, there are three main types of actors who engage in such practices: 'generators', who create or threaten to create cross-border population movements; 'agents provocateurs' who deliberately act to incite others to generate migration outflows; and 'opportunists' who exploit the outflows generated by others for their own gain (Greenhill, 2010).

The ways in which supposedly weaker actors hosting refugees challenge powerful liberal democracies in the Global North have been the focus of recent debate on migration diplomacy (Adamson & Tsourapas, 2018; Greenhill, 2010; Thiollet, 2011; Tsourapas, 2019). Based on the case study of Jordan, Lebanon and Turkey, Tsourapas argues that 'refugee rentier states' engage in strategies of either 'back-scratching' based on bargaining, or 'blackmailing', based on threats, to attain concessions from more powerful states. Ultimately, the success of such strategies depends on the susceptibility of donor states to

the threat of refugees or migrants seeking asylum in their territories (Tsourapas, 2019). Indeed, successful outcomes in such instances of 'strategic engineered migration' have been defined as: 'persuading a target to change a previously articulated policy, stop or reverse an action already undertaken, or disburse side payments, in line with a challenger's demands; in other words, most of a challenger's demands were met' (Greenhill, 2010, p. 119).

Such dynamics are exemplified by recent negotiations between Turkey, which hosts the largest number of Syrian refugees world-wide, and the EU (Norman, 2019). In the face of a deepening stalemate across EU member states and a public backlash in response to the arrival of refugees, in 2016 the European Union signed the so-called 'EU-Turkey Deal'. As part of the deal, Turkey pledged to limit the departure of refugees towards European shores in exchange for economic and political concessions from the EU. These concessions included €6 billion in foreign aid and visa-free travel to Europe for Turkish citizens. In what has been defined as 'migration interdependence' (Adamson & Tsourapas, 2018), the interweaving of interests and power dynamics surrounding refugee protection lies at the core of this thesis.

In this section I have positioned migration and refugee movements within the realm of inter-state relations and North-South power asymmetries. Beyond the role of state actors, however, international non-state actors have an important and often overlooked part to play in the modern refugee system.

2.2 The politicization of the humanitarian system

Traditionally, humanitarianism has portrayed itself as a noble cause intent on relieving the suffering of countless individuals, and as far removed from the 'dirty business of power politics' (Khakee, 2018, p. 19). In this context, humanitarian actors rely on perceptions of their neutrality, impartiality and independence to ensure access to victims and to gain the respect and cooperation of various powerful state and non-state actors. As such, humanitarian actors present their actions as solely driven by humanitarian 'need' (Curtis, 2001). The fact that humanitarian activities are not driven by need alone, however, is hardly

new or surprising and has been analysed from various perspectives by various scholars (Curtis, 2001; Fox, 2001; Ticktin, 2014). As Donini writes: 'The manipulation of humanitarian action in support of political objectives is nothing new. What is new is the breadth and depth of the manipulation as well as the tightening web of connections with global political agendas' (Donini, 2010, p. 4).

In this section, I turn to an analysis of the development of humanitarianism since the end of the Cold War in what has become an increasingly politically charged space. In other words, how do humanitarian actors relate to other powerful actors in international politics? As scholars have argued, recent decades have witnessed a blurring of the boundaries between politics and the humanitarian space (Brun, 2016; Terry, 2002; Yamashita, 2015). Along with this shift, IR scholars have observed how the rapid proliferation of institutions and regimes in crisis settings has led to frequent competition and overlap among institutions and organizations delivering aid (Alter & Raustiala, 2018; Betts, 2013). In this context, I discuss the concept of 'regime complexity' to address the ways in which the politicization of the humanitarian space has affected the behaviour of humanitarian organizations.

Traditional versus 'new' humanitarianism

Recent IR scholarship acknowledges the role of international non-state actors as autonomous sites of authority which exercise considerable power within the international refugee regime (Barnett, 2012; Dadusc & Mudu, 2020; Ticktin, 2014). Since the end of the Cold War, scholars have observed a gradual shift in the principles and priorities of many humanitarian organizations, in particular when it comes to their wider engagement with international politics (Kennedy, 2004; Terry, 2002). From a focus on alleviating suffering in its most elemental forms, humanitarian objectives have evolved to include the responsibility to bear witness to atrocities and advocating for the respect of human rights (Yamashita, 2015). Within the context of a shifting world order, the disengagement of western governments from the geopolitical peripheries after the end of the Cold War left many humanitarian and development actors as the sole representatives of western powers in non-strategic countries (Duffield, et al., 2001; Fox, 2001). As a result, scholars have noted

a blurring of the distinction between politics, humanitarianism, and development assistance (Hoffman & Weiss, 2017; Ticktin, 2014). Moreover, the linking of development with global security concerns within policy discourses over the past two decades has transformed the remit of many humanitarian and development organizations from one of minimizing suffering to one of bringing 'order' to 'disorder' (Duffield, et al., 2001). Critics of this shift contend that, over time, humanitarian organizations have become an integral component of the ambitions of western governments to bring about peace, stability and liberal development (De Lauri, 2016; Duffield, 2014).

In particular, scholars have noted the ways in which humanitarian organizations have engaged in new forms of government. In this context, states have frequently been seen to outsource certain functions to NGOs, which have not only grown exponentially in diversity and number, but have also broadened and deepened the scope of their activities (Ticktin, 2014). Indeed, a large number of NGOs have begun to expand the range of their activities to include advocacy and lobbying for certain causes, and longer-term assistance for a wide range of issues (Yamashita, 2015). At the same time, organizations identifying with the emergence of a 'new humanitarianism' have shifted away from the original principles of humanity, neutrality, impartiality and universality to include a more critical stance in the face of injustice and human rights violations (Hilhorst, 2018; Hoffman & Weiss, 2017). While these principles served to ensure a separation between the humanitarian space and the realm of politics, the blurring of the boundaries between politics and humanitarianism represents the hallmark of the 'new humanitarianism'.

This blurring of boundaries has been attributed to two processes. First, the politicization of humanitarianism has seen humanitarian organizations embrace political processes and act as political actors through closer association with military actors, and through negotiations with warring factions to gain access to the field (Yamashita, 2015). Second, the 'humanitarization' of politics has frequently instrumentalized humanitarian action to serve the purposes of political actors (Donini, 2010). In the aftermath of 9/11, the concept of humanitarianism has been increasingly employed to justify military interventions around the world. And while the use of humanitarianism to justify military action has been widely

condemned, the lack of a clear definition and of conceptual boundaries of humanitarianism has been seen to increase the power of humanitarian actors (Watson, 2011).

Humanitarianism and regime complexity

Along with an increase in power of humanitarian organizations, scholars have noted the large number of humanitarian actors which have appeared on the international stage. According to recent estimates, there are more than 2,400 intergovernmental organizations and more than 37,000 organizations engaged in international politics (Alter & Raustiala, 2018). The frequent overlap in rules, laws, memberships and mandates among the various actors of this transnational community has been defined as a 'regime complex'. Initially defined as 'an array of partially overlapping and non-hierarchical institutions governing a particular issue area' (Raustiala & Victor, 2004, p. 279), regime complexes have since been redefined and expanded in various ways, and have engendered a significant growth in literature over the past 15 years. More recently, the broader notion of regime complexity has been defined as the 'presence of nested, partially overlapping and parallel international regimes that are not hierarchically ordered' (Alter & Meunier, 2009, p. 13). A more comprehensive definition by Orsini, Morin and Young introduces a regime complex as 'a network of three or more international regimes that relate to a common subject matter, exhibit overlapping membership; and generate substantive, normative or operative interactions recognized as potentially problematic whether or not they are managed effectively' (Orsini, et al., 2013).

Though definitions vary, some of the central components that make up regime complexity are the presence of multiple, overlapping, non-hierarchical regimes with a common subject (Alter & Raustiala, 2018; Orchard, 2017). In other words, the absence of a clearly defined hierarchy among institutions and rules means that there is no method for definitively resolving potential disputes over which rules, norms and decision-making procedures should be prioritized (Alter & Raustiala, 2018). As a result, various actors react strategically in ways which can both enhance cooperation and bring about conflict. Scholars have noted that regime complexity can present an advantage to actors with greater amounts of resources at their disposal. Powerful states can, for instance, engage in 'regime shifting' and

'forum shopping', which allows them to circumvent their obligations under one regime by strategically shifting their focus to another institution (Morse & Keohane, 2014).

The international refugee regime is a case in point. As discussed previously, the refugee regime emerged in the aftermath of World War II and is based on the 1951 Refugee Convention. In this context, UNHCR was established as the institution responsible for implementing the rules and norms of the refugee system (Orchard, 2017). In the ensuing decades, the refugee regime has seen a rapid proliferation of its institutions and has vastly expanded the issue areas it governs. In particular, the politicization and progressive securitization of refugees has created an overlap with international institutions focusing on migration and security (Betts, 2009). In other words, the large number of parallel institutions among various regimes allows states to circumvent UNHCR and the Refugee Convention, and to find alternative ways to prevent refugees from reaching their territories. This includes focusing on internal displacement as a means of providing 'protection in the region of origin' and thus preventing the onward mobility of persons seeking asylum in the Global North (Betts, 2009). As a result, scholars have recognized the role of regime complexity in influencing the strategies and behaviours of international organizations (Gómez-Mera, et al., 2020).

As Alter and Raustiala have it, regime complexity produces both winners and losers (Alter & Raustiala, 2018). According to realist perspectives in IR, the ability of states to 'forum shop' fundamentally disempowers traditional multilateral institutions (Drezner, 2009). Competing views, however, argue that regime complexity can also provide opportunities for non-state actors to become skilled navigators of a regime complex (Orsini, et al., 2013), and allows international organizations to act as organizers and managers (Margulis, 2013). In the case of the refugee regime, for instance, UNHCR has been seen as a 'challenged institution' which has developed certain strategies which allow it to continue to deliver assistance to the refugees under its remit (Betts, 2013). On the one hand, UNHCR has built stronger partnerships and has shared and coordinated its activities with other actors involved in humanitarian and development responses. On the other hand, UNHCR has expanded the scope of its work to other areas, including the protection of internally

displaced populations, a fact which carries the risk of undermining its core mandate of refugee protection (Betts, 2013). Similarly, the organization has been seen to engage with state actors through the use of 'issue-linkages' by advocating for the protection of refugees through causal links with other issue-areas such as human rights or security (Betts, 2013).

Scholars acknowledge that the politicization of issues and the widespread proliferation of institutions result in a greater scope for strategic behaviour among all actors. In what has been seen as a more challenging bargaining space, one of the established end results is an undermining of overall accountability (Alter & Raustiala, 2018). In the case of the refugee regime, strategies among non-state actors and, in particular, UNHCR to maintain their relevance in the eyes of states, have been seen as weakening overall accountability towards refugees (Gómez-Mera, et al., 2020). Moreover, despite greater recognition of the political influence of non-state actors on the domestic policymaking of recipient countries, by and large IR scholarship has tended to relegate the role of international organizations to one of subservience to other, more powerful state actors (Khakee, 2018). In other words, humanitarian and development actors are frequently regarded as strategic manifestations of the power and influence of donor governments, and as a means for enhancing the national security and hegemony of the Global North (Cuttitta, 2018; Dadusc & Mudu, 2020; Donini, 2010). Beyond IR, we must then look to studies on medical humanitarianism and global health to better illuminate the role of international organizations in allocating and delivering services to refugees.

2.3 Health in world politics

So far, I have reviewed state responses to the presence of refugees within the global political backdrop of North-South relations and unequal power dynamics. I now turn to one of the central themes of this dissertation: the inherently political dimensions which underlie global health and medical humanitarian responses. On a global scale we have seen a considerable increase in development assistance for health— from US$ 5.6 billion in 1990 (Ravishankar, et al., 2009) to US$ 23.9 billion in 2017 (Schäferhoff, et al., 2019). On the one hand, this has resulted in impressive public health gains, including the eradication of

communicable diseases such as polio from many countries, and a world-wide increase in life expectancy. On the other hand, scholars have begun to critically assess the political implications of global health financing and the allocation of health care resources in low- and middle-income settings (Panter-Brick, et al., 2014). As I argue in this thesis, the actors involved in the distribution and delivery of humanitarian assistance are also involved in the allocation of resources for health. In this regard, many of the considerations which apply to humanitarianism can also be analysed in the context of assistance for health. In this section, I begin by addressing the growing trend of securitizing health and health policies before discussing the role of global health within world politics.

From disaster medicine to medical humanitarianism

While the genealogy of the concept of 'disaster medicine' can be traced back to the early 20th century, the discipline only became institutionalized in the 1980s (Stehrenberger & Goltermann, 2014). In fact, before World War Two, the concept emerged mainly as a response to sudden disastrous events such as large-scale accidents and explosions in factories and mines (Good, et al., 2014). Disaster medicine then gained prominence at the height of the Cold War in the 1960s as part of a concerted effort to prepare for nuclear war. It was during this time that non-governmental organizations such as the Red Cross became increasingly concerned with training civilians in disaster preparedness, and, indirectly, with war, peace and civil defence (Stehrenberger & Goltermann, 2014). On an international scale, the Red Cross and other organizations such as Médecins Sans Frontières (MSF) began to inform humanitarian operations, especially in countries considered to be strategic within the complex spheres of influence among eastern and western powers (Gottlieb, et al., 2012; Panter-Brick, et al., 2014).

Notwithstanding the close links between military and humanitarian intervention, and the relevance of foreign policy for the deployment of disaster medicine, media and popular discourses tended to portray such operations as depoliticized and heroic (Gottlieb, et al., 2012). It was during this time that a 'new humanitarianism' emerged to counter the apparently neutral and impartial stance of 'classical humanitarianism' (Hilhorst, 2018; Yamashita, 2015). As part of the 'new humanitarian' stance, organizations such as MSF

actively engaged in attempting to determine the root causes of conflict and displacement, and played a greater role as advocates for victims. Indeed, a fundamental component of the mandates of 'new humanitarian organizations' includes bearing witness to and informing the public of human rights abuses and atrocities committed by states (Gottlieb, et al., 2012). In this context, the 'obligation to act' and to 'bear witness' in the face of large-scale suffering can be seen as countering the principles of state sovereignty (Stehrenberger & Goltermann, 2014). Despite the inherent tension between the two philosophical stances, medical humanitarian organizations from both spectrums of the 'traditional' and the 'new' humanitarian divide have continued to feature prominently in the provision of health and health care services to excluded populations in both developed and developing countries.

With the proliferation of medical humanitarian organizations and their growing role as service providers in international contexts, there has also been increasing recognition of the complex workings of international organizations in terms of activities and decision-making (Barnett & Weiss, 2008), in relation to state actors (Asad & Kay, 2014), and as political actors within processes of global health governance (Harman & Wenham, 2018; Lakoff, 2010). As Stehrenberger and Goltermann argue, understanding the historicity of disaster medicine as a political phenomenon and the role of discourses which deny or obfuscate its political nature is of fundamental importance (Stehrenberger & Goltermann, 2014).

Scholars have noted the rise of multiple forces which influence the role and responsibilities of the state in regulating, allocating, and delivering health services (Reich, 2002). In particular, international financial institutions (IFIs) such as the World Bank and the International Monetary Fund (IMF) have exerted considerable influence over the formulation of national health policies and priorities since the 1980s (Babb & Kentikelenis, 2018). Through the use of conditionality, IFIs have, over the decades, offered middle- and low-income states access to financial resources which are conditional on domestic policy reforms. Labelled as 'neoliberal policies', such reforms are broadly defined as 'any measure intended to lessen the role of states and enhance the role of markets in at least one national economy' (Babb & Kentikelenis, 2018, p. 16). Common reform measures have included the

privatization of public assets, austerity measures aimed at cutting public spending, and structural reforms such as trade liberalization and labour market reforms (Stubbs & Kentikelenis, 2017). Overall, critics contend that conditionality has had little success in promoting economic growth. To the contrary, evidence suggests that conditionality not only restricts the scope of state action and undermines national development agendas, but also increases inequalities and weakens human rights, including the right to health (Reich, 2002; Stubbs & Kentikelenis, 2017).

Beyond the role of IFIs, some scholars have pointed to the responsibility of international organizations in supporting processes of 'neoliberalization' and privatization (Babb & Kentikelenis, 2018; Stubbs & Kentikelenis, 2017). Indeed, some scholars argue that the political involvement of international organizations arises out of a historical necessity to compensate for weak 'state responsibility' based on the principle that 'states have primary responsibility for the welfare of refugees on their territory' (Slaughter & Crisp, 2009, p. 2). Others have pointed out the role of international organizations in replacing state functions as the main providers of services (Gottlieb et al., 2012) and in supporting the retrenchment of the welfare state (Chung, 2012). In particular, the presence of external financing and especially of Development Assistance for Health has been correlated with a decrease in national health spending (Global Burden of Disease Health Financing Collaborator Network, 2019). For instance, though ministries of health may remain committed to strengthening national health systems, ministries of finance may cut budgets based on the presence of external financing (Farag, et al., 2009; Lu, et al., 2010). In other words, evidence suggests that international aid tends to substitute rather than complement government spending on health.

Since 2001, there has been a renewed focus on disaster medicine along with an increased concern for national security and the need to protect western countries from the threat of pandemics (Harman & Wenham, 2018; Sjöstedt, 2010). Indeed, an analysis of the preferences and priorities of state and non-state actors would not be complete without an examination of refugee responses through the lens of an increasing securitization of refugees and health. Since the beginning of the 'Global War on Terror' in the aftermath of

9/11, 'security' and, in particular, 'national security' have become increasingly relevant concepts within analyses of forced migration and displacement. Health concerns expressed as existential threats frequently serve the purpose of pursuing security and other national goals within the international system (Rushton, 2011).

Global Health and security

Global health security scholars have begun to combine the notions of 'securitization' and 'health' to describe the increasing articulation of persons and health issues as security concerns (Emmers, 2019; Jin, 2010; Rushton & Youde, 2015; Wenham, 2019). Over the past decade, both global health threats – such as the spread of communicable diseases and pandemics – and refugee and migrant populations have been increasingly framed as existential threats to national and economic security due to their perceived potential to exacerbate conflict, increase poverty and terrorism, and inspire fear of diseases (Huysmans, 2006; Labonté & Gagnon, 2010; Loescher & Milner, 2005).

Scholars maintain that securitization can now be viewed as a permanent feature of public health governance (Yuk-ping & Thomas, 2010). In the US, for example, fears over the rapid spread of HIV/AIDS led to the disease being designated as a threat to national security (McInnes, 2006; McInnes & Rushton, 2012; Sjöstedt, 2010). More recently, the Ebola outbreak in West Africa in 2014 and 2015 became the second disease in history to be addressed by the UN Security Council and to be declared a 'threat to international peace and security' in Resolution 2177 (Kamradt-Scott, 2016; McInnes, 2015). Moreover, a perceived link between health and economic development has further strengthened the connection between health issues and foreign policy concerns. For instance, the perception that diseases can weaken state capacity and destabilise states has led to the rebuilding of health systems in Iraq and Afghanistan as part of counterinsurgency and nation-building efforts (Feldbaum & Michaud, 2010).

Though health securitization processes have led to an overall increase in global health financing in recent decades, this has also diverted funds from fundamental poverty-related issues towards individual, securitized illnesses such as HIV/AIDS or Ebola (DeLaet, 2014;

Stevenson & Moran, 2014). Indeed, global health priorities such as non-communicable diseases (NCDs), road traffic accidents, and social determinants of health have received comparatively little international attention and financing due to their lack of perceived significance for national security, economic well-being, and foreign assistance objectives (Feldbaum & Michaud, 2010).

According to some scholars, the securitization of global health risks has increased the authority of global health actors such as the WHO (Hanrieder & Kreuder-Sonnen, 2014). In this context, international organizations have been conferred with the power and authority to determine the existence of an emergency, and to set the agenda for state behaviour in times of crisis (Hanrieder & Kreuder-Sonnen, 2014). In what has been defined as an 'emergency trap', the articulation of health issues as global threats can have lasting institutional effects. In other words, the securitization of global health issues from the part of international organizations may lead to self-reinforcing tendencies which securitize further issues (Hanrieder & Kreuder-Sonnen, 2014). As scholars have cautioned, this authority can pave the way for the institutionalization of emergency powers among state and non-state actors, and condone the use of illiberal measures (Elbe, 2006; McInnes & Rushton, 2012; Yuk-ping & Thomas, 2010).

Others, however, have recognized the limitations of actors such as the WHO which rely on the financing of their member states (Harman & Wenham, 2018). Indeed, recent scholarship calls for a greater recognition of the co-dependency between global health actors and medical humanitarian actors. In this context, global health actors such as the WHO, which are necessarily political, rely on humanitarian actors to deliver services and to criticize the behaviour of state actors. Similarly, humanitarian actors rely on the WHO to coordinate and negotiate funding and to engage in state-based diplomacy (Harman & Wenham, 2018). Beyond the role of strictly medical humanitarian actors in delivering services to affected populations, it is thus necessary to analyse the ways in which global health actors such as the WHO directly engage in inter-state negotiations and participate in world politics.

Global health diplomacy

Building upon this research, recent scholarship has called for a greater integration of IR principles and theories within global health. In a context of emerging health alliances, new instances of South-South cooperation, and shifting donor-recipient relationships, health crises in many ways represent a battleground for global influence (Anderson, 2018). Similarly, global health challenges which transcend national borders call for more coordinated policy responses among the many actors involved in global health which, in turn, requires diplomatic coordination (Ruckert, et al., 2016). In this context, a theoretical focus on the emerging concept of 'global health diplomacy' (Ruckert, et al., 2016) is of particular relevance to this thesis. According to Smith et al., 'global health diplomacy' is defined as 'policy-shaping processes through which States, intergovernmental organizations, and non-State actors negotiate responses to health challenges or utilize health concepts or mechanisms in policy-shaping and negotiation strategies to achieve other political, economic or social objectives' (Smith et al., 2010, as cited in Ruckert et al., 2016 p. 62). In other words, not unlike the concept of 'migration diplomacy' explored in the previous section, 'global health diplomacy' can be seen as a reflection of the interests of powerful actors engaged in negotiating their respective positions in the current world order.

Similar to frameworks on 'migration diplomacy', conceptualizations of global health diplomacy are rooted within realist theories of foreign policy which see international politics as a struggle for power and survival among self-interested states (Anderson, 2018). In this context, the increasing securitization of health concerns can be used strategically by states to pursue national security or other foreign policy objectives (Ruckert, et al., 2016). Similarly, states may engage in global health diplomacy to further their influence and reputation (Feldbaum & Michaud, 2010; Ruckert, et al., 2016) or as attempts to sway global health agendas (Labonté & Gagnon, 2010). As a form of 'soft power', health interventions can be seen as instruments which advance foreign policy objectives. Such objectives include improving security, projecting power and influence, and improving a state's international image (Feldbaum & Michaud, 2010). Such instances have been observed in US military operations in which well-publicised health interventions have served strategic interests

aimed at 'winning hearts and minds' (ibid.). Similarly, Brazil has leveraged its model for fighting HIV/AIDS within South-South assistance as a means to improve its international diplomatic standing and to gain preferential access to new markets (Kickbusch, et al., 2013).

In an increasingly multipolar and globalized world, power and influence have been exerted in different ways by a variety of new and emerging actors (Kickbusch, et al., 2013; Harman & Wenham, 2018). Indeed, since the 1980s, scholars have observed the emergence of new players on the international stage along with a growing need for cooperation on global health (Kahler, 2016). In particular, the role of medical non-state actors in humanitarian crises has been the object of interdisciplinary studies across the social sciences (Gottlieb, et al., 2012; Good, et al., 2014; Stehrenberger & Goltermann, 2014; Ticktin, 2014). Despite the focus of recent scholarship on the growing role and responsibilities of non-state actors in global health governance processes, however, some scholars have questioned whether the shift of public health authority to a supranational level is as significant as it has been made out to be (Hanrieder & Kreuder-Sonnen, 2014). As political actors, NGOs find themselves in the difficult position of having to negotiate and cooperate with other powerful state actors, including donors and national authorities (Smith, 1989), while also competing with other organizations for limited funding and resources (Asad & Kay, 2014). In particular, funding structures compel NGOs to engage in power negotiations with state actors in order to influence national policies and to garner support for development projects. Moreover, international organizations such as WHO lack direct enforcement capacities to induce states to comply with their directives (Hanrieder & Kreuder-Sonnen, 2014). In this respect, evidence suggests that NGOs tend to be more successful when they adjust their discourses and align their priorities with those of the state, and eschew rights-based narratives which might directly or indirectly censure the actions of national authorities (Asad & Kay, 2014).

In sum, despite the rise in global health initiatives and institutions, by and large states retain control over the competencies of international organizations and of the state-level implementation of health initiatives. At the same time, however, NGOs find themselves in a privileged position which allows them to not only identify humanitarian emergencies, but also to determine an appropriate course of action (Hanrieder & Kreuder-Sonnen, 2014;

Wenham, 2019). An analysis of the securitization practices undertaken by humanitarian actors illuminates not only how humanitarians construct crises, but also the ways in which such constructions empower certain actors over others (Watson, 2011). This is particularly significant when analysing the effects of the politicization and securitization of humanitarian discourses upon the final recipients of humanitarian assistance: the refugees themselves.

2.4 Refugees, vulnerability, and the allocation of resources

In examining the political nature of forced displacement within the wider context of the global refugee system, what has emerged in this analysis is that refugees, health issues, and humanitarian assistance are clearly steeped in politics. What remains to be addressed is the ways in which such politics permeate the apparently apolitical methods designed to guide the allocation and delivery of humanitarian resources. On the one hand, we have seen how humanitarian actors present their activities as an objective response to humanitarian 'needs'. On the other hand, it is necessary to question the politics which underpin such assessments of 'needs' and the methods which are employed to measure and determine 'need', suffering, and, by extension, 'vulnerability'. Such an analysis requires a critical look at the concepts and labels which are employed to determine the allocation of resources and the levels of assistance that refugees are eligible for.

First, it is of central importance to determine who is – or is not – a refugee. In other words, who has a right to claim national and international assistance? According to the 1951 Refugee Convention, a refugee is defined as a person who:

> …owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it. (UNHCR, 2020, p. 14).

Moving beyond the narrow definition of refugees proposed by the Convention, there is widespread recognition of the inherently political nature of the 'refugee' label. On the one hand, labels present a necessary instrument for bureaucracies such as UNHCR and other international organizations to identify and select beneficiaries who are eligible for international assistance (Crawley & Skleparis, 2018; Janmyr & Mourad, 2018; Zetter, 2007). On the other hand, the very concept of labelling, 'is a powerful tool to explore the political in the seemingly apolitical arena of bureaucratic practices' (Zetter, 2007, p. 184). In other words, as I discuss in depth in this thesis, labels such as 'refugee', 'internally displaced person' (IDP), or even 'vulnerable person' more often than not reflect the values, priorities, and power dynamics of those who conceive them.

Some scholars have seen the expansion of the field of 'refugee studies' to the broader category of 'forced migration studies' as a case in point. From an academic standpoint, the new label has served to broaden the scope of inquiry to include asylum seekers, victims of human trafficking, and IDPs (Black, 2001). In practice, however, the subsequent expansion of UNHCR's mandate to include IDPs, in addition to refugees, in the late 1990s has been seen as inherently problematic. Indeed, an increased interest in the protection of IDPs has been viewed by some as a strategy supported by western states to prevent IDPs from crossing international borders – thus becoming 'refugees' – and seeking asylum in the west (Chimni, 1998). In other words, the concept of forced migration has been seen in many ways to reflect the geopolitical and strategic concerns of western states (Chimni, 1998).

As I explore in the following chapters, the labels and categories applied within a context of displacement are rarely objective or apolitical. To the contrary, labels frequently rely on 'predetermined stereotypes, inappropriately applied models from other cultures, crisis-imposed identities of powerlessness and dependency…' (Zetter, 1991, p. 60). In sum, the label of 'refugee' is not only a legal category which bestows certain rights and entitlements, but also a complex and necessarily problematic concept which both reflects and obscures the hidden power dynamics and politics of the international refugee system.

Beyond legal classifications such as 'refugee' or 'asylum seeker', recent scholarship addresses the ways in which categories and labels increasingly provide limited services to

select groups of refugees. As Holzberg et al. put it, the 'protection of some lives remains contingent on the deterrence of others' (Holzberg, et al., 2018, p. 536). In the wake of the European 'refugee crisis', for instance, evidence shows that media representations of refugees in 2015 and 2016 largely constructed migrants and refugees arriving in Europe as either 'vulnerable' or as a threat to the safety, economy and identity of receiving countries (Gray & Franck, 2019; Johnson, 2011). Ultimately, the ways in which refugees were perceived had significant ramifications as to which refugees received protection and access to services. Refugees perceived as 'vulnerable' have been seen to receive preferential access to benefits and entitlements, while refugees considered 'threatening' were largely relegated to the category of 'undeserving' (Gray & Franck, 2019; Sözer, 2020).

The notion of 'vulnerability' in refugee settings emerges as a significant concept which requires further analysis. Indeed, notions of 'vulnerability' have not only become central to the allocation of resources in refugee settings, but have also recently begun to attract scholarly attention. Moreover, and perhaps most importantly in regard to this thesis, depoliticized and technical approaches to measuring vulnerability fail to capture the essential power relations which constitute individual vulnerabilities (Cannon & Müller-Mahn, 2010). Rational and 'scientific' approaches to vulnerability conceptualize individuals as idealized actors who behave in optimal ways without accounting for individual rationalities and cultural and historical contexts (ibid.). Overall, the widespread adoption of a natural science perspective among policymakers and international organizations responding to crises has at times downplayed the significance of the economic and political conditions – including the power dynamics among self-interested actors – which alleviate or exacerbate individual vulnerability.

To date, research on vulnerability has been increasingly applied to refugee settings (Brun, 2016; Flegar, 2018; Janmyr & Mourad, 2018; Sigona, 2014). In Jordan and Lebanon, for instance, UNHCR and its partners have pioneered two evaluation models which guide the refugee responses: The Vulnerability Assessment Framework (VAF) and the Vulnerability Assessment of Syrian Refugees (VASyr) respectively. Rather than focusing on the inherent vulnerability of certain socially constructed categories of refugees based on gender and age,

these assessments provide an innovative, multi-dimensional framework for understanding the contextual factors which determine individual and household vulnerabilities (Brown, et al., 2019; Brun, 2016; Verme, et al., 2016). At the same time, however, scholars contend that the rise of 'humanitarian methodologies' which claim to capture and define universal humanitarian 'needs' through the use of quantitative data are simplistic and reductive (Glasman, 2019). As Glasman puts it, 'the more the definition of "needs" has been claimed to be applicable to all, the more it has been simplified, in an eternal search for the lowest common denominator of humanity' (Glasman, 2019, p. 2). Similarly, Janmyr and Mourad observe that constructions of 'vulnerability' in refugee settings not only determine access to varying degrees of humanitarian protection and support, but also reinforce perceptions of what a 'real' and, by extension, 'deserving' refugee looks like (Janmyr & Mourad, 2018). To paraphrase Crawley and Skleparis, such 'categorical fetishism' serves to divide refugees who are 'good' and thus worthy of support, from the 'bad' who seek economic advantages in their host countries (Crawley & Skleparis, 2018).

In particular, scholars have noted how perceptions of both 'vulnerability' and 'threat' can coexist within public debates surrounding a refugee population. Within public and media discourses, for instance, refugees are often portrayed as 'suspended between victimhood and malevolence' (Chouliaraki & Zaborowski, 2017, p. 616). In a study of UK media representations of refugees, Gray and Franck note how modern discourses are intertwined with ideas of racialized masculine threat and racialized feminine vulnerability (Gray & Franck, 2019). Within this gendered dimension, general representations of 'womenandchildren' (Enloe, 1993) depict women and children as a single category of passive subjects that are unable to participate in public discourse. Similarly, representations of refugee men tend to focus on threatening aspects of masculinity and aggression which limit the possibility of viewing men and, especially, young men as vulnerable (Turner, 2016). As Gray and Franck put it, such discourses reproduce 'the deeply rooted gender dichotomy between threatened and threatening racialized subjects, and obscure the possibility that male bodies, too, are weak and breakable in the face of war, intense cold or the ocean' (Gray & Franck, 2019, p. 281).

In sum, the concept of 'vulnerability' is not clearly codified within either academic research or humanitarian discourses. Differing and at times conflicting definitions of the term have led to diverging approaches to measuring and assessing vulnerability. In turn, this has led to varying constructions as to who is vulnerable and, in particular, *vulnerable to what* during a crisis. Across academic research, various fields emphasize differing facets of vulnerability. Some scholarship highlights the elements of risk which expose populations to catastrophic events, while other narratives focus on the outcomes of risk management. Across civil society reports, the media, and popular perception, vulnerability is often confused or equated with 'risk', 'poverty', 'need', or with a general perception of femininity, victimization and helplessness. This is particularly true of media representations, which frequently portray women and children as the ideal, vulnerable objects of humanitarian assistance (Freedman, 2019; Johnson, 2011).

I argue that the concept of 'vulnerability' plays a significant role in guiding humanitarian and development responses, and in identifying the multifaceted factors which affect individual 'vulnerability'. At the same time, the political nature of constructions of vulnerability which underpin refugee responses remains underexplored within current scholarship. As I examine in this thesis, uncritical readings of vulnerability obfuscate the asymmetrical power dynamics and institutional preferences which permeate the allocation of resources in refugee settings. In what follows, I outline the questions which have guided my research.

2.5 Research questions and conceptual framework

As discussed in the previous sections of this chapter, scholarship on the politics of migration has highlighted the commodification of refugees and human mobility as fundamental aspects of intra-state negotiations. As Thiollet puts it, 'migration policy should be analysed as an indirect form of foreign policy that uses the selection of migrants and quasi-asylum policy as diplomacy' (2011, p. 110). Within the politics of the Middle East, scholars have noted how 'refugee rentier states' hosting large numbers of refugees have frequently commodified refugee movements as bargaining chips to maximize benefits and

international concessions (Greenhill, 2010; Norman, 2019; Thiollet, 2011; Tsourapas, 2019). More specifically, emerging scholarship has emphasised the role and agency of refugee host states in the Global South in negotiating or renegotiating the stakes and balances of the international refugee regime (Adamson & Tsourapas, 2018).

The role and use of health policies towards refugees in host countries in the Global South requires further scholarly attention. Recent scholarship has emphasised how donor governments and national authorities have successfully integrated health within national foreign policy goals and diplomatic strategies due to its interlinkage with global security concerns, economic interests, and principles relating to social justice (Ruckert, et al., 2019). Yet little attention has been paid to an in-depth analysis of the politics of health and health care in a refugee setting. The research questions addressed in this dissertation are:

How has the increasing politicization of both refugee movements and global health influenced the priorities of the Syrian refugee health response in Jordan?

1. Have health care policies become instruments of migration diplomacy and, if so, how?
2. How do non-state actors negotiate and legitimize access to the humanitarian space?
3. How is 'vulnerability' constructed in the refugee health response?

To answer these questions, I examine the priorities and interests of three main groups of political actors engaged in the refugee response: (1) bilateral and multilateral donor organizations, (2) the Government of Jordan, and (3) international humanitarian and development organizations.

I identify two steps through which migration diplomacy and, by extension, foreign policy interests fundamentally influence spending priorities for health for refugees (see Figure 1). First, I distinguish the process of 'politicization', understood as the ways in which diplomatic aims, strategic interests, and relations between international donors and national Jordanian government authorities affect policymaking for health. I demonstrate that health policies affecting Syrian refugees have been subsumed within the foreign policy agendas of donor governments and refugee host states. Building on the concept of

migration diplomacy, I demonstrate how donors and host states instrumentalize not only refugee mobility, but also health financing as bargaining tools within inter-state relations.

Second, I analyse how such 'politicization' affects the 'prioritisation' of humanitarian spending and the distributional politics of the refugee health response. Drawing on the concept of 'regime complexity', I investigate how bargaining among state actors affects the behaviour of international organizations. In a context in which humanitarian and development organizations are increasingly subjected to the principles of the free market, my analysis demonstrates that international organizations have devised certain strategies that allow them to better negotiate access to the humanitarian space and legitimize their presence in Jordan.

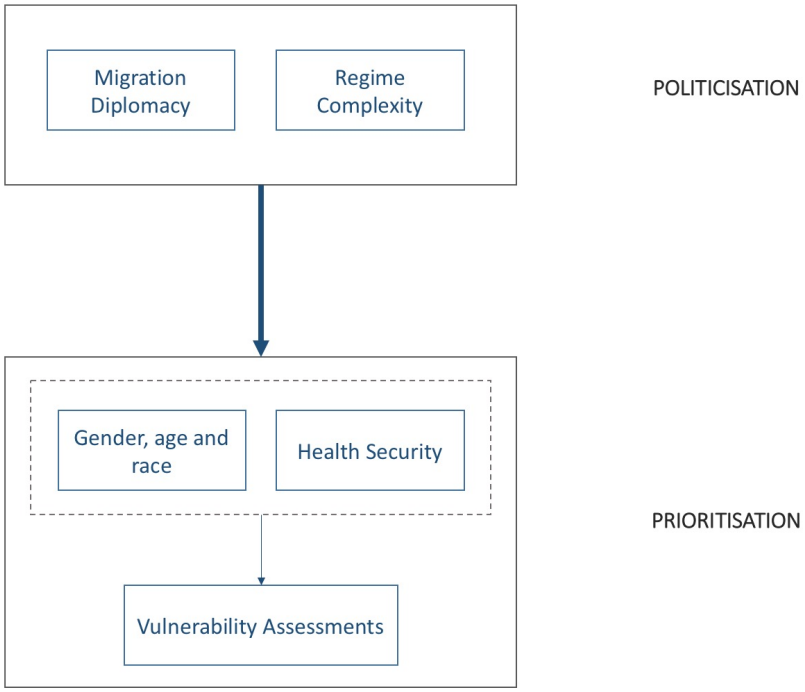

Figure 1: Conceptual Framework

Such strategies, however, can have intended and unintended consequences on the spending priorities of the overall health response. For instance, while international organizations select recipients of humanitarian assistance based on supposedly objective

criteria such as 'vulnerability' and 'need', I find that the interests of powerful states have a significant influence on which diseases and which refugee groups receive priority assistance. When political interests are combined with preconceived gendered and racialized notions of refugees and their 'vulnerability' among humanitarian actors, I find that certain demographics such as women and children are constructed as vulnerable and helpless. Others, such as young men and older people, are constructed as threatening, dangerous or low 'value for money'.

Overall, this research illuminates how international politics, security and diplomacy fundamentally influence spending priorities for health in refugee settings and how such processes produce and reproduce gendered and racialized constructions of refugees in humanitarian responses.

2.6 Conclusion

In this chapter I have engaged with the main theoretical debates which underpin my case study on Syrian refugees in Jordan. These include emerging research on migration diplomacy and global health diplomacy, and an expansion of critical approaches to the securitization of both migration and health. I base my research on theories which have emerged from IR and global health, which serve to explain the ways in which power dynamics and relationships between and among state and non-state actors within the international system have ultimately shaped humanitarian priorities for health care in refugee settings.

Despite progress in recognizing the complexity and multidimensional nature of vulnerability, studies have emphasized the presence of considerable gaps in the allocation of resources. For instance, research conducted by international organizations has shown that some groups, in particular older people and individuals with disabilities, are consistently overlooked in emergencies and face higher morbidity and mortality rates (Bolzman, 2014; Mokdad, et al., 2005; Thompson, 2012). In this dissertation, the case of older persons and, in particular, older Syrian refugees is used as a privileged example to illustrate how constructions of vulnerability have deep and long-lasting effects on the

degree of support and protection that categories of refugees receive within national and humanitarian responses.

My aim is to contribute to a better understanding of the political dimensions of global health within the international system and its role in shaping both national policies and inter-state relations. In the following chapters I examine the case of Syrian refugees in Jordan and analyse how the politics of health and humanitarianism have affected apparently objective and apolitical constructions of vulnerability and, ultimately, the allocation of resources to refugees.

Chapter 3 | METHODS AND RESEARCH DESIGN

This chapter outlines the methods I employed to answer the research questions presented at the end of Chapter 2. I begin by discussing the case study selection, its significance, and the generalizability of my findings. I then describe my methods, which include semi-structured interviews, document analyses, and participant observation, before addressing some of the challenges that I encountered during my fieldwork and the strategies that I employed to overcome them. Lastly, I turn to a discussion of the implications of my positionality and how it may have both facilitated and challenged data collection and analysis. I conclude by delineating the limitations of this study.

3.1 The case study approach

In this thesis I employ a case study approach based on an analysis of the policy priorities of the principal health actors involved in the Syrian refugee response in Jordan. A critique of case study research posits that data gleaned from a specific country context are not necessarily generalizable to other populations and contexts (Eisenhardt, 1989; Flyvbjerg, 2006; Meyer, 2001). And while this may be a valid observation, the purpose of this research is not primarily to derive generalizable knowledge from the specificities of the Syrian refugee response in Jordan, but rather to draw theoretical conclusions about the politicization of refugee responses.

In particular, scholars have stressed the positive contributions of case study research in the field of international relations (Bennett & Elman, 2007). To borrow Bennett and Elman's words, case studies can help illuminate the 'interaction effects among many structural and agent-based variables, path dependencies, and strategic interaction among large numbers of actors across multiple levels of analysis with private information and strong incentives to bluff or deceive other actors' (Bennett & Elman, 2007, p. 171). In other words, case studies not only provide a valuable, in-depth analysis of the asymmetries, power dynamics, and political motivations among individual actors, but can also improve our understanding of

decision-making processes in world politics. As the purpose of this research is to illuminate the often sensitive and politically-driven decisions and priorities which influence health policies in refugee settings, a case study approach serves to capture the nuances and implicit biases within the decision-making processes of elite actors and policymakers.

The selection of a single case study provides a significant tool for exploring sensitive decisions and processes, while also taking into account history and context (Meyer, 2001). Focusing on the complex workings of the humanitarian system in Jordan allowed me to not only provide an in-depth analysis of politically sensitive issues, but also to track changes and policy developments over time. For instance, after having completed the largest proportion of my interviews in 2017, I returned to Jordan in May 2018 to follow up on a sudden policy shift which had occurred at the beginning of the year. Similarly, a reversal of this policy in early 2019, which had significant implications for my research, prompted a third visit to the country. As David Collier put it, individual country case studies not only allow researchers to extract 'new ideas at close range', but also to 'see the general in the particular' (Collier, 1999, p. 4).

In this context, Jordan presents an important case study for an analysis of the growing politicization of refugee responses and health care policies. In a first instance, the country hosts the second-largest number of refugees relative to its national population of any country in the world. According to recent statistics, as many as 72 out of 1,000 residents in Jordan are refugees (Amnesty International, 2020). In the wake of the Syrian refugee 'crisis', Jordan has not only seen a rapid increase in international funding, but has also become a significant base for international organizations involved in the refugee response in the country and in larger regional operations. To the extent that hundreds of aid workers and a plethora of organizations (see Chapter 6) are currently operating in Jordan. As such, the development of complex coordination mechanisms and the close collaboration among state and non-state actors provides the perfect opportunity to observe the interaction, overlap, and frequent collisions among actors and their political interests. Moreover, Jordan's political and historical context makes this country a compelling case for the study of the impact of transnational dynamics on national policymaking. In particular, historical

dependency on foreign aid (see Chapter 4 for more details) and the country's position as a U.S. ally in the Eastern Mediterranean has important ramifications for its foreign policy decisions in the context of the Syrian refugee 'crisis'.

3.2 Methods

This research is based on six months of fieldwork in Jordan, divided between August to December 2017, and April to May 2018. I conducted a shorter trip in March 2019 in which I also attended a Lancet Palestinian Health Alliance conference on health and social policies affecting refugees in the MENA region. This research is based on a combination of methods which include semi-structured interviews, document analysis, and direct participant observation. While interviews form the basis of my research, a thematic analysis of relevant policy and advocacy documents along with participant observation helped to triangulate often competing versions of reality described in interviews. As most government ministries and international organizations are based in Amman, I spent most of my time in the capital.

Interviews

During my fieldwork, I conducted 61 semi-structured interviews with key informants, including government officials, senior officials from international organizations, and representatives from the largest and most influential international donor organizations (for a list of interviews, see Appendix A). Interviews with donors focused primarily on the health care funding landscape for 2017, the year in which I undertook the main part of my fieldwork. During this time, the top five donors which accounted for more than 66.6% of all aid funding to Jordan were: The U.S., the Government of Germany, the European Commission, the Government of Japan, and the U.K. (OECD, 2018). To ensure a comprehensive picture of the priorities and interests of these major players, I interviewed multiple representatives from each donor organization. As to state actors, I interviewed senior officials from the Ministry of Health, Ministry of Social Development, and from several semi-autonomous agencies. These agencies, including the High Population Council and the National Council for Family Affairs, function as policy advisers to the government ministries. Interviews with government officials were identified through a snowball

technique thanks to contacts provided by other interviewees at international NGOs which had established relationships with several government ministries.

Given the large number of organizations dealing with health, interviews with international NGOs occurred through purposeful sampling based on a list of all organizations participating in the UN Health Sector Working Group, which was provided to me by UNHCR (see Appendix B). This list included a total of 22 organizations, of which 19 agreed to participate in my study. I then interviewed at least one – but usually two or three depending on the size of the organization—of the most senior available representatives working on health issues. Interviewees ranged widely in terms of gender, age and nationality. Overall, interviewees from the NGO sector happened to be roughly balanced in terms of gender, though their nationalities ranged from Jordanian nationals to international staff from France, Germany, the U.S., the U.K., Japan and Italy among others. Most interviewees occupied senior positions which ranged from advisors and senior officers in charge of health programmes to country directors. My purposeful selection of senior staff members was based on the assumption that senior officials have more decision making power on issues affecting policies, and would be in a greater position to comment on the politics of high-level cooperation efforts with and among health actors and government authorities. Where possible, in this case as well, I interviewed at least two representatives from each organization to ensure greater validity and to include a plurality of perspectives (Meyer, 2001).

In addition to these three main groups of key informants, I also met with several academics working on health and refugees at the American University of Beirut, Lebanon. These informal conversations helped to gain feedback on my initial findings from other researchers in the field and to gain a perspective on the regional context beyond Jordan. Furthermore, before beginning my first round of fieldwork between August and December 2017, I had contacted an organization called HelpAge International, one of the only NGOs advocating for the rights and needs of older people in crisis settings. After several Skype conversations about the component of my research focusing on political constructions of 'vulnerability', which was of particular interest to the organization, I was allowed to join

the team in Amman as a guest researcher for the duration of the four months.

The amount of support I received from HelpAge staff was invaluable. I not only benefited from conversations with national and international staff members about the ways in which the organization negotiated its role within a crowded humanitarian space and strict government oversight, but also met many colleagues who guided me through the complexities of living in Amman. From discussing gender roles, cultural norms and religious practices, to pointing me towards the best *shawarma* in town, HelpAge staff members soon made the office my 'home away from home'. The office itself, a small building only steps away from the French Institute and the Paris Circle – one of the central hubs of Amman – offered the perfect location to access other NGO offices and the well-known Rumi Café, frequented by humanitarian and development staff members. As mentioned previously, colleagues who had well-established professional relationships with government officials were able to introduce me to the various ministries and help me to gain access to what would have been an otherwise impermeable space.

Interviews lasted on average 60 minutes and were conducted with prior ethical approval from the University of Cambridge. I usually met my interlocutors at their offices located in various neighbourhoods in Amman as this was convenient to them and afforded the most amount of privacy for the interview. In some cases, interviews took place in a café when offices were too crowded or, in particular, in the case of interviews with representatives from donor organizations based at embassies in Amman. Due to strict security regulations, gaining access to many of the embassies was time consuming and would not have permitted me to bring a phone or a recording device. Several interviewees thus suggested meeting somewhere nearby.

Before each conversation, I asked interviewees to sign a consent form which outlined the purpose of my research and emphasized the precautions which would be taken to protect the privacy and anonymity of all key informants. The form also requested consent for recording the conversation. Most interviewees, especially in the NGO sector, had previous experience working with researchers and were comfortable with signing the consent form. In some instances, however, interlocutors became extremely uneasy. In such cases in which

the consent form created a sense of mistrust which would have affected the interview, I agreed to forego a formal signature and opted for verbal consent instead. In several instances interviewees declined to be recorded in which case I took detailed notes which I transcribed immediately after the meeting. In addition to the consent form, I also presented interviewees with further details about my research, my contact information in Jordan and Cambridge, as well as the contact information for my supervisor and director of studies. I also reiterated verbally that the identity and, in many cases, the institutional affiliation of my interviewees would remain confidential, and that interlocutors were free to withdraw their consent for the interview at any time.

In order to make the most of each interview, I conducted previous background research and tailored my questions depending on the specialization and experience of my interlocutor, and their organizational affiliation. However, several of the main questions remained consistent across interviews so as to allow for the comparability of the data. These included questions about an organization's priorities for health, the interviewee's understanding of 'vulnerability' and target beneficiaries, and any changes in these priorities over time. To avoid any potentially 'leading' interview questions which might induce interviewees to tailor their responses to my specific research project, I not only started out each interview with a general (rather than overly specific) introduction to my research project, but also carefully planned the sequence of my questions beginning from broader and ending with narrower and more specific queries (see Appendix C).

A typical interview included a general introduction with a description of my research interests focusing on the priorities of the Syrian refugee health response. In the first part of the conversation I would ask interviewees to expand on their personal understandings of their organization's priorities, including target recipients and particular health issues, before following up on how these priorities came about and how they may have developed over time. I then asked interviewees to explain how their organization made funding decisions (in the case of donors) or how resources are allocated (in the case of international organizations). In all cases, I enquired about the strengths and challenges of collaboration among actors involved in the refugee response, and asked for concrete examples based on

interviewees' personal experience. In the second part of the interview, I enquired in more detail about which recipients of humanitarian assistance are considered 'vulnerable' and why, and whether some refugee groups which were rarely mentioned – such as older refugees and young men – were considered at all a priority. I would then probe further by enquiring whether the organization had any projects or funding specifically dedicated to these often underrepresented groups. In most cases, interlocutors recognized that such groups were indeed a priority, but then acknowledged that their organization had no specific projects, training or funding catering to the needs of these demographics.

Overall, I did not encounter major difficulties in securing interviews, aside from the usual frustrations of chasing down extremely busy staff members and dealing with last-minute cancellations. Despite the fact that I was often far from the first researcher to approach many of my key informants, I was surprised at how generous interviewees were with their time. At UNHCR, I was included in the Health Sector Working Group mailing list and invited to attend the group's monthly meetings held at UNHCR or WHO offices. This allowed me to not only gain a general understanding of the health priorities and projects being undertaken by NGOs across Jordan, but also to make personal connections with many of the participants with whom I was then able to secure an interview.

Participant observation

A second method was participant observation, which allowed me to observe the spontaneous interactions and decision-making processes among actors without influencing the dynamics or outcomes. One of the advantages of participant observation includes the possibility of observing group processes which may illuminate discrepancies between what interviewees say and how they act (Pettigrew, 1990). There are several forms of participant observation which range from covert participation, in which researchers conceal their intentions, to participant-as-observer interactions, in which researchers form relationships and participate in activities with the clear intention of observing them (Meyer, 2001). In my research, I employ a mixture of participant-as-observer approaches described above and simple observer interactions, in which I attended but did not participate in activities.

As discussed earlier, I spent several months as a guest researcher with HelpAge International. As a participant-observer there, I was invited to attend meetings and observe the ways in which staff members discussed their policy priorities, and framed their messages to their funders, national government officials, and the wider public. I was also asked to collaborate on two grant proposals. The first was a response to a call for proposals from UNHCR, while the second was a proposal for a project which required prior approval from the Government of Jordan. These collaborations allowed me to observe first-hand how international organizations frame their discourses and shape their activities to cater to the priorities of donors - or larger, better-funded international organizations such as UNHCR – and maximize their chances of gaining rapid government approval.

As a simple observer, I was invited to attend the UNHCR- and WHO-led Health Sector Working Group meetings. Held on a monthly basis at either the UNHCR or the WHO offices in Amman, the meetings were an excellent opportunity to observe the dynamics among the participants representing various NGOs working on health issues. Occasionally, representatives from the Ministry of Health or from various government advisory groups would also be in attendance which provided an excellent opportunity to analyse the interactions between NGOs and government authorities. National NGOs and local advocacy groups were absent from these meetings.

In all instances of participant observation, I would introduce myself as a researcher from the University of Cambridge and would take notes of what was said, and by whom, before following up with some of the participants individually. This provided valuable insight into the at times conflictual and competitive dynamics which emerged from the collaboration among various national and international actors.

Documents

In addition to qualitative interviews, I relied on quantitative data on overseas development financing supplied by the OECD and the WHO, as well as national statistics provided by the Jordanian Ministry of Health and the High Health Council. To triangulate the information gained from government officials during interviews, I also consulted national

policy documents relating to health which have been published over the past decade and are available online and in both Arabic and English.[3] In particular, the four iterations of the nationally-led 'Jordan Response Plan for the Syria Crisis' between 2015 and 2020, which contain requests for international assistance for health care for both Syrian refugees and Jordanian host communities, provided valuable information on government priorities. The analysis was conducted by reviewing the documents and, in particular, the mission statements, and coding the content in the qualitative data analysis software Atlas.ti. This served to highlight any policy shifts over time, and to search for references which might reveal implicit government attitudes towards the presence of Syrian refugees.

To better validate the information gained from interviews with key informants, I conducted an analysis of several advocacy and civil society reports. Throughout my research these reports provided valuable evidence that at times conflicted with what I had been told during interviews. In particular, reports by MSF, Amnesty International and Human Rights Watch provided important information about the context within which many national and international organizations operate in Jordan, particularly when it comes to such issues as freedom of speech and the ever-present possibility of illegal deportations of refugees back to Syria. Such documents served the dual purpose of providing background information which I used to structure my interview guides, and counteracting the individual biases which frequently emerged in interviews (Meyer, 2001).

As the situation in Amman is in a state of constant flux as regards policy developments and agreements among health actors, I kept abreast with these developments by monitoring major news outlets such as the Times of Jordan, The Guardian, and the social media pages of major UN agencies based in Jordan. I also conducted several formal interviews and

[3] These documents include: the 'National Health Strategic Framework 2008-2012,' (High Health Council, 2008) the 'National Strategy and Plan of Action Against Diabetes, Hypertension, Dyslipidemia and Obesity in Jordan (Government of Jordan, 2011),' the 'Ministry of Health Strategic Plan 2013-2017 (Ministry of Health of Jordan, 2013),' the 'National Strategy for the Health Sector 2015-2019' and, finally, the 'National Strategy for Health 2016-2020'. As several government policy documents on reforms and national agendas include sections on health care, these have also been incorporated in the analysis, including the 'National Agenda 2006-2015' and the 'Jordan 2025: A National Vision and Strategy' (Government of Jordan, 2015).

informal follow up conversations in 2018 and 2019 to gain further insight into evolving priorities, values, and dynamics as many of the Syrian refugees entered their sixth, seventh and even eighth years of exile in Jordan.

Research collaborations

Several consultancies and research opportunities which presented themselves during this time have helped shape and situate my research within a more regional and global context. In January 2018, for instance, I contributed to a report for the United Nations Research Institute for Social Development (UNRISD) focusing on social policy in the MENA Region with a particular focus on developments in Egypt, Jordan, Morocco, Oman and Tunisia.[4]

From September to December 2018, I was awarded a second term of an Alexander von Humboldt German Chancellor Fellowship[5] which allowed me to collaborate with the University of Bremen's Research Center on Inequality and Social Policy. As a guest researcher at the 'Global Dynamics of Social Policy' research consortium, I contributed a perspective on international influences on health care system development in middle-income countries in the Middle East. The results of these collaborations have served as a basis for setting my research on health care policies towards refugees in Jordan into a more global social policy context.[6] At present, I am a collaborator on a multi-country Global Challenges Research Fund project looking at the political economy of health in Jordan, Lebanon, Turkey and the Gaza strip. While the data from the project are not included in this thesis, this research has served as a framework for a better understanding of the impact of foreign aid and the presence of refugees on the national health care system. This has also

[4] The full report, 'New Directions in Social Policy in the MENA Region: Country Cluster Study of Egypt, Jordan, Morocco, Oman and Tunisia' can be found at: http://www.unrisd.org/unrisd/website/document.nsf/(httpPublications)/3A22EDA67CBDF1E7C1258386004F42D0?OpenDocument

[5] My research stay at the University of Bremen was awarded as an extension of a one-year Humboldt German Chancellor Fellowship which I held in 2012-2013.

[6] Results of the collaboration include the following publication: Lupieri S., Frisina Doetter L., (2020) 'Transnational Interdependency and Healthcare System Change: The Role of Humanitarian and Development Aid in Shaping Health Policy in Jordan', *Global Social Policy*.

helped to frame the perspectives of various health actors within the complex politics of health which guide the refugee response to the Syrian refugee 'crisis' in Jordan. In the following section I turn to the particular ethical implications of my thesis, my positionality as a researcher, and the limitations of this particular study.

Interpretation of the data

To analyse the ways in which health policies affecting refugees have become increasingly politicized and how these, in turn, influence humanitarian priorities, I employed an interpretivist approach based on Critical Discourse Analysis (CDA). In order to make sense of and interpret reality, interpretive approaches analyse the ways in which the researcher interacts with and potentially influences the studied world. Through a process of abduction, the approach then becomes an iterative back-and-forth between the theoretical framework, the lived experience of the research participants, and the socio-cultural and institutional context in which the researcher is embedded (Kurowska & Bliesemmann de Guevara, 2020). Moreover, qualitative interpretations guided by CDA reconstruct the ideologies and power relationships implicit within public and political discourse. In other words, CDA 'studies the way social power abuse, dominance, and inequality are enacted, reproduced, and resisted by text and talk in the social and political context' (van Dijk 2015, p. 352).

The objective of this analysis was, in a first instance, to reconstruct the ways in which an issue – such as a refugee 'crisis' or health 'crisis' – becomes recognized and defined as an actionable problem. For instance, how does the social interpretation of the presence of Syrian refugees as a 'crisis' and a security concern become widely accepted as legitimate? A central concept in critical work on discourse is that power can be understood as the ability of social groups and institutions to control various types of discourse. By this definition, those who are more powerful are able to control more – and more influential – discourse (van Dijk, 2018). As such, a CDA-based approach allowed me to trace the ways in which dominance, power, discrimination and control are manifested in the language employed by more or less powerful actors in refugee settings.

In a second instance, this research questions how power dynamics and inequalities within international politics shape the ways in which humanitarian actors make sense of their policies and priorities. How do foreign policy interests and assumptions about the 'value' of human life intertwine and ultimately determine which health issues are considered more urgent and which refugee groups more 'deserving' of humanitarian assistance? My evaluation thus employed conversation and textual analysis based on the use of diction, predicates, images and metaphors, as well as an analysis of language structure, based on frames, narratives and discourses presented within policy documents and interviews with elite decision makers.

An analysis of politics and power, however, does not occur in a vacuum. In addition to examining the language employed within the humanitarian response as a representation of the ways in which actors make sense and derive meaning from their lived reality, I consider context to be of fundamental importance (Wodak & Meyer, 2015). To this end, my analysis focused on the discursive elements that emerge from interviews and written texts as well as on participant observation.

Participant observation allowed me to not only analyse informal conversations and exchanges among actors, but also to observe and examine the context in which these conversations occurred. The four months of participant observation I spent at HelpAge International were fundamental to better understanding the context and power dynamics within which national and international staff members operate, and to better capture the narratives and frames that these actors employed to make sense of the often complex ethical dilemmas they faced within everyday conversations.

3.3 Ethics and positionality

In regard to my positionality in conducting interviews with experts and key informants, several factors came into play including my identity in terms of gender, nationality, former profession, and as a researcher from a U.K. university. For the most part, gender came to play a role when considering safety and travel arrangements. Though Jordan is generally considered a safe country for travellers and researchers, female researchers inevitably face

greater amounts of planning to account for safety and, as a result, additional expenses. Once in Amman, logistical challenges included a lack of readily available public transportation. While buses do exist, bus stops are not clearly defined, routes can be unpredictable, and no signage was available in English. Local taxis were also frequently unreliable.

Though gender clearly played a role in making the logistics more complex and expensive, I did not have the impression that this played a particularly important role in how I was perceived as a researcher. My dual nationality (Italian and American) and institutional affiliation with Cambridge University, however, may have played a larger role in providing access to interviews. As an Italian national, I believe I received a more positive reception among Italian NGO workers who form a tight-knit community and often meet at Italian-themed dinners and cultural events organized by the Dante Alighieri Society of Amman. Word of mouth and a sense of shared cultural identity meant that recommendations from members of the Italian community may have paved the way for some interviews and, in particular, for interviews with more senior officials.

To a lesser extent, this may have been true for some representatives of the US embassy and USAID who were extremely generous with their time and in some instances met with me more than once and referred me to other interviewees. Similarly, my affiliation with Cambridge gave credibility to my research and may have presented an advantage in securing interviews. These advantages, which are problematic when using the snowball technique, may have to some extent skewed my sample of interviewees. At the same time, however, a purposeful sampling method based on the official list of participants in the Health Sector Working Group and the top five donors contributing to the refugee response served to limit the effects of these biases.

As a former staff member at a UN agency, my positionality among key informants was somewhat more ambiguous. On the one hand, I felt more comfortable tapping into my network of former colleagues who introduced me to some of the key decision-makers in the field in Jordan. On the other hand, my position as a researcher and, in particular, as a student meant that I was no longer an ‘insider’ to what is an often hierarchical and tightly

guarded space among development workers and humanitarians. While occupying this interstitial space, I was cognizant of how my previous professional experience might influence my perceptions and interpretations of the data. Especially when it came to critiquing humanitarian and development responses, I often felt uncomfortable with academic discourse which levelled strong criticisms without proposing or contributing to a solution. At the same time, when my own critique of the humanitarian system emerged in my research, I struggled to balance an increasingly cynical view of the politics of humanitarianism with the often positive interactions I have had with dedicated officials who at times went well beyond their professional capacities to help others.

While ethical considerations and positionality in academic research are necessarily complex, as a western researcher from a UK university it is particularly important to address the preconceived notions which can arise in conducting research as an 'outsider' in an unfamiliar setting. Having worked as a journalist and in the development sector in unfamiliar contexts – including for instance in Armenia, Georgia and India – I was cognizant of the potential pitfalls of conducting research in a country of which I had limited first-hand experience. In order to minimize these effects, I spent the first year of the PhD programme conducting in-depth background research to situate Jordan within an historical and regional setting, which later informed my context chapter (see Chapter 4). Before embarking on my fieldwork, I also reached out to and had several Skype conversations with academics working on health and refugees in the MENA region. In many ways, I believe that my concerns over being underprepared pushed me to gain a better understanding of the specificities of the case study and to tailor my interview questions more successfully. As Lawson put it when recalling her research experience, 'I felt, much as other field workers before me, unfamiliar with the social world under investigation and a resulting sense of edginess, uncertainty, discomfort, and anxiety' (Lawson, 2000, p. 135). Overall, research in an unfamiliar setting, while certainly challenging, can invite greater critical scrutiny of the data and information partially because cultural and social events in unfamiliar settings are more visible.

3.4 Delimiting the case study

This thesis does not aspire to provide a complete analysis of all the factors which influence decisions and preferences of elite policymakers with regard to health policies for refugees. Rather, my focus has been on investigating the most significant political factors arising from fundamentally unequal power relations. Given the vast and complex architecture of the humanitarian and development response in any refugee setting and, in particular, in one that has been the centre of such media attention and public scrutiny as the Syrian refugee crisis, I have inevitably circumscribed my interviewees both by necessity and by design.

First, as this thesis focuses on an *international* level of analysis, interviews include international and national state actors. While not discounting the importance of domestic-level politics and influences (briefly addressed in Chapter 5), for the purpose of this research I view the Jordanian state as an international actor engaged in international policymaking. As a result, I do not include an in-depth analysis of the perspectives of Jordanian national and local civil society actors – save for the Jordanian NGO JHAS, which is considered to be a fundamental UNHCR partner in the health response. Similarly, interviews with refugees are not included in this analysis as the focus is on the political, macro-level factors which influence policy level decision-making. In this context, key informant and expert interviews are more appropriate for determining the interests and preferences of powerful actors and gaining insight into international processes, negotiations, and power dynamics.

Second, as this thesis focuses on the case of Syrian refugees, which make up the vast majority of refugees residing in Jordan, I do not include an in-depth analysis of policies affecting other groups such as Somali, Iraqi and Yemeni refugees to name a few. More specifically, Iraqi refugees are mentioned briefly insofar as they have been largely forgotten in the overall refugee response and do not enjoy the visibility of their Syrian counterparts. Palestinian refugees and their descendants are mentioned in Chapter 4 to better illustrate the historical backdrop which positions Jordan as a prominent receiving and exporting

nation of migrant labour. Overall, when it comes to health care policies, most refugee groups aside from Syrians and some Palestinians are considered 'foreigners' and have little or no access to subsidized services.

Third, it is important to address the limitations surrounding the availability and reliability of quantitative data in Jordan. In particular, national statistics including on the total number of Syrian refugees residing in Jordan, on national budgets and expenditures, and population statistics should be handled with a degree of caution. Such statistics have been known to be unreliable and, at times, manipulated for political advantage. Similarly, tracking funding flows from donors, UN agencies, and private groups which support various funding streams including humanitarian, development, bilateral, and multilateral streams, are notoriously difficult to keep track of. Part of the challenge lies in a lack of transparency in accounting mechanisms, and the use of different accounting systems, which often duplicate funding flows or exclude certain forms of funding such as funding from Gulf donors, national budgets, or development funding (Culbertson, et al., 2016). Moreover, data collected by international organizations such as the World Bank and the WHO are not only based on government statistics, but also present a considerable delay in reporting. At times the most recent available statistics range from between five to 10 years old, which, in a rapidly evolving refugee setting characterized by sudden and unpredictable policy changes, can present a considerable gap. As a result, while data used in this thesis reflect the best possible available sources, I cannot rule out potential inaccuracies in reporting.

3.5 Conclusion

In this chapter I have provided an overview of the methods I employed in my research as well as addressed any ensuing ethical considerations and positionality as a researcher. In particular, I contend that the use of semi-structured interviews with elite decision-makers provides the most effective means for establishing how and why actors involved in the refugee response decide to allocate scarce resources for health care. Surprisingly frank conversations with donors, national policymakers, and humanitarian and development

actors have highlighted some of the complex factors which influence and, ultimately, affect decision-making in refugee settings. As I will discuss in depth in the following chapters, the data gleaned from my interviews, in addition to an analysis of national policy documents, form the basis for my investigation of the distributional politics which affect the lives of Syrian refugees in Jordan. In what follows, I contextualize my arguments via an analysis of the historical antecedents of recurring crises in Jordan, and of the contemporary pressures for transformation brought about both by the large presence of international actors operating in the country and by popular demand.

Chapter 4 | AT THE CROSSROADS OF THE MIDDLE EAST: REFUGEES, REGIONAL INSTABILITY, AND THE RIGHT TO HEALTH IN JORDAN

This chapter provides an historical overview of the political and economic backdrop to the development of the nation-state since Jordan's declaration of independence in 1946. Within a context of recurring regional instability, political crises, and refugee movements, I argue that Jordan's ambivalent policies towards refugees and migrants represent an historical continuity of welfare policies aimed at excluding large parts of the population based on national origin. While mainstream narratives among donors and humanitarian responders have largely constructed the presence of Syrian refugees in Jordan as a 'crisis' and, more specifically, a 'health crisis', this chapter demonstrates the ways in which Jordan has, over time, attempted to capitalize on the recurring presence of refugees within its territory.

Such attempts at 'refugee rentierism', however, do not occur in a vacuum. Rather, they are situated within an historical context shaped by colonial legacies, existing migratory practices and understandings in the region. To date there is a dearth of scholarship that systematically contextualizes the politics of migration and social policy in Jordan within the wider experiences of colonial and postcolonial nation-building, welfare state formation, and development trajectories. Indeed, historical interpretations of the development of migration and social policies in the region have mainly emerged from the Global North and frequently rest on data gathered by international financial institutions such as the World Bank and the IMF. Despite the limitations and the contested nature of the source material, what becomes evident in this analysis is the ways in which refugees, international actors, and humanitarian aid have become deeply intertwined with the historical context of domestic politics and policymaking in Jordan.

In what follows, I situate the arrival of Syrian refugees within an historic context characterized by frequent and recurring refugee 'crises' and considerable dependence on foreign aid. I then provide an overview of the development of the health care system since the country's declaration of independence in 1946 to the present, and a snapshot of the

current health care system and the impact of the arrival of Syrian refugees beginning in 2011. Lastly, I describe the overall architecture and structure of the medical humanitarian and development response. While Jordanians and Syrians generally face different conditions and eligibility criteria in accessing services, this chapter provides a more complete picture of how national and international medical responses for refugees have – or in many cases have not – been integrated into the national health care system and strategic plans of the host country.

4.1 Regional instability and dependence on foreign aid

The Hashemite Kingdom of Jordan has undergone several periods of rapid and at times sudden transformation from its inception to the present day. From abrupt fluctuations in population demographics due to refugee flows and border expansions and retractions, to recurrent economic crises, both external and internal shocks have influenced the course of national policymaking. A combination of factors, including the country's colonial legacy, its lack of natural resources, and its strategic geopolitical position in the region, has led to a continuous presence and influence of external state and non-state actors. International organizations such as the Red Cross and the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) have been operating in Jordan since the end of World War II. Moreover, while it is difficult to trace external funding flows due to a lack of a unified financial tracking systems, World Bank reports and OECD statistics on overseas development aid point to a marked reliance on international support (World Bank, 1951).

The decades following independence were characterized by a time of radical transformation, instability, and an alternating expansion and retraction of the state as the provider of services and protection for both refugees and Jordanian nationals. Recurring armed conflicts, political regime change, and the arrival of large numbers of Palestinian refugees ensured the continued presence of international organizations and the financial support of bilateral and multilateral institutions. An initial open-door policy towards Arab migrants, which supported the Hashemite Kingdom's pan-Arabist aspirations, saw a first

wave of refugees from Palestine settle in Jordan in 1948 (De Bel-Air, 2016; Thiollet, 2011). The new arrivals, who became naturalized Jordanian citizens, nearly tripled Jordan's population (Massad, 2001). Despite granting citizenship, however, Jordan's policy towards Palestinian refugees supported their right to return and rejected the 1951 Convention and its 1967 Protocol. To date, Palestinian refugees are still considered the responsibility of a dedicated UN agency – UNRWA (De Bel-Air, 2016).

In 1951, the assassination of King Abdullah and the subsequent deposition of his son Talal brought about the reign of King Hussein in 1953. During this time, strong anti-colonial sentiments swept away the last vestiges of the British presence in Jordan and called for democratic reforms (Massad, 2001). However, fearing that the existence of the monarchy itself was in peril, Hussein, aided by American and British allies, staged a palace coup and ushered in a new era of repression whose political repercussions are arguably still felt in the country today (ibid.).

The 1960s continued along this vein of instability and unrest. The 1967 war with Israel concluded with the loss of the West Bank and, as a result, the demographic and geographic contraction of the Jordanian state. At the same time, the rise of the Palestinian Liberation Organization (PLO) called into question the Jordanian identity of millions of Palestinians living in Jordan and the West Bank, and posed a threat to Jordanian sovereignty (Fruchter-Ronen, 2008). To the extent that, after the outbreak of armed conflict between the Jordanian army and PLO militias, the regime intervened to crush the Palestinian uprising. A subsequent period of 'Jordanisation' saw the Palestinian Jordanian component of the population subjected to increasingly discriminatory measures including restrictions to opportunities in the public sector, academia and in government participation (Fruchter-Ronen, 2008).

Despite this turbulent political backdrop, the 1950s and 1960s marked a period of economic expansion and average growth rates of up to 9%. This was accompanied by an expansion of social policy measures funded in part by international donors and development organizations. At the time, financial aid flowing into the country was so substantial that a World Bank report painted a bleak picture of the country's economy:

> The Kingdom has been unable to provide productive employment for most of the Palestinian refugees living within its borders who account for roughly one-third of the population; a high rate of population growth, thought to be 3%, has further aggravated this situation…As a result, Jordan has always been heavily dependent on foreign aid, which has been forthcoming on a rising scale.
>
> (World Bank, 1961, p. iii)

The 1970s and early 1980s were a time of relative stability, in which Jordan enjoyed a period of rapid economic growth due in part to remittances paid by Jordanian labour migrants working in more prosperous Gulf states and to foreign aid provided by Gulf states and the U.S. Thanks to the sudden rise in oil prices, the demand for Jordanian workers reached its peak in the early 1980s when close to one-third of the Jordanian labour force was working in oil-rich Arab states in the Gulf region (Harrigan, et al., 2006). In economic terms, this meant that an average of US$ 918 million per year was injected into the Jordanian economy under the form of remittances between the mid-1970s and mid-1980s, constituting more than 21% of Jordan's GDP (Harrigan, et al., 2006). Between 1972 and 1982 Jordanian GDP grew at an annual rate of 7.9% and real per capita GDP also grew by an average of 3.7% per year leading to an improvement in living standards for most Jordanians (ibid.). From a social policy and health policy perspective, this was a time of rapid growth in which priorities such as employment, greater equality and poverty reduction were at the forefront of the development agenda. As a result, poverty rates declined from 24% in 1980 to less than 3% in 1987 (Harrigan, et al., 2006).

In a continuation of the policies implemented in previous decades, the 1970s and 1980s saw an expansion of the civil and social rights of citizens, with women gaining the right to vote in 1974 (Massad, 2001). While exact population data are hard to come by, a 1991 report commissioned by the U.S. Library of Congress estimated that close to 2.9 million people resided in Jordan in 1987 (Metz, 1991). Compared to the early days after independence, the population had not only increased by a factor of seven, but had also largely transformed from a rural to an overwhelmingly urban population, with 70% of residents living in cities

(Metz, 1991). A decline in the crude death rate, reduced infant mortality rates, and higher life expectancy meant that the annual population growth rate remained high. By the end of the decade, more than half of the country's population was below 15 years of age.

Despite improvements in living conditions, however, standards varied greatly between the upper- and middle-class urban population, and Jordanians and Palestinians living in rural areas or refugee camps. Life for the rural poor and refugees was characterized by a lack of running water and by open sewage in the streets (Metz, 1991). Moreover, the country's economy continued to be largely dependent on foreign sources of income in the form of foreign aid and remittances from Jordanians working in Gulf countries. Defined by some as a 'non-oil rentier economy' (Beblawi, 1987), Jordan's foreign sources of income made up 54% of its budget with 40% of its labour force working outside of the country in 1980 (Baylouny, 2008). In part as a result of its dependence on foreign income, skewed labour market incentives led to a decline in agriculture, the neglect of rural areas, and a bloated state bureaucracy (Baylouny, 2008).

By the mid-1980s, the country's fortunes had reversed leaving the economy on the brink of collapse. The sudden drop in oil prices in 1983 led to economic stagnation across the region. Demand for Jordanian workers decreased, and remittances became less predictable. Furthermore, the Iraq war against Iran diverted the attention of wealthier Arab countries from delivering development aid to Jordan. Between late 1988 and early 1989 the Jordanian Dinar lost almost 35% of its value and caused a 25% rise in prices (Harrigan, et al., 2006). A year later, with the banking sector in disarray, the currency had lost almost 50% of its value (ibid.). By the end of the decade, spiralling foreign debt led Jordan to seek financial support from the World Bank and the IMF, a move which would influence both economic and social policies for decades to come (Martínez, 2016).

The 1990s and 2000s were thus characterized by problematic social and economic reforms based on structural adjustment plans negotiated with the IMF. An initial period of liberalization of the financial sector in the early 1990s saw the privatization of public sector investments in telecommunications, water, electricity, and even the national Royal Jordanian airline (Baylouny, 2008). Under the leadership of King Abdullah II, who ascended

the throne after Hussein's death in 1999, Jordan experienced a period of more intensive reforms, including the politically problematic removal of major food subsidies (Martínez, 2016). Following IMF and World Bank guidance, Abdullah II proceeded to push for greater privatization, trade liberalization and civil and military pension reform (Martínez, 2016). The combination of the reform process and significant financial assistance from the World Bank and the IMF helped boost the economy to an annual average growth rate in GDP of 5.4% between 2000 and 2004 (Harrigan, et al., 2006).

Despite the gradual economic recovery, however, the structural adjustment programmes and austerity measures largely imposed by the IMF have had long-lasting consequences for the Jordanian population. Throughout the 1990s, Jordan was plagued by rising poverty and unemployment rates, soaring prices for basic necessities, and a growing divide between the wealthiest citizens and the most vulnerable (Baylouny, 2008). Between 1992 and 1997 Jordanians saw prices double on food, education, rent and health care, accompanied by a progressive decrease of per capita income – from $1,500 in the mid-1980s, to $850 in 1998 (Baylouny, 2008). To aggravate matters, the spill over effects of the First Gulf War led to the sudden return of more than 300,000 Jordanian labour migrants, which increased the labour force by 30% between 1992 and 1995. The termination of financial assistance from the US and its Gulf allies further affected the economy and contributed to a drastic reduction in revenue from tourism (Harrigan, et al., 2006). From the almost complete eradication of poverty in the country a few decades earlier, by the year 2000 approximately one-third of the population was deemed 'poor' (Baylouny, 2008).

In 2003, the Second Gulf War and the collapse of Saddam Hussein's regime brought hundreds of thousands of Iraqi refugees to Jordan. Once again, Jordan's ambivalent policies towards refugees came to the fore. Initially, fears over the long-term settlement of Iraqis in Jordan led the government to downplay the number of new arrivals and to label them as 'guests' rather than 'refugees' (De Bel-Air, 2016). Subsequently, however, a policy of inflating the number of Iraqi refugees proved to be an economic opportunity for increasing international assistance (Gibson, 2015). Overall, foreign policy decisions, including cooperation with the U.S. War on Terror in the wake of September 11, 2001, and in the

Second Gulf War, led to significant amounts of international aid, and made Jordan one of the highest recipients of development aid from the U.S. in the world (Harrigan, et al., 2006).

In the long run, neo-liberal reforms implemented in the 1990s and 2000s did not lead to sustainable growth (Abugattas-Majluf, 2012; Zureiqat & Shama, 2015). Despite incremental improvements in political representation and economic wellbeing among the general population (Zureiqat & Shama, 2015), Jordan remained plagued by high unemployment and dependence on foreign aid. Fiscal and monetary austerity measures appeared to lead to recession and unemployment, while drastically cutting social services such as health care and failing to raise living standards (Jawad, et al., 2018). While GDP has more than tripled since 2005 and now accounts for close to US$ 37.5 billion, levels of GDP per capita have remained nearly stagnant at under US$ 5,000 over the past decade (United Nations, 2018). At the same time, unemployment rates have continued to rise and now include one of the highest youth unemployment rates in the world, at 36% among people aged 15 – 24 (World Bank, 2017).

Recent public protests in 2011 and 2018 emphasised the frustration and disillusionment of a population facing high costs of living and a reduction in wages, welfare services and subsidies (Salameh, 2018). Austerity measures advocated by the World Bank and the IMF have contradicted government policies calling for an expansion of universal health coverage (al-Saadi, 2014; Harrigan & El-Said, 2014). While such measures strengthened safety nets for some of the poorest and most vulnerable sectors of the population, they concomitantly cut back services and increased out-of-pocket expenses for the majority of Jordanians (Awad, 2017; Salameh, 2018). Furthermore, increased fears over security and national stability have contributed to marginalizing the needs of a large Palestinian and Syrian refugee population.

The 'Palestinian question' continues to remain unresolved in Jordan. Over time, the PLO-Israel Oslo agreements in 1993 and the Wadi Araba Accords signed between Jordan and Israel in 1994 *de facto* settled Palestinian refugees from 1948 in their host countries (De Bel-Air, 2016). As a result, Palestinian refugee camps have become integrated into urban landscapes across Jordan. Though an estimated 90-95% of refugees from Palestine have

been granted Jordanian citizenship, UNRWA representatives contend that Palestinians are far from integrated. A refugee from Palestine and former senior medical officer put it eloquently: 'You can ask other Palestine refugees as well. Yes, they are Jordanians, but if you ask them where their home is they tell you that it's on the other side of the [Jordan] River in Palestine…so they will never accept that they are normal Jordanians.'[7] Moreover, representatives from UNRWA point to systemic discrimination against Palestinians who are largely excluded from prestigious employment opportunities in the government and military and, in the case of Syrian refugees of Palestinian origin, have been turned back at the border or forcibly repatriated. As one official explained:

> I know of many cases who were repatriated because they were Palestinian. Discrimination is a policy now. The Palestinian situation is very sensitive because Palestinians are becoming a majority and Jordan wants to maintain its identity. There is a concern that Palestinians from Syria may remain because of family ties in Jordan.[8]

Meanwhile, Palestinians and Palestinian-Jordanians remain under the protection and responsibility of UNRWA and are largely split between various legal and political categories which afford various levels of access to services, including health care. With peace processes stalled for the foreseeable future, the issue of Palestinian refugees in Jordan remains a contentious one. As an UNRWA official stated: 'UNRWA exists until there is a durable solution for the Palestinian situation.'[9]

In conclusion, the significant presence of refugees, international donors, and international organizations has been a constant feature throughout the Kingdom's recent history. Most importantly, the frequent and recurring presence of large refugee movements has fundamentally altered and shaped Jordan's population and national identity from independence to the present date. At the same time, the considerable presence of

[7] Former medical officer, UNRWA, Amman, December 2017

[8] Former senior medical officer, UNRWA, Amman, December 2017

[9] Former senior medical officer, UNRWA, Amman, December 2017

international organizations and the continued flow of overseas development aid to Jordan has had mixed effects. On the one hand, external actors and funding contributed to Jordan's economic growth in the 1970s and early 1980s (Awad, 2017; Harrigan, et al., 2006). On the other hand, critics of the IMF and the World Bank's structural adjustment programmes, which ushered in a climate of austerity and unpopular market reforms, suggest that these policies were not only unevenly implemented, but also contributed to the country's economic woes (Abugattas-Majluf, 2012; al-Saadi, 2014; Martínez, 2016). Overall, unsustainable economic growth is deemed to have contributed to the country's continued dependence on external support to the present day (Awad, 2017).

When it comes to policies affecting access to services for migrants, the presence of large numbers of refugees has brought about parallel systems which cater to the needs of the large Palestinian population, to Syrian refugees, to Jordanian citizens, and to a subset of the migrant and refugee populations considered 'foreign'. In the section that follows, I provide a snapshot of the development of the current health care system and present-day demographics, along with an overview of evolving objectives surrounding universal health coverage.

4.2 The development of the health care system

In 1947, Jordan counted fewer than 400,000 inhabitants (Samha, 1990). In 2017, the most recent population census estimated the total population to have reached more than 10 million (Department of Statistics and ICF, 2018). This rapid increase is due in part to higher life expectancy rates of 74 years for both men and women, high fertility rates of 3.4 children per woman, and the arrival of refugees from Palestine, Syria and Iraq which now account for as much as 30% of the population (ibid). In recent years, Jordan has begun experiencing a demographic and epidemiological transition typical of many middle-income countries: an estimated 6.5% of the population is now above the age of 60 (Department of Statistics and ICF, 2018), and non-communicable diseases such as cardiovascular diseases, diabetes, cancer and respiratory diseases are responsible for 78% of deaths (Nazer & Tuffaha, 2017; WHO, 2018).

When it comes to health and health care policies, both donors and international organizations have played an integral role throughout the country's history since independence from British administration. While an early, rudimentary health care system before independence mainly served to protect British nationals living in Jordan and to provide charitable care for the destitute, it was only after independence that a more complex system began to take shape (Jawad, et al., 2018). As in the case of other former British colonies such as Egypt, Iraq, and Sudan, Jordan maintained continuity with its colonial institutions and followed a model of health care system driven and regulated by a strong public sector, and financed by the treasury (Kronfol, 2012).

In the late 1940s, in a new era of independence and relative stability, most MENA countries began to expand the health coverage of their respective populations by implementing new social and economic development agendas. Similarly, under the leadership of its national government, Jordan began to increase social protection for various categories of workers and expand its employer-based insurance schemes (Kronfol, 2012). Following trends developed in Europe, the idea of health care as a universal policy began to take hold as states gradually moved from a paternalistic understanding of health care services as a form of charity to the view of health as an entitlement (ibid.). Indeed, government expenditure increased more than five times between 1950 and 1955 (World Bank, 1957). By early 1955, Jordan had 43 hospitals, 16 of which were public (ibid).

Despite the growing role of the public sector in health care reform, however, the Jordanian health sector was fragmented since its inception. A large proportion of health care improvements and public health reforms were led by external non-state actors such as UNRWA and WHO. In 1955, UNRWA not only operated several medical clinics, but also provided physicians and subsidized both government and private hospitals. Its successful anti-malarial programme transformed the Yarmuk-Jordan Valley – one of the most hyper-endemic malarial areas in the world – allowing the government to gain control over the disease (World Bank, 1957). Other instances of collaboration between the Ministry of Health, UNRWA and WHO improved living conditions in refugee camps, promoted health education, ran vaccination programmes, and conducted insecticidal campaigns (ibid.).

Overall, the nascent Jordanian health care sector remained largely dependent on foreign aid, mainly from the U.K., the U.S. and UNRWA (World Bank, 1951). Since the very beginning, health care services in Jordan were divided between the public sector, the private sector, services provided for the Palestinian refugee population, and international religious and secular NGOs such as the Red Crescent, Save the Children Fund and the Near East Christian Committee (ibid.).

Indeed, before the IMF-supported economic reforms described above, the legitimacy of the government largely rested on the understanding that the state would provide economic goods in return for political loyalty (Harrigan & El-Said, 2014). Widespread clientelism ensured that social groups which were crucial to the state obtained coveted public sector employment and, by extension, access to social insurance and health care. In what became a largely 'dual system' of welfare provision, a minority of workers in key employment sectors benefited from social policies, leaving the majority of the population with minimal or no coverage (Baylouny, 2008). In the aftermath of the economic crisis of the 1980s, structural adjustment continued to erode health care standards while largely investing in the military and security services (Harrigan & El-Said, 2014). Some populations, such as Jordanians of Palestinian origin who are largely employed in the private sector, continue to be excluded from public health insurance schemes and rely on pay-as-you-go schemes (Gabbay, 2014). For the very poor, free or subsidized health care is offered by the Ministry of Health (Jawad, et al., 2018).

To date, Jordan continues to struggle to implement universal health coverage to a population facing high rates of poverty and unemployment, and high levels of participation in the informal labour market (Zureiqat & Shama, 2015). According to the most recent data, only approximately 55% of the total population is covered by formal health insurance, including government-sponsored insurance, private health insurance schemes, and insurance provided by UNRWA to Palestinian refugees (High Health Council, 2016). Of those who have health insurance, of whom 70% are Jordanian citizens, the majority are either covered by the Health Insurance Fund run by the Ministry of Health, or the Military Health Insurance Fund run by the Royal Medical Services. Private medical insurance covers

a remaining 12.5% of the insured population, while approximately 2.5% are covered by UNRWA for primary health care services (Nazer & Tuffaha, 2017). For Jordanian citizens classified as 'poor', the Ministry of Health waives out-of-pocket expenses and offers free treatments for certain conditions such as cancer, dialysis, AIDS and addiction (Ajlouni, 2011).

Recent reforms to the public Health Insurance Fund have expanded coverage to include all children under the age of six years, family members of organ donors for up to five years, and disadvantaged rural populations. Furthermore, all citizens, including pregnant women and older people above the age of 60 may now participate in the insurance scheme on a voluntary basis (High Health Council, 2016). Uninsured Jordanians, who are often unemployed or working in the large informal sector, can access public health services through a 20% co-payment (ibid.). Though services for the uninsured are heavily subsidized by the government, access can be unaffordable for many Jordanians living below the national poverty line. Between 1995 and 2013, for instance, out-of-pocket expenditure for health rose from 23% of total health spending to more than 40% (Wang & Yazbeck, 2017).

Most migrants and some categories of refugees are excluded from domestic insurance schemes and are required to pay an unsubsidized 'foreigner rate' for access to health services (Achilli, 2015). For instance, an estimated 200,000 Palestinians fall into the political-legal category of 'ex-Gazans' who arrived in Jordan in the wake of the 1967 war with Israel. Though residing in Jordan for more than 50 years, this group is considered 'foreign' and not eligible for subsidized public services or government assistance. According to sources at UNRWA, access to health care can be deeply unequal:

> Frankly speaking, Palestinians do not have the same access [to health care]. For example, many Jordanians used to work in the army, the government, or security and have official [health] insurance. But most Palestinians worked in the private sector, which often does not provide insurance. So the

> proportion of Palestinians without insurance is much higher than Jordanians.[10]

Beyond a lack of inclusiveness, other significant challenges remain. An aging population has brought about a rise in disability rates – 1.9% among the general population and 9.6% among older people above the age of 65 (WHO, 2018; National Council for Family Affairs, 2018). And though a signatory of the UN Convention on the Rights of Persons with Disabilities since 2007, Jordan is struggling with a lack of qualified professionals, inadequate systems for collecting data, difficult collaboration among health actors, and the influx of refugees with higher rates of disability and war-related injuries (ibid.). Furthermore, a lack of unified standards for care means that the quality of services can be uneven.

As discussed in this section about the current state of the health care system, a plethora of actors involved in the financing, regulation and delivery of services make up the institutional landscape in Jordan. Over time, health and health care have not only improved considerably, but have also made incremental advances to providing greater and more inclusive health coverage. A review of national plans and strategies for health suggest that the government aspires to achieving universal health coverage for all citizens and to implementing health as a basic right (Lupieri & Frisina Doetter, 2020). However, such universalistic aspirations exclude a considerable proportion of the population such as migrants, those working in the informal sector, and refugees labelled as 'foreigners'. In what follows, I discuss how the arrival of Syrian refugees has not only had an impact on the health care system, but has also brought about a greater role for international organizations in the financing and provision of health services.

4.3 The Syrian 'refugee crisis' in context

In 2015, more than 1.25 million refugees, mainly from Syria, applied for asylum in EU member states (Greussing & Boomgaarden, 2017). The significant and sudden population

[10] Interview with a former senior medical officer at UNRWA, Amman, December 2017

movement of refugees towards Europe came to have considerable implications for both the domestic politics of many EU member states and for the EU as a whole, sparking fierce debates over 'responsibility-sharing' among states and over 'durable solutions' for refugees (Greussing & Boomgaarden, 2017). At the height of the 'refugee crisis', both new and pre-existing tensions had begun to flare up among member states at a time when many countries were contending with low economic growth, uncertainty over the UK's membership in the Union, and the rise of both left- and right- wing populism (Heisbourg, 2015). At a domestic level, the arrival of hundreds of thousands of refugees provided fuel to political movements based on xenophobia and Euroscepticism, with many countries experiencing a backlash of *souveranisme* – the return of an ideology based on the sovereignty of nation-states and tightly controlled borders (Heisbourg, 2015).

At an international level, the Syrian 'refugee crisis' has had critical implications for EU security choices and priorities in regard to conflicts in the Middle East. By 2015, one of the main priorities among European officials had become limiting the arrival of refugees to Europe (De Genova, et al., 2018). European 'externalization' policies, which aim to contain migrants and refugees within their states of origin (Bigo & Guild, 2005), are not a particularly new phenomenon in countries such as Libya, Morocco, and other African states (Gazzotti, 2019; Paoletti, 2011). Yet the arrival of Syrian refugees prompted a renewed attention and interest in the politics of the East Mediterranean region and, in particular, to containing refugees in their first states of asylum in Turkey, Lebanon, Jordan and Egypt. Indeed, the 2016 EU-Turkey deal (discussed in Chapter 2) is one of the most well-known and widely cited examples of a turning point within an EU strategy largely focused on containing the arrival of Syrian refugees in Europe.

In what follows, I turn to the effects of the arrival of Syrian refugees in Jordan. As I explore in the following section, the 'refugee crisis' in Jordan elicited considerable amounts of international financing – particularly from western donors – and prompted the arrival of large numbers of international organizations and NGOs, along with hundreds of aid workers. As a result, a large-scale coordination mechanism has taken shape to manage

relief efforts and funding flows, and to support collaboration among state and non-state actors.

4.4 The refugee response in Jordan

While many wealthier members of the upper and middle classes had already emigrated before the crisis, the majority of Syrian refugees in Jordan – mainly from poorer and less educated backgrounds – arrived in 2013 and 2014 (UNHCR, 2017). The majority of refugees live in urban areas, with the largest concentration residing in the capital, Amman (32%), and the northern city of Irbid (29%) near the border with Syria (ibid.). More than 80% of Syrian refugees live outside of camps in what is commonly referred to as 'host communities'. Of the approximately 126,000 refugees living in camps (UNHCR, 2018), the majority are hosted in Za'atari and Azraq camps, the Emirati Jordanian Camp, and King Abdullah Park (UNHCR, 2017).

In response to the arrival of Syrian refugees, a large-scale emergency response coordination mechanism has served to ensure communication and collaboration between the government and a plethora of international non-state actors operating in Jordan. In 2014, the Jordanian Ministry of Interior set up the Syrian Refugee Affairs Directorate, which has become the main government entity for the coordination of the refugee response (UN, 2017). Under the leadership of the Ministry of Planning and International Cooperation (MOPIC), along with more than 200 partners among humanitarian and development actors, the Jordan Response Plan to the Syria Crisis (JRP) is the first national strategy document which formulates a response to the refugee presence and maps out the country's development priorities. The government-led Jordan Response Platform for the Syrian Crisis oversees the implementation of the JRP and its two main pillars – 'refugees' and 'resilience' – which focus on providing services to Syrian refugees and Jordanians defined as 'vulnerable' (MOPIC, 2015). To date, there have been five versions of the JRP between 2015 and 2020. Since 2014, all project proposals from non-state actors must be registered through the Jordan Response Platform and receive prior government approval (Ministry of Planning and International Cooperation, 2016).

In terms of service provision, various entities provide health care services to Jordanians deemed 'vulnerable' and refugees. A large number of international donor agencies, financial institutions and international NGOs provide capacity building, technical expertise and financing for projects that help support targeted recipients from poor or 'vulnerable' communities. UNHCR is the lead UN agency for the refugee response, working in close collaboration with the Government of Jordan, other UN agencies, and international NGOs. More specifically, the organization is in charge of managing the refugee camps, coordinating the UN response, providing technical support to the ministries, mobilizing funding, and contracting NGOs to implement programmes (Culbertson, et al., 2016). UNHCR also provides primary, secondary and tertiary health care services free of charge for refugees in the Azraq and Za'atari refugee camps, and for Syrians and non-Syrians categorized as 'vulnerable' in urban areas (UNHCR, 2019).

Given the high number of state and non-state actors involved in the refugee response, several coordination mechanisms ensure greater collaboration across sectors and actors, and limit the duplication of relief efforts. In particular, the Inter-Agency Task Force, made up of the heads of UN humanitarian agencies, INGOs and government ministries, is chaired by a representative from UNHCR and oversees the inter-agency response (see Figure 2 below). 'All agencies have autonomy in terms of decisions and budget, but more and more they try to build a "One UN" which is promoted by the S-G [UN Secretary-General],' a UNHCR spokesperson said about coordination efforts in Jordan. 'It's like a web or a puzzle where everyone is meeting in their space. It makes sense because we are all "UN", but have different mandates and different strategies and everyone has a role to play."[11]

Through the UNHCR-led Inter-Sector Working Group, the Task Force oversees the individual sector working groups and ensures effective coordination with the Humanitarian Partners Forum and the UN Country Team in addition to supporting the development of the JRP and its yearly updates.

[11] UNHCR, Amman, March 2018

The Inter-Sector Working Group includes the chairs from each working group sector to ensure better coordination between sectors, consistent processes and standards, and the representation of crosscutting issues. In parallel, the Jordan INGO Forum (not depicted in Figure 2) is a network of approximately 58 international NGOs involved in the refugee response and serves to share information and strengthen advocacy campaigns. Forum members meet on a monthly basis to discuss their priorities and challenges.

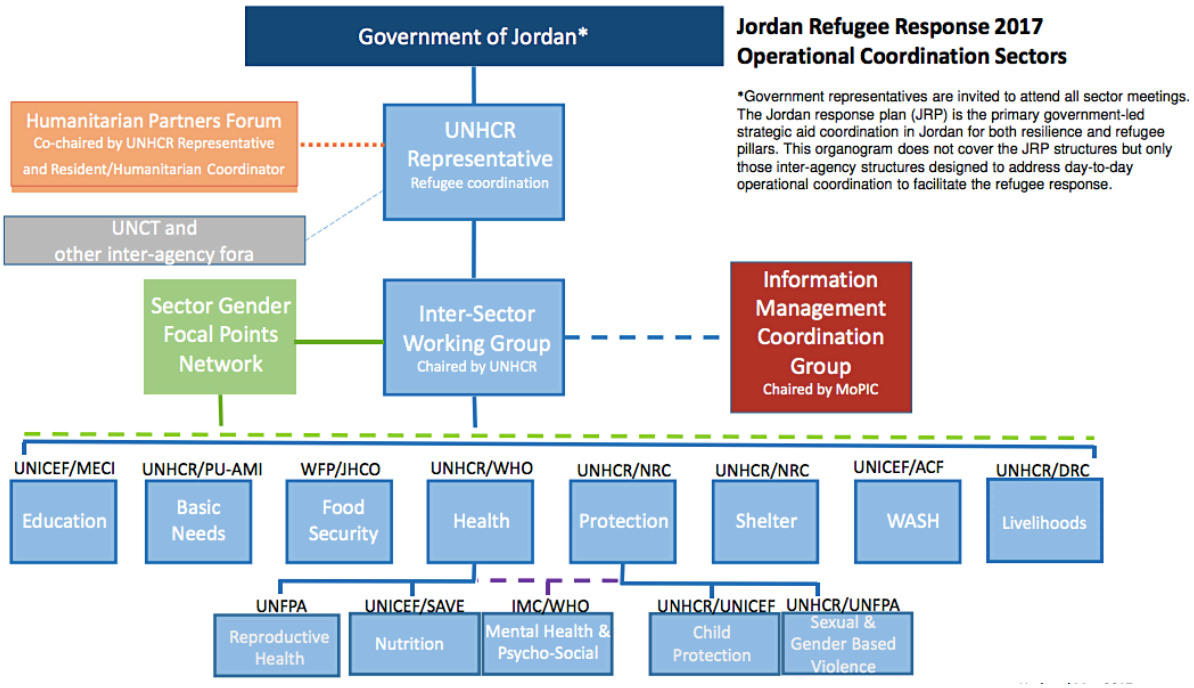

Figure 2: Inter-Agency Refugee Response Coordination Structure (2017)

Source: (UNHCR, 2017)

As can be observed in Figure 2 above, the eight sectors providing support to the refugee response include: Basic Needs, Livelihoods, Education, Food Security, Health, Protection, Shelter, and Water, Sanitation and Hygiene. In particular, the Health Sector is divided into three sub-sectors which include Mental Health and Psycho-Social Support, Reproductive Health, and Nutrition. The sectors meet regularly to share challenges, best practices, and project results. At the time of my fieldwork in 2017 and 2018, the health sector included 22 participating organizations (see Appendix B). The large number of actors involved in the

delivery of health care services requires a large and complex coordination mechanism which has been characterized by the use of online platforms to improve collaboration and increase transparency. As one NGO worker explained:

> The whole technology side of things here in the Middle East is pretty phenomenal. I think probably globally, things are changing, but here all our assessments are done on tablets and then they're uploaded. Obviously there are problems with that also, but it just makes life so much easier when you're not doing everything paper based. In theory, it means that sharing information is much easier as long as everyone is contributing.[12]

A case in point is the Refugee Assistance Information System (RAIS), a platform initially developed by UNHCR in 2009 for sharing best practices during the response to the Iraqi refugee crisis. Since 2014, RAIS has been expanded to include the UNHCR-led Vulnerability Assessment Framework which helps to target means-tested assistance to the most vulnerable populations in Jordan. Since 2015, RAIS has become the main assistance coordination tool in Egypt, Iraq, Jordan and Lebanon. Through RAIS, more than 200 partners have been recording data such as home visits and the delivery of assistance to refugee households deemed vulnerable.

The overall budget for the refugee response is outlined on a yearly basis within the JRP – Jordan's main framework for the refugee response. The plan, which includes a section dedicated to refugees and one to host communities, not only describes the needs and gaps in the response, but also presents an estimate of costs borne by the government as a direct consequence of the arrival of Syrian refugees. In 2018, for instance, the JRP calculated that the direct cost of the arrival of Syrian refugees amounted to US$ 10.3 billion since 2011 (Ministry of Planning and International Cooperation, 2018).

Since the establishment of the JRP in 2015, funding for the proposed budget has varied widely. Table 1, below, shows the amount of financing requested by the government over

[12] Health NGO, Amman, November 2017

the years alongside the percentage of funding received from international donors. More specifically, during the early years of the refugee 'crisis', funding requests remained largely unanswered – at only 36% of the requested amount. However, disbursements from the international community nearly doubled to 62% and 65% of the requested amount in 2016 and 2017 respectively – before gradually declining in the following years. As I discuss in the following chapters, government grievances over a lack of funding and international support contrast the narrative promoted by humanitarian and development actors who consider the amount of funding to be a relative success. Indeed, 87% of the 'refugee' and 78% of the 'resilience' components were financed in 2017.

Table 1: Funding of the Jordan Response Plan to the Syria Crisis (2015 - 2019)

Source: UN OCHA Financial Tracking Service

Year	Amount requested (USD)	Amount received (USD)
2015	1,191.4 billion	772.6 million (64.8%)
2016	1,105.5 billion	736.6 million (66.6%)
2017	1,196.9 billion	648.8 million (54.2%)
2018	1,036.8 billion	593.4 million (57.2%)
2019	1,036.9 billion	527.0 million (50.8%)

Overall, the considerable external financing to Jordan appears to be in the form of funding from international donors as well as concessional and non-concessional loans from international financial institutions. As discussed in Chapter 3, in 2017 and 2018, the top five donors providing more than 65% of all grant financing were the U.S., Germany, the

European Commission, Japan, and the U.K. (See Figure 3, below). Among all funders, the U.S. provided the largest bulk of financing, or more than 25% of the total (OCHA, 2017).

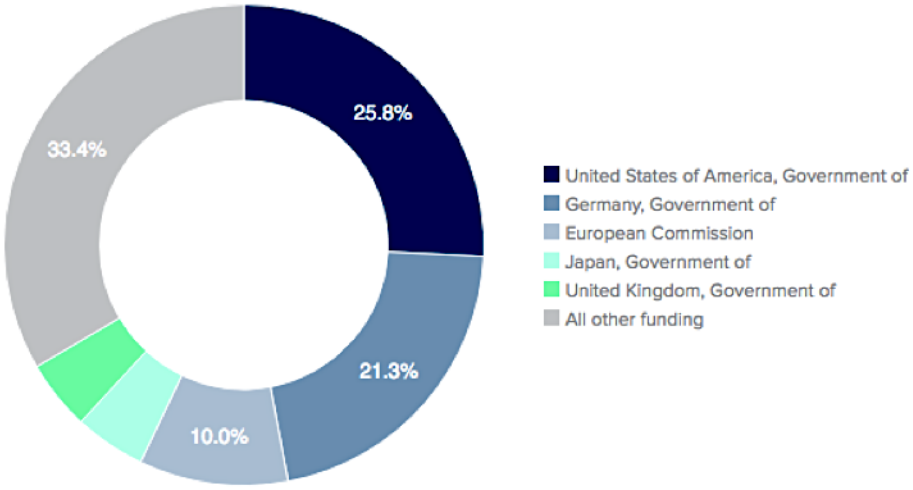

Figure 3 : External funding to Jordan by source (2017)

Source: OCHA, Financial Tracking Service, 2017

The main financial institutions providing loans to Jordan are the International Monetary Fund (IMF) and the World Bank Group. A Stand-By Arrangement with the IMF between 2012 and 2015 brought a $2 billion loan for Jordan to 'address fiscal and external challenges and foster high and inclusive growth' (IMF, 2012). Conditions of the loan included a commitment from the part of the government to implementing fiscal, monetary and structural policies so as to improve the investment climate and reduce the country's bloated deficit.

In 2016, a $723 million Extended Arrangement brought about a new loan to continue to support economic and financial reform programmes, and to help support Jordan's response to the arrival of Syrian refugees. Conditions attached to the three-year plan include implementing fiscal consolidation and structural reforms 'while protecting the poor' (IMF, 2016). The ultimate aim is to reduce public debt from 93% of GDP to 77% by 2021 while

'preserving social spending' and improving public accountability and 'good governance' (ibid.). In early 2019, a second IMF review concluded that progress along these fronts was slow. Overall, the review recommended increased support from the international community and called on Jordan to extend work permits for refugees to more sectors of the economy (IMF, 2019).

World Bank involvement in Jordan has also been substantial and has increased over time. From a $51 million investment in 2015, by September 2019 the World Bank's active portfolio included 10 projects valued at US$ 2.9 billion in grants, concessional financing and low interest loans. Of particular interest is the involvement of members of the World Bank Group which generally only operate in developing and low-income countries. However, in the face of the ongoing crisis in Syria, the International Development Association (IDA), which generally grants interest free loans to the poorest countries, disbursed exceptional resources to support the Syria crisis response (see Figure 4, below). More specifically to health, the World Bank has also invested heavily in the Jordan Emergency Health Project, which runs from 2017 to 2023. While initially valued at US$ 50 million, the project was expanded to include a further US$ 200 million in 2019.

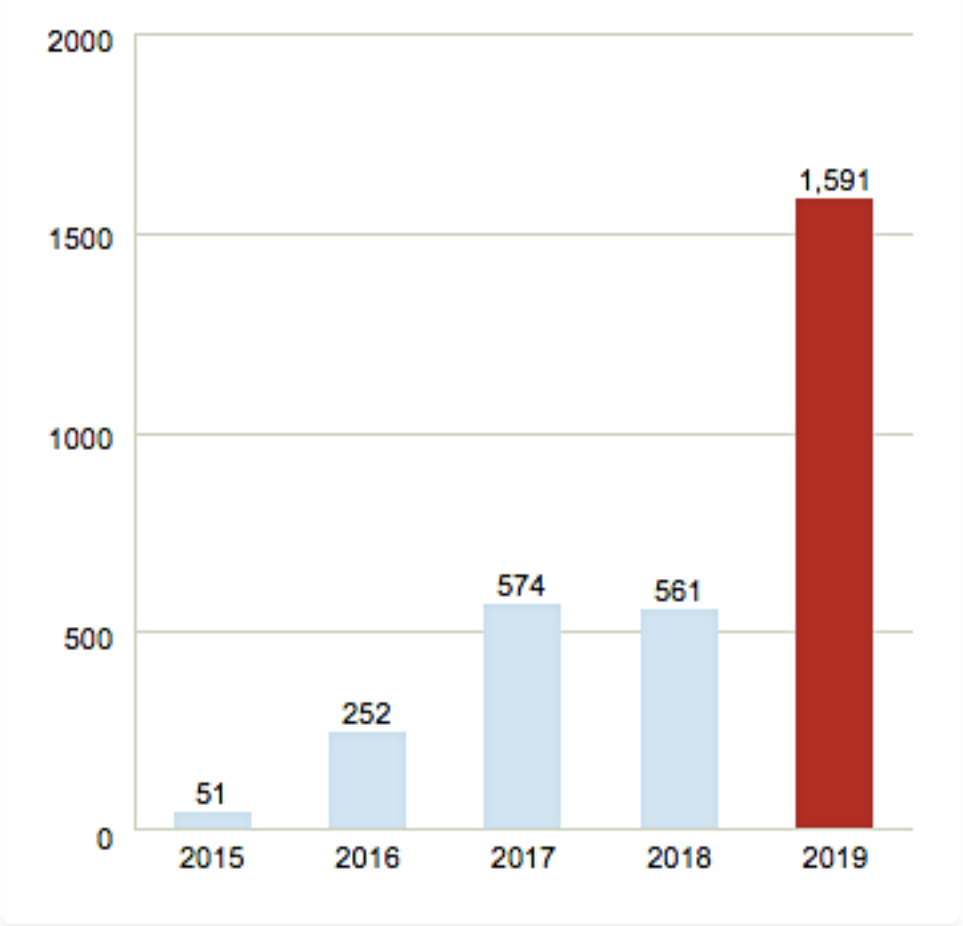

Figure 4: World Bank commitments to Jordan by fiscal year (in millions of dollars) [13]

Source: World Bank

With the majority of international funding going to the UN and other well-established international non-governmental organizations, the government has expressed frustration over a perceived lack of support for expanding national services and infrastructure. And while Gulf donors have tended to subsidize governments, including the Government of Jordan directly, a majority of western donors prefer to finance UN agencies due to a perceived lack of transparency and accountability within national governments (Culbertson, et al., 2016). Complaints about a lack of transparency, however, are also

[13] Amounts include IBRD and IDA commitments

endemic to the international humanitarian and development system as a whole. In fact, many different funding flows from donors, UN agencies, and private groups which support various funding streams including humanitarian, development, bilateral and multilateral streams, have proven to be difficult to keep track of. Different accounting systems which often exclude certain forms of funding such as funding from Gulf donors, national budgets or development funding further complicate the overall picture (Culbertson, et al., 2016).

In sum, the large number of actors coordinating and providing health services to Syrian refugees and vulnerable Jordanians have continued an historic fragmentation of services across public, private and non-state actors. In this context, Jordanians considered vulnerable and refugees are compelled to seek out health services from various actors with often differing bureaucracies and eligibility criteria. At the same time, however, a relatively strong centralized coordination mechanism and government leadership have imposed increasingly restrictive conditions on the operations of INGOs and UN organizations (Human Rights Watch, 2012). Moreover, the registration process for NGO projects has not only become lengthier, but also ensures that any project deemed 'political' can be rejected by the government with no explanation (Human Rights Watch, 2016). Overall, the large and complex coordination mechanism along with competition for funding and pressure to conform to government sensibilities has important ramifications as regards the delivery of services to target populations.

4.5 Syrian refugees in Jordan: health needs and access to health services

Historically, the Syrian and Jordanian populations presented similarities in terms of demographic characteristics, levels of female labour force participation, and educational attainment. In the years preceding the crisis, however, the Syrian population was exposed to increasing levels of inequality and financial distress, due in part to a drastic increase in oil and food prices, a prolonged drought, and a series of domestic and agricultural shocks (Verme, et al., 2016). When it comes to the demographic make-up of the refugee population, the Syrian population in Jordan tends to be younger with lower levels of education as compared to the host population (ibid.). Moreover, after spending more than

half a decade in exile, increasing numbers of refugees have fallen below the national poverty line (Achilli, 2015). With the majority of refugees from poorer agricultural areas in Syria having settled in even more deprived areas in Jordan, an estimated 87% of refugees were living in poverty in 2017 (UNHCR, 2017)

When it comes to the health status of Syrian refugees, surveys report health needs in line with those of populations living in middle-income countries which present an older population demographic with health needs predominantly centred on the management of chronic diseases (Ay, et al., 2016). While 60% of survey respondents said they required health care services for the treatment of acute illnesses, as many as 30% reported needing primary care services for the management of chronic diseases. The high levels of reported acute illnesses can be explained in part by the often overcrowded conditions, lack of adequate shelter and sanitation, and other general conditions associated with displacement (ibid.). In comparison, an older refugee population – up to 5% of refugees in Jordan are estimated to be 60 and above – accounts for the relatively high prevalence of chronic conditions (UNHCR, 2017). To the extent that 50% of households reported having one or more members with a diagnosis of at least one of the most common non-communicable diseases (NCDs), including hypertension, arthritis and diabetes (Doocy, et al., 2015). As the director of a medical of an NGO explained the health conditions among refugees:

> Per month we have almost 15-20 patients with ischemic heart disease and I've never seen this level before. Also, we can say that the context in which the refugee camp is set up, with the stress that [the refugees] have to undergo, and there's no diversification of food and the quality is low, there's hardly any activity, along with high smoking rates – we can see the result and it's really problematic.[14]

While 21% of the population between the ages of 49-59 reported being diagnosed with hypertension, this figure rises to 52% among older refugees (Doocy, et al., 2015). Similarly, due in part to exposure to violence and conflict, disability rates are considered to be

[14] Medical NGO, Amman, November 2017

particularly high, with 34% of households reporting having one or more members with special needs or with a disability (UNHCR, 2017). An estimated 20% of impairments are caused by war injuries or accidents (UNHCR, 2017).

When it comes to health care, access and the availability of services vary widely in Jordan. For refugees living in camps, primary and some secondary and tertiary health services are offered free of charge by NGOs or UN agencies (Arab & Sagbakken, 2018). While this can be a significant advantage compared to refugees in urban areas, life in the camps is characterized by poor water and sanitation services, a lack of freedom of movement, and limited access to specialized health care (ibid.). Moreover, frustration over what has been perceived by refugees as inadequate living conditions in the camps has resulted in protests and minor riots (Healy & Tiller, 2013). According to an MSF report, Syrian refugees had previously enjoyed a relatively high standard of living in Syria and considered life in the camps 'an affront to their dignity' (Healy & Tiller, 2013, p. 9). Though UNHCR and several partner NGOs provide free primary care services, they tend to prioritize emergency health care services often at the expense of chronic disease management and care (Arab & Sagbakken, 2018). Among non-camp refugees, more than half of Syrian refugee households report having at least one member with a chronic disease. Of these, a significant minority reported not having had access to any treatment in 2014 (Doocy, et al., 2015). As the vast majority of Syrian refugees have settled in urban areas outside of refugee camps, it is to this population in particular that this dissertation turns. In fact, reports have highlighted the lack of visibility of refugees residing in urban areas who not only have to fend for themselves to access services, but are largely overlooked in the international response.

Overall, health policies towards Syrian refugees have followed an uneven trajectory between 2011 and the present date. In the early years, when thousands of refugees were arriving in Jordan on a daily basis, all Syrian refugees could access public health care services free of charge, including free vaccinations for all children (UNHCR, 2018). Soon, however, public services began to register the strain of the sudden population increase. Between January and March 2013, the number of Syrian refugees who underwent surgery increased six-fold, from 106 to 622 patients (Murshidi, et al., 2013). By 2013 public hospitals

had seen a 14% rise in the number of cancer patients compared to two years earlier which contributed to longer waiting times for treatment for both refugees and Jordanians seeking care in the public sector (ibid.). Government hospitals began to report shortages of drugs as well as specialists (Ay, et al., 2016).

In response, the government put in place increasingly restrictive policies which severely curtailed access to health care for refugees. In 2014, a policy reversal required refugees to pay the same rate for public health care services as uninsured Jordanians (see Figure 5). Though still subsidized by the state, this meant increased levels of out-of-pocket expenditures for a population already suffering from high levels of poverty and limited access to the labour market. For refugees without the required documentation certifying their refugee status, which includes a valid Asylum Seekers Certificate and Ministry of Interior service card, the rates for health care services are up to 35%-60% higher (Amnesty International, 2016). In 2016, many families reported having to make the difficult choice between meeting the basic needs of their households and the health care needs of individual family members (Amnesty International, 2016).

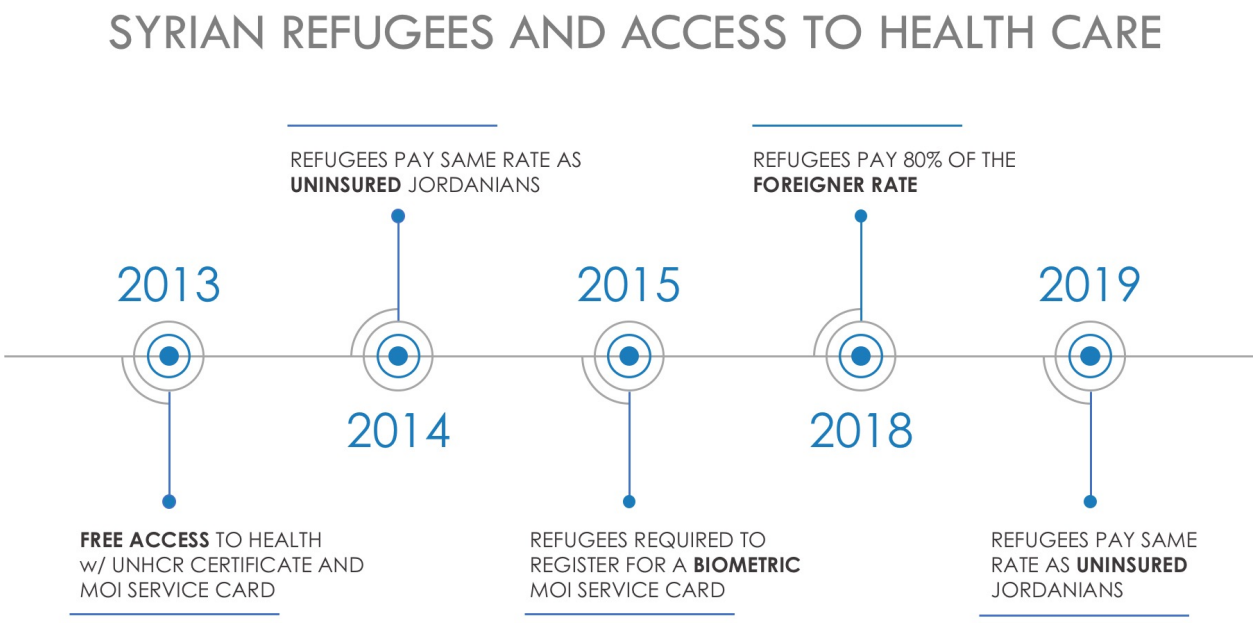

Figure 5: Timeline of government policies affecting access to health care for Syrian refugees in Jordan

Source: compiled by the author

In 2017, close to 80% of survey respondents reported spending money on health care services in the previous month. With a mean combined household income of as little as JD 243 (circa US$ 342) per month, households reported spending more than 41% of their incomes on health care (UNHCR, 2017). In a recent and unexpected policy development in early 2018, access to health care for refugees became even more difficult and expensive. Refugees were then required to pay the equivalent of the 'foreigner' rate. Even for registered refugees, out-of-pocket expenses became 60% higher than for Jordanians without health insurance. For instance, before the new policy was introduced, a birth in a public hospital cost approximately JD 50 to JD 60 ($70-$80). By 2018, refugees were expected to pay between JD 140-220 (Us$ 200 to US$ 300) for a delivery (Amnesty International, 2016).

In 2019, yet another policy reversal reinstated the status of refugees as 'uninsured Jordanians' (see Figure 5). While this brought about an improvement to access to basic health services, access to secondary and tertiary care remain limited, and refugees are rarely able to find alternative solutions such as access to costly private hospitals and clinics (Achilli, 2015; Arab & Sagbakken, 2018). For refugees suffering from chronic conditions there are often few options available due to a lack of funding and services. In fact, though NCDs account for the great majority of deaths in Jordan, little attention has been paid to the needs of refugees with chronic conditions (Akik, et al., 2019; Spiegel, et al., 2014). In part as a result of more restrictive health policies, a UNHCR study reported that 57% of refugees with chronic health conditions said they could not afford the care that they required in 2015 (UNHCR, 2015). A subsequent report uncovered that 45% of patients said they were unable to obtain medications due to their cost or unavailability, and 80% of those who stated they were unable to access medical services cited high user fees as the main reason (UNHCR, 2017).

For specialized care, UNHCR and its partners provide limited support which amounted a maximum expenditure capped at $2,000 per person per year between 2009 and 2012 (Spiegel, et al., 2014). For cases which require advanced specialist care, External Care

Committees review each case to determine the cost, the effectiveness of the suggested treatment, the financial vulnerability of the patient, the feasibility of the treatment plan, and the overall disease prognosis (ibid.). Patients whose applications have been rejected are compelled to turn to NGOs and charities or access the private sector for treatment. One NGO representative and medical doctor explained the extreme difficulties associated with providing adequate care for NCDs:

> We have problems in funding and so we know that we are not treating everybody because there are undiagnosed patients that we need to screen. But we know that we do not have enough medicine to treat everybody so we do not screen all patients until we can ensure medical supply. This is a huge challenge for us.[15]

For refugees with life-limiting conditions, a small exploratory study on palliative care services reported high levels of pain and unhappiness among patients with the care they received (Pinheiro & Jaff, 2018). In particular, refugees reported feeling frustrated with services which are often fragmented across various NGOs, charities and government hospitals. Among those who completed lengthy applications for funding for their treatments, several reported having been rejected or ignored (Pinheiro & Jaff, 2018).

In addition to structural barriers which limit access to health care based on cost, complex registration processes, and difficulties with expensive or unavailable transportation, refugees have reported facing hostility and antagonism from members of their host communities and, in particular, from health care professionals. In a report by the Inter-Agency Standing Committee, for example, pregnant refugee women reported being criticized by health professionals for having children (Groenveld & Abu-Taleb, 2016). This, in turn, has influenced health-seeking behaviour to the extent that 18.8% of refugees reported difficulties in accessing antenatal care due to either long waiting times or rude staff (UNHCR, 2015). Undocumented or 'unregistered' refugees in particular reported delaying seeking care for fear of being reported to the authorities. In fact, a lack of civil

[15] Medical NGO, Amman, November 2017

documentation for those who either crossed the border illegally or who do not possess the required documents for registration creates a situation of de facto 'statelessness', in which refugees delay seeking care or depend on home remedies, midwives and NGOs. In the case of chronic diseases, this often means receiving fragmented or inadequate care and delays in obtaining diagnoses and treatment (Arab & Sagbakken, 2018).

The lack of adequate access to secondary and tertiary care and to chronic disease management (Amara & Aljunid, 2014), means that the category of older refugees – above the age of 60 – have been largely overlooked in the medical response. Despite increasing international recognition of the specific needs and the challenges older people face during times of crisis (WHO, 2016; UNFPA, 2017; UNDP, 2015; UN DESA, 2017), this age group still remains one of the most forgotten categories within the humanitarian and development response, in particular when it comes to health. In fact, studies have shown that older persons and individuals with disabilities are consistently overlooked in emergencies, where they face higher morbidity and mortality rates (Mokdad, et al., 2005). During Hurricane Katrina in the United States, for example, more than 70% of deaths were attributed to persons above the age of 60 (Médecins Sans Frontières, 2012). However, in the aftermath of the disaster, only 0.2% of the funds generated by the UN Consolidated Appeals Process and Flash Appeals went to projects providing specific assistance to older people. On a more global scale, only 18 out of 1,912 global aid projects reviewed by Médecins Sans Frontières, had activities that specifically targeted older adults (ibid.).

The case of older Syrian refugees in Jordan is no exception. While all refugees have been struggling to access services – especially health care services – older refugees face additional challenges such as poorer health, restricted mobility, and social isolation (HelpAge International, 2014). In accordance with the expected disease burden in most middle- to high-income countries, Syrian refugees in Jordan present relatively high rates of non-communicable diseases, which appear to grow increasingly common with age. Despite recent recognition of the particular needs of older refugees during humanitarian crises, however, there is very little information not only on the needs but also on the services available to older Syrian refugees. Based on some reports, approximately 77% of all older

adults above the age of 60 have specific needs related to mobility, nutrition and health care; and more than half report suffering from forms of psychological distress (HelpAge International, 2014). Among refugees with specific needs, approximately one-third of the population suffers from more than one condition with a clear correlation between age and the likelihood of having specific needs (ibid.). Overall, the dearth of data on the health needs and availability of services for older Syrian refugees in Jordan – and the Middle East in general – appears to further confirm the widespread neglect of this population demographic (Al-Makhamreh, et al., 2011). Though interviews with representatives from national NGOs confirmed the presence of large numbers of older refugees, especially in clinics and other health care facilities, as I examine in the following chapters, policymakers claimed to be either unaware of or uninterested in the specific needs of older refugees.

In addition to now facing a 20% co-payment and high costs of transportation to access health services in urban areas, refugees frequently lack adequate access to specialized care. For refugees requiring more complex treatments, the fragmentation of the health response means that services may be spread out across government hospitals, NGOs and charities. The frequent policy changes determining access to services are a stark reminder that refugees have increasingly become unwelcome guests in the country. In sum, the refugee population in Jordan has been largely marginalized from the national health care system and excluded from universalist and rights-based approaches reserved to the national population (Lupieri & Frisina Doetter, 2020). As I examine further in Chapter 6 and Chapter 7, access to health care for refugees has been relegated to the realm of charity-based organizations which deliver means-tested assistance for refugees considered the 'most vulnerable'.

4.6 Conclusion

In this chapter I provided the background for situating the Syrian refugee 'crisis' within an historical context of recurring refugee movements, regional conflicts, and intrinsic political and economic instability. Three main trends stand out in my analysis. First, the historic involvement of external actors reflects postcolonial legacies and political interests which

are closely related to Jordan's geopolitical position in a turbulent region rather than the magnitude of documented needs. In fact, external funding to Jordan since its independence to the present day has very much been influenced by global and regional interests in the Middle East, the country's long standing relationship with the U.S., and its support of the global 'War on Terror'. Moreover, as will be explored in the following chapters, investment in the Iraqi refugee crisis pales in comparison to current investment in the arrival of Syrian refugees.

Second, the snapshot of the present day health care system shows the magnitude of the involvement of international actors in the funding and provision of services. Here, the continuation of the historic fragmentation of the health care system across a plethora of national, international and supranational actors and funding mechanisms has brought about both gaps and frequent overlap in services. This comes to the fore in the case of the management of common non-communicable diseases such as cancer. In fact, despite the priorities stated in the JRP, non-communicable diseases remain underfunded with many refugees struggling to access regular health care, medication, and management options for chronic conditions.

Lastly, despite universalist objectives and a gradual expansion of services and rights for citizens, policies towards Syrian refugees have involved a progressive curtailing of access to government services. With humanitarian and development actors increasingly shouldering the burden of providing services, this has not only created a parallel health system for non-citizens, but also contributed to shifting the discourse from a rights-based approach to health care to a more selective and targeted approach based on vulnerability assessments. As I analyse further in Chapter 7, this trend has important ramifications as to which diseases and which groups of refugees receive particular attention and funding – and which do not – within the complex politics of the health response.

Chapter 5 | 'WE DON'T WANT REFUGEES ON OUR DOORSTEP': STATE ACTORS AND THE DRIVERS OF MIGRATION AND HEALTH DIPLOMACY[16]

This chapter addresses the research question: Have health care policies become instruments of migration diplomacy and, if so, how? Based on theories developed by Wæver and others at the Copenhagen School (Wæver, 2011; Yuk-ping & Thomas, 2010), I argue that an increasing securitization of health and, in particular, of infectious diseases within the discourses and practices of international donors and the Government of Jordan has led to a wider public acceptance of health and refugees as a security threat. In turn, this has led to the perception of the presence of refugees in Jordan as a 'state of exception' (Hanrieder & Kreuder-Sonnen, 2014) with the subsequent mobilization of international financial resources. In particular, this chapter will show how some of the factors influencing policy decisions on who receives health care services and what service are funded are based on the confluence of both domestic and international political objectives. Overall, the lack of a legal status for refugees – Jordan is not a signatory of the 1951 Refugee Convention – means that all refugees in the country are dependent on often indiscriminate and volatile policy decisions.

To better understand the political implications surrounding the financing of health and health care from the part of national and international state actors, this chapter is structured as follows. I begin by analysing the complex processes and influences involved in the Jordanian government's decisions on the allocation of health care funding and the provision of health services to Syrian refugees. First, I contend that government decisions have been strongly influenced by concerns over Jordan's political, social and economic stability. Second, I argue that Jordan's foreign policy objectives have included the use of health care and, in particular, of a 'health crisis', as a bargaining chip in the global

[16] Several sections of this chapter are made up of an earlier draft of a paper published in: Lupieri, S., 2020. When 'brothers and sisters' become 'foreigners': Syrian refugees and the politics of healthcare in Jordan, *Third World Quarterly*, 41(6), 958-975.

policymaking arena. Third, data reveal that restrictive health policies towards refugees have had the express aim of resisting international pressures for the long-term integration of Syrian refugees in Jordan. In all instances, the provision of health care services has been wielded as an instrument of diplomacy and the withholding of services at critical junctures has provided political leverage within the international response to the refugee crisis.

I then provide a snapshot of the current donor landscape and an overview of the main bilateral organizations involved in the allocation of health care resources to Syrian refugees. I question when and why donors have decided to invest in Jordan and its refugees, and how receptive donors have been to negotiations from the part of Jordanian authorities. I argue that donor priorities have largely been influenced by two main considerations: the geopolitical importance of the country as a largely pro-western ally in the Middle East, and the fear of Syrian refugees arriving in the West. In particular, I discuss the implications of the arrival of Syrian refugees in Europe, followed by a series of terrorist incidents in 2015 and 2016, as a significant turning point within the political manoeuvrings which determine humanitarian and development assistance. I argue that the increased framing of refugees as security threats elicited a sudden and dramatic increase in funding for Syrian refugees in Jordan and to a greater donor receptiveness to the demands of Jordanian authorities. Ultimately, the intertwining of these factors has a strong impact on when – and how much – donors have been willing to invest in Syrian refugees.

5.1 Government agendas: national security and the production of a health crisis

From the perspective of the Government of Jordan, when Syrian refugees began arriving in Jordan they were hailed as 'brothers and sisters' and offered free access to public services including education and health care (Ministry of Planning and International Cooperation, 2013). As international funding started pouring into the country in 2012 and 2013, Ibrahim Saif, the Minister of Planning and International Cooperation at the time, had reasons to be optimistic. The conflict in Syria was expected to end soon and refugees would then return to their home country. In the meantime, the scope for international cooperation with

external state donors and multilateral international organizations appeared promising, bringing in almost unprecedented amounts of funding in the form of grants and conditional loans. In 2016, Jordan received $3 billion and became the seventh-largest recipient of overseas development funding in the world (OECD, 2019). As Ibrahim Saif stated confidently in early 2015:

> I call upon our partners, including donors, the United Nations, NGOs and other development stakeholders to support Jordan to address the mounting challenges it faces in providing for *our Syrian brothers and sisters* in their time of need. I have every confidence that through our joint efforts, we will be able to achieve the objectives of this important plan. [17]

By the end of the year, however, the tone of international cooperation had evolved to include a strong undercurrent of resentment. As King Abdullah II stated at the 70th Plenary Session of the United Nations General Assembly in September:

> We have been taking on a significant part of the *burden of this humanitarian disaster* off the international community's shoulders since the beginning. However, support to our country has been a small fraction of the costs we have endured. It is high time that the international community acts collectively in facing this unprecedented humanitarian crisis, and supports countries like Jordan and Lebanon which have been carrying the brunt of this burden over the past years.[18]

Clearly, Jordan had begun to encounter the limits of international cooperation and responsibility-sharing towards Syrian refugees – a population increasingly viewed as a burden. In the following years to the present date, Jordan's policy strategies towards refugees have included a gradual curtailment of services, especially when it comes to health care. As discussed in Chapter 4, government grievances over the real or perceived impact

[17] Jordan Response Plan for the Syria Crisis, 2015, emphasis added

[18] Emphasis added

of Syrian refugees on Jordanian health care services and host communities in general has been accompanied by a progressive strategy of cutting health care expenditures and services dedicated to Syrian refugees beginning from 2014. While Syrian refugees initially enjoyed a particular advantage compared to other refugee groups – such as their Iraqi counterparts – the past six years have seen the progressive dismantling of any preferential treatment. From free health care services for Syrian 'brothers and sisters', in early 2018 refugees were required to pay a two-to-four times more expensive 'foreigner rate' with often catastrophic consequences on household expenditure (Jaffery, 2018). After years of relatively inclusive policies towards refugees, what had prompted the government to progressively cut all health care subsidies to non-citizens?

Domestic policies: from national stability to appeasing Jordanian constituents

Findings show that the allocation of health care services to Syrian refugees has been strongly influenced by national concerns over Jordan's political, social and economic stability. Over the past decade, Jordan has remained afflicted by high levels of poverty, unemployment, and a significant dependence on foreign aid. Fiscal and monetary austerity measures (see Chapter 4) have not only drastically cut social services for the Jordanian population, but have also led to a sharp decline in living standards for the majority of poor citizens and the middle class (Martínez, 2016; Baylouny, 2008). Simmering popular frustration and anger over high costs of living, stagnating wages, and a reduction in services culminated in large-scale street protests in wake of the Arab uprisings in Tunisia in 2011 (Abbott & Teti, 2017). When it comes to health care, the arrival of refugees from Syria has led to overstretched resources and long waiting times for services (Ministry of Planning and International Cooperation, 2013). The competition for services has forced many Jordanian citizens to resort to more expensive private medical care which, in turn, has increased hostility and tensions towards refugees (Doocy, et al., 2015).

Within this context of faltering economic and political stability, the abrupt policy change in 2018, which excluded Syrian refugees from accessing subsidized health services (see Chapter 4), served in part to appease popular discontent. According to interviewees among representatives from INGOs, the sudden exclusion of Syrian refugees came as a response

to international pressures from financial institutions such as the IMF to remove gas and food subsidies for the Jordanian population. Indeed, the IMF and the World Bank's long-standing involvement in Jordan has brought about unpopular policies based on austerity measures (Martínez, 2016). More recently, in an attempt to rein in Jordan's high public debt (currently at 93% of GDP), Jordan and the IMF signed a US$ 2 billion Stand-By Arrangement in 2012 and a US$ 723 million Extended Arrangement in 2016 (IMF, 2012; IMF, 2016). Some of the loan stipulations include comprehensive tax reforms to expand the tax base, and labour market reforms to increase employment opportunities for Syrian refugees (Ibid.). In particular, the removal of bread subsidies in early 2018 resulted in protests and rioting among Jordanians and proved to be politically unpopular (Al-Khalidi, 2018). As one official working for the government described the situation: 'This year there have been four cuts in the budget because of financial hardship. Also the world promised Jordan to support the country, but only 35-36% [has been funded] so there is hardship. The government now are thinking of increasing taxes on bread. This is very difficult.'[19]

When it comes to health care, amid a climate of increasing resentment toward refugees and unpopular government policies, cutting health services for Syrian refugees was intended as a means to appease Jordanian constituents. As one member of the INGO forum stated:

> The decision is seen as very political. Even the Ministry of Health was not aware as this [decision] was taken at the prime minister level. It is a political kind of pressure within the narrative of austerity measures as [the government] could not justify the subsidy for Syrian refugees while cutting bread subsidies.[20]

In many ways health care policies towards refugees reflect public attitudes which have ranged from welcoming to overt hostility as time wears on. Indeed, an increasing securitization of Syrian refugees has brought about the widespread perception of refugees as a multiple threat to the economic security, national security, morality, and even health

[19] Government official, Ministry of Health, November 2017

[20] INGO Forum representative, Amman, April, 2018

security of the Jordanian population. Officials frequently pointed out the financial burden imposed by the presence of Syrian refugees. In particular, the rising costs of housing and subsequent overcrowding especially in urban areas has been attributed to the arrival of refugees from Iraq and Syria. As one official complained: 'For Jordanians, we were negatively affected. In 2004, you could buy a house for 30,000 JD. After the Iraqis, you couldn't find an apartment for less than 100,000 JD. And after the Syrians you can't find one for less than 300,000 JD. I don't believe prices will go down.'[21] [22]

Moreover, the views expressed by a government official in an interview exemplified this ambivalent perception of Syrian refugees, which oscillates between an acceptance of refugees as 'family' to concerns over precarious political and social stability in Jordan:

> There are 420,000 refugees in Amman only and then there is the issue of social cohesion. Jordan has one special thing in hospitality. Even in the beginning it dealt with [Syrian refugees] as brothers and kept them in our homes. In Syria and Jordan there is often some family, the only separation is the border.[23]

Though the official recognized Syrian refugees as 'family', my interviewee also stressed that the presence of Syrian refugees represented a 'crisis'. 'I am sad for them [Syrian refugees], but I am also sad for my country,' my interviewee said.[24]

Indeed, the increasing marginalization of the health needs of Syrian refugees comes amid fears that the long-term presence of refugees poses an existential threat to the stability of the Jordanian state. These fears were further compounded in June 2016 when an explosive-laden car drove at high speed across the Syrian border and detonated at a Jordanian military outpost near the Rukban refugee camp. The attack, attributed to ISIS supporters, killed six

[21] Ministry of Social Development, Amman, November 2017

[22] The values expressed in Jordanian Dinar are approximately the equivalent of US$ 42,313, US$ 141,000, and US$ 423,136 respectively as of 10 March 2020

[23] Ministry of Health, Amman, November 2017

[24] Government official, Ministry of Health, Amman, November 2017

and injured 14 members of Jordan's security forces, and led to an immediate heightened security response (Ghazal, 2016; BBC, 2016). The ensuing closure of Jordan's border with Syria left an estimated 50,000 refugees stranded on a desolate rocky barrier of sand called 'the berm' (Hajzmanova, 2017). With little access to water and almost entirely absent medical care, these refugees have been waiting – and dying – at the berm for years (Simpson, 2018). In particular, government officials focused on the threat posed by young men and expressed a deep-rooted fear of the spread of extremist ideology: 'We are also running youth programmes to fight against ISIS and to understand the root of why Jordanians are joining these silly people. It is young males…'[25] Advisors at the Ministry of Social development agreed: 'Jordan is facing radicalism and terrorism.'[26]

Among government officials, the large number of Syrian refugees not only raised fears over the spread of extremist ideology, but also as a form of moral corruption of Jordanian society. As one government official from one of the ministries stated about the perceived security threat, both physical and moral, posed by Syrian refugees:

> Among the youth, when we have Syrian refugees with a mature ideology about Da'esh or other terrorist groups, juveniles come…and transfer their ideology to other juveniles. Maybe we need to establish a unit to eradicate terrorism.[27]

Other officials supported this view, claiming that the arrival of Syrian refugees brought about an increase in rates of child marriages and, in particular, human trafficking. Along with such assessments, interviewees frequently expressed racialized and essentialist views of Syrian refugees:

> People from Syria are very skilled and very smart and they come with a different ideology and are affecting our work opportunities. There is an impact with child labour, begging, second marriages…There is also prostitution and human trafficking. We established a centre for protection against trafficking and got

[25] Higher Population Council, Amman, May 2018

[26] Ministry of Social Development, Amman, November 2017

[27] Government official, Ministry of Health, Amman, November 2017

> many Syrians. And the funny part is that they didn't even know they were trafficked, it's part of their culture. Some dance and practice prostitution for money or food and it's a family tradition.[28]

In the case of child marriages, rather than viewing these as a health challenge and the result of negative coping mechanisms, government officials perceived them to be part of the Syrian culture and a moral failing on the part of a population increasingly viewed as 'other', 'foreign', and a threat to overall security and social cohesion.

Overall, despite the clearly unequal treatment afforded to Syrian refugees in accessing health care, especially after the sudden policy change in 2018 which exponentially raised costs for health care, prevailing attitudes among officials point to bitterness over a perceived disproportionate amount of international funding provided for refugees. In fact, officials I interviewed stated a firm belief in the better access to health care and quality of treatment afforded to refugees by international organizations. This, they said, was creating community tensions between Jordanians and Syrians and raising the prospect of national instability. Several officials stated that refugees received higher subsidies than vulnerable Jordanians and better health care services, with poor Jordanians having to resort to lower-quality services in public hospitals. One official in particular complained about the signing of the Jordan Compact, in which a condition for donor funding required Jordanian companies to employ Syrian refugees in an attempt to curb unemployment and dependence on international aid. 'It is a condition of the Clinton Global Initiative as a condition to supply Jordan,' my interviewee stated. 'We respect their condition on the ground that Syrians are better off than Jordanians. I believe this. For example, when you take the poverty line, when you compare Jordanians and Syrians, the Syrians are better off than Jordanians.'[29]

In sum, national decision making on health care policies for refugees has frequently been based on a perceived need to appease the domestic population and maintain national

[28] Government official, Ministry of Health, Amman, December 2017

[29] Government Official, Ministry of Health, Amman, December 2017

stability. Over time, the trend has been to increasingly privilege the allocation of resources – and in particular health resources – to Jordanian citizens, while marginalizing the needs of non-citizens. In what follows, I analyse how health care policies towards refugees have been integrated into the broader foreign policy objective of increasing external support in the form of overseas development aid. This has occurred mainly in two ways: through the construction of a 'health crisis' warranting additional funds, and through the gradual exclusion of refugees from the national health care system.

Foreign policy: attracting foreign aid and maintaining the attention of donors

As suggested by scholars theorising on the international refugee regime, the lack of a binding framework for nation-states in the Global North to provide support to refugees residing in other territories creates an intrinsic power imbalance which largely places refugee host states at a disadvantage (Achiume, 2015; Aleinikoff & Poellot, 2014; Panebianco & Fontana, 2018). Interviews with government officials in Jordan confirmed a prevailing sense of precariousness and fear of abandonment in their dealings with donors and international organizations. In particular, donors' resistance to providing direct funding to the government or to projects not directly benefiting refugees created hostility and indignation. As one government employee put it: 'If you ask for help for infrastructure you don't get a dollar. Thank you very much, but the resources are very limited. No, it's not only our responsibility.'[30] This pervasive sense of abandonment has become particularly strong since 2016 amid discussions among donors and international organizations about 'exit strategies' in the face of a protracted crisis. Though the amount of overseas development funding remained relatively stable until 2018, one government official described the potentially catastrophic effects of an 'exit strategy' on the health care system:

> The greatest gaps I am facing is that some international organizations are withdrawing from Jordan. They are taking the first step towards leaving Jordan. I think there will be gaps in treating the patients…If NGOs leave, I don't know where the patients will be treated if there are no facilities…The MoH [Ministry

[30] Government Official, Ministry of Health, Amman, December 2017

> of Health] is lacking sophisticated services and operations such as heart surgery, brain surgery and plastic surgery. We get help from NGOs and we have asked them to extend their work in Amman, but there is not enough money.[31]

The bitterness and complaints over the Syrian refugee presence in part reflect a reality in which the sudden population increase has created overstretched health care resources, longer waiting times for services, higher fertility rates, and, according to government sources, a decline in population life expectancy. All factors which have been largely attributed to the presence of Syrian refugees. In particular, women are blamed for contributing to rising fertility rates and thus to an increase of dependency ratios across the refugee population. As one government advisor focusing on population affairs reflected: '[Syrian refugees] live in camps and have the idea that they want to compensate for losing their population so there is a high population growth.'[32] Another official echoed a similar sentiment amid fears over increased dependency ratios in a country with high unemployment rates and limited resources:

> The problem with Syrian refugees is that they come with their families and they are very young. About 40% are children or women who are not working. The objective is to get the highest percentage of the population working and to decrease the percentage of the population that are dependents like children and old people.[33]

Similarly, Jordanian authorities voiced concerns over what they considered to be a looming health crisis. Amid fears of international abandonment in the face of what has become a protracted refugee setting, officials worried about having to shoulder the burden of high rates of chronic diseases and NCDs among the Syrian population. According to an official from the Ministry of Health, in 2017 there were approximately 120 Syrian refugees in need

[31] Government Official, Ministry of Health, Amman, November 2017

[32] Higher Population Council, Amman, May 2018

[33] Higher Population Council, Amman, May 2018. Note: The interviewee's comment on low employment rates among refugees counters the political reality in which few refugees so far have been granted access to legal or formal employment.

of haemodialysis in Amman.[34] International NGOs in Jordan confirmed that haemodialysis is in fact a significant concern as it is expensive and requires specialized medical equipment. Furthermore, each patient requires treatment three times per week at a cost of JD 45 (US$ 65) per session (SAMS Foundation, 2018) - not including the high costs of transportation required to reach the hospital.

Several officials pointed out that the arrival of large numbers of Syrian refugees not only had an impact on Jordan's development trajectory, but had also interrupted plans for vital reforms – such as the expansion of universal health coverage and national insurance programmes. One official explained the dilemma:

> There is a need to reform and rearrange pre-payment mechanisms for the civil insurance. But I spoke to his Excellency [the Minister of Health] and he said 'don't talk about this right now'. They see that unemployment and poverty have increased and cannot do anything for the time being. We cannot push more people into poverty.[35]

As one government official lamented: 'Jordan is a small country with limited resources, and we don't know if the crisis will extend. As you see, all borders are closed around us.'[36]

Without discounting their validity, such complaints obfuscate the fact that the refugee 'crisis' came at a time when Jordanian citizens were already struggling with high unemployment rates, limited access to social protection, and a declining quantity and quality of state-provided health care services (Abbott, et al., 2016). In this context, the 'catastrophization' of the presence of Syrian refugees along with the construction of a 'health crisis' play an important role in maintaining the attention of international donors – so as to delay potential 'exit strategies' – while strengthening calls for external financing. As the minister of Planning and International Cooperation, Imad Najib Fakhoury, stated in

[34] Government Official, Ministry of Health, Amman, November 2017

[35] Government Official, Ministry of Health, Amman, November 2017

[36] Government Official, Ministry of Health, Amman, December 2017

the introduction to the 2018-2020 Jordan Response Plan (JRP):

> The Syria crisis, including its unprecedented refugees' odyssey (sic), has been globally recognized as the worst humanitarian disaster the world has faced since the Second World War, posing an increasing threat to human security, development and economic growth (MOPIC, 2018).

To maintain a state of 'health crisis', the use of health and population indicators has served an important purpose in describing the magnitude of the threat and defining its severity. As several donors and academics pointed out in interviews, estimates surrounding the actual number of Syrian refugees are steeped in political calculations. Similarly to inflated government statistics on the presence of Iraqi refugees a few years earlier (Gibson, 2015; Lenner, 2016), differing views on the number of Syrian refugees range from 670,000 (UNHCR, 2017) to 1.4 million (Alshoubaki & Harris, 2018). According to one academic focusing on Syrian refugees in Lebanon, indicators on refugees are powerful tools that obfuscate the economic contributions of migrants and the historical dimensions of migration and refugee flows:

> The UN focuses on indicators, but you need to think of the historical factors and the region itself as a geopolitical entity which is beyond indicators. For example, you can have good indicators, but these may not be sustainable and you cannot rely on government indicators because obviously they need more money. For example, the number of refugees. The number is a lie and is supported by UNHCR to inflate the numbers…But actually the refugees are contributing to the economy because their families are now here and they are no longer sending money back to Syria.[37]

The perception of a health crisis has been used as an important bargaining tool not only to maintain donor investment in Jordan, but also to exert control over the unequal power dynamics inherent in the global refugee system. Similarly, the sudden announcement of

[37] Academic at the American University of Beirut, Beirut, September, 2017

the government's intention of cutting subsidized health services for Syrian refugees three months in advance of the 2018 Brussels Conference served to further heighten the sense of crisis and mobilize international support. Indeed, the gradual exclusion of refugees from the national health care system not only increased the vulnerability of many refugees, but also increased the costs for international organizations providing health assistance (Tiltnes, et al., 2019). As a member of the International NGO Forum in Amman described the government's strategy at the donor pledging conference:

> I was in Brussels for the conference and it was interesting as the government was showcasing health as an achievement. What we understand is that they were trying to negotiate with donors to have more capacity building like they do for education. Health was not a part of the Jordan Compact but now it was introduced as a new pillar in the outcome document from the Brussels Conference. Everyone was surprised about the decision to cut health care for refugees…[38]

The results of these national policies involving health care services have been mixed. On the one hand, donors complain that the government is allocating international financing to its national population to the exclusion of refugees. As a representative from a major European donor stated: 'Jordan has asked for structural things and asked for money for things that they should already be providing for their own people.'[39] Another donor raised a similar objection: 'There is no incentive to deliver welfare to Syrian refugees so we can't leave every decision to [the government]. That's why after one year we found out that they didn't target any refugees. Even now they don't listen to us.'[40] On the other hand, despite these objections, donor investment in Jordan has remained high. In 2016, the London Pledging Summit resulted in a deal called the Jordan Compact, in which donors agreed to invest more heavily in the Jordan Response Plan which was only 36% funded in 2015.

[38] INGO Forum representative, Amman, March 2018

[39] Health adviser, donor organization, Amman [date withheld]

[40] Donor representative, Amman [date withheld]

Subsequently, investment in the JRP nearly doubled to 62% and 65% in 2016 and 2017 respectively (Ministry of Planning and International Cooperation, 2018). Moreover, the World Bank's Jordan Emergency Health Project provided a $150 million loan as an exceptional measure (The World Bank, 2017).

From the perspective of international actors, the link between restrictive health care policies for refugees as a strategy to obtain greater financing is abundantly clear. As a report funded by the European Union stated in early 2019: 'It is expected that GoJ will reverse this policy [restricting access to health care] in 2019, subject to donors providing adequate financing.' (Agulhas Applied Knowledge, 2019). In fact, total World Bank commitments to Jordan almost tripled to $1.6 billion in 2019 compared to the previous year. In June 2019, the World Bank approved a further $200 million to support health care. As a result, as predicted by the EU report, the Government of Jordan recently reversed its policy affecting Syrian refugees, who now once again pay the same rate for health care as uninsured Jordanians. As I discuss in the following section, the marginalization of the health needs of Jordan's refugee population reflects the country's strong opposition to international pressures supporting the long-term integration of Syrian refugees.

'Local integration' or 'temporary protection'?

In the absence of the possibility of a safe return to Syria, international donors have increasingly supported the long-term integration of refugees in Jordan. However, according to Jordanian officials, there are no plans for the long-term or permanent integration of more than half a million Syrian refugees. In fact, despite recent internationally brokered policies and IMF conditions facilitating the integration of Syrian refugees into the labour market, government officials privately acknowledged that the government was aiming for an opposite result: replacing Syrian workers with Jordanians. As one population adviser working closely with the government stated in an interview: 'We can study the market now and study non-Jordanians and what they are doing and start to replace them with Jordanians. For example, in hotel management, those are good jobs. For example, like what

they are doing in Saudi Arabia – they are replacing non-Saudi workers.'[41] In interviews, government officials further specified that the ideal long-term solutions envisioned by the government were either the repatriation of refugees to Syria or, at the very least, increased international commitments towards financing refugees until their return to their country of origin.

This fundamental discrepancy between the objectives of international donors and the Jordanian government became particularly apparent in the discussions – led by UNHCR and several donors – about extending health insurance to refugees. Recent national strategy documents appear to support this goal and call for universal health coverage for the entire population residing in Jordan (High Health Council, 2016). Moreover, the Government of Jordan has undertaken several public commitments towards its implementation, including signing the International Health Partnership UHC2030, also known as the UHC2030 Global Compact in 2018. More specifically, the Compact emphasizes the principle of 'Leaving no one behind: a commitment to equity, non-discrimination and a rights-based approach' (UHC2030, 2018). Though the government was encouraged to include refugees and other vulnerable populations as part of its commitment to universalist principles, as discussed earlier, Jordan has continued along a path of gradual exclusion of refugees from the national health care system (UHC2030, 2018).

Part of the reason is that universal health coverage appears to have particular political implications. That is, the inclusion of refugees in national insurance schemes would give the impression that refugees might not only reside in Jordan for the long-term, but may also become integrated within Jordanian society. On this account, private conversations with government officials show a clear resistance to international pressures. As one representative from the Ministry of Health put it: 'There have been some attempts of international organizations to include Syrian refugees under the civil insurance umbrella, but this is very costly and the government cannot afford the insurance coverage. There is

[41] Government advisor, Amman [date withheld]

also no policy to stabilize Syrians forever in Jordan.'[42] In sum, while appearing to concede to the demands of the international community, many of Jordan's international commitments towards refugees remain commitments on paper only.

Overall, tracking major health policy decisions from 2014 to the present day and interviews with key informants show that at critical junctures in time, the Jordanian Government has attempted to place pressure and exert influence on international donors through border closures and policy shifts. In sum, the Government of Jordan emerges as an important actor that uses its power and agency to shape global agendas, especially when it comes to health policies for refugees. More specifically, policies expanding or withholding health care services for Syrian refugees have been commodified with the express aim of maintaining national stability and security, while serving as leverage to maximise concessions from the international community and resist pressures to integrate refugees. The general perception of a 'crisis' has served to not only defer donor 'exit strategies', but also to exert control over otherwise prescriptive policies and conditions imposed by international creditors such as the World Bank, the IMF and powerful bilateral donors.

5.2 International donors and the politics of fear

This section maps out the particular constellation of donor priorities and decision-making, and how these have influenced policies – or the lack thereof – affecting Syrian refugees. More specifically, when and why have donors provided assistance to refugees residing in Jordan? In 2003, the Good Humanitarian Donorship meeting, an informal forum where major donors share best practices and principles for improving humanitarian action, concluded that overseas development assistance should be guided more effectively by the needs of affected populations and determined by needs assessments (Good Humanitarian Donorship, 2003). When it comes to allocating humanitarian assistance, however, evidence suggests that funding decisions are often only lightly guided by data and humanitarian need (Gazzotti, 2019; Leite & Mutlu, 2017; Olsen, et al., 2003). A study on the funding

[42] Government Official, Ministry of Health, Amman, November, 2017

practices of the Swedish International Development Cooperation Agency, for instance, found that a majority of the organization's investments in health-related programmes lacked reliable quantitative data and were greatly influenced by geopolitical interests, media coverage, and the presence of international humanitarian organizations (Schreeb, et al., 2008). Overall, studies show that donors invest more in some crises than others based on such political considerations as geographic proximity, political ties and strategic alliances, and media attention (Drury, et al., 2005; Fink & Redaelli, 2011).

Over the past two decades, donor investment in Jordan's recurrent 'crises' is particularly significant when viewed through the lens of security as one of the main drivers of international interest in the country and its refugees. As my analysis will show, donor investment in the country's recurring 'refugee crises' has only loosely corresponded to the number of refugees or to the magnitude of humanitarian needs. Rather, overseas development assistance has more often than not corresponded to donor perceptions of 'proximity' to the crisis and, by extension, to fears over the arrival of refugees in the West. What emerges in my analysis is that the years 2015 and 2016 constitute a significant turning point in the trajectory of donor investment in Jordan.

Donors and the crises that count in Jordan: 2000-2015

As can be seen by tracking humanitarian and development assistance before 2015, Jordan's geopolitical significance has more or less guaranteed a constant stream of funding from major donors. Indeed, over the past few decades, the Kingdom of Jordan's foreign policy decisions have strategically positioned the country as an important ally to the West and, in particular, to the U.S. (see Chapter 4). By the late 1990s, Jordan had not only secured a steady stream of international overseas development assistance, but had also become the first Arab state to be granted Most Favored Nation status and to thus occupy an advantaged position as a U.S. trading partner (Schwedler, 2012). Such privileges were eclipsed in the wake of 9/11, when Jordan's cooperation in the War on Terror and in the second Gulf War made the country one of the highest recipients of development aid from the U.S. in the world (Harrigan, et al., 2006).

Jordan's strategic importance to U.S. interests in the Middle East region became particularly apparent during interviews with donor representatives based in Amman. 'Other governments typically have a diplomacy arm and a development arm,' one of my interviewees said about the extraordinary amount of U.S. representation in the country. 'Jordan is a strategic location so we have all three arms: diplomacy, development and defence.'[43] For instance, USAID, the U.S. agency dealing with overseas development assistance, has been present in the country for more than 60 years and has been running a health programme for over three decades. According to representatives from USAID and its humanitarian counterpart the Bureau of Population, Refugees and Migration, funding has rarely fallen short of expectations. As one interviewee put it: 'We were able to keep the same level of funding with just some minor variations. I remember [that] even one year, we were able to get more money than we had even asked for. That was really great.'[44]

As depicted in Figure 6 below, the early 2000s began with a relatively stable amount of funding provided by a handful of donors, including the U.S., European donors, and the United Arab Emirates (UNOCHA, 2000). In the wake of the arrival of refugees from Iraq and Syria funding increased from its previous levels, mainly in response to government calls for international support. Despite initial similarities, however, the international response to the presence of Iraqi and Syrian refugees followed very diverse trajectories. In the first case, the arrival of an estimated 500,000[45] refugees fleeing the U.S.-led invasion of Iraq in 2003 resulted in an uptick in funding in particular from the U.S., which famously doubled its international assistance. By the following year, however, donor attention to the presence of Iraqi refugees had already begun to wane. In November 2005, a series of suicide bombings carried out in part by Iraqi nationals at three popular hotels in Amman strengthened government calls for international support (Kvittingen, et al., 2018;

[43] USAID, Amman, November 2017

[44] PRM, US State Department, Amman, September 2017

[45] As in the case of Syrian refugees, the number of Iraqis who sought refuge in Jordan is highly contested and estimates range between 450,000 and 1 million. According to a study conducted by the Fafo Research Foundation, there were approximately 500,000 Iraqi refugees living in Jordan in 2007 (Fafo, 2007).

Schwedler, 2012). Though this resulted in a modest increase in funding, international donor interest for Iraqi refugees remained lukewarm, with funding only covering 35.5% of the requested amount by the UN in 2010 (UNOCHA, 2010).

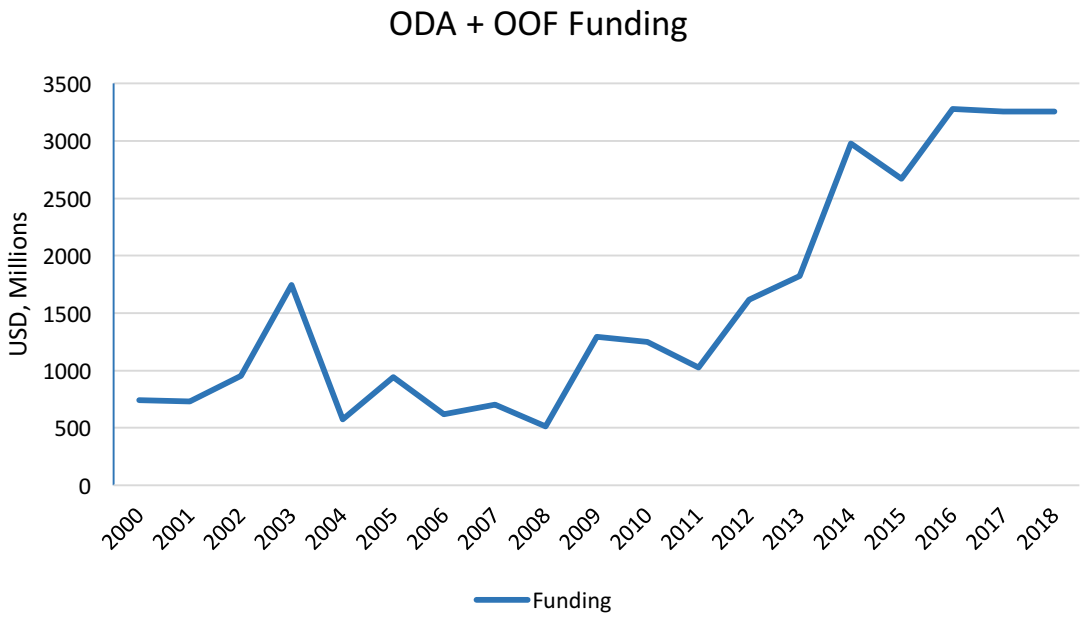

Figure 6: Total Official Funding Flows to Jordan (2000-2018)[46]

Source: OECD Statistics

In the second case, the initial response to the arrival of large numbers of refugees arriving from Syria in 2012 appeared to show a similar arc. In 2012 and 2013, for instance, the arrival of more than 600,000 Syrian refugees seeking shelter in Jordan elicited similar levels of funding as the previous arrival of refugees from Iraq. During this time, most funding focused on providing humanitarian assistance in the form of food items, provisional shelter such as tents and caravans, sanitation services, camp hospitals, and support for the management of the camps. Small amounts of funding also went to support the 'rehabilitation and reconstruction of basic services in Jordanian municipalities' as well as

[46] Total Official Flows: The sum of Official Development Assistance (ODA) and Other Official Flows (OOF) represents the total (gross or net) disbursements by the official sector at large to the recipient country.

to support the creation of jobs for young people, and provide assistance to poor Jordanian families for a period of up to five months (UNOCHA, 2013). With the arrival of Syrian refugees, it appears that Iraqi refugees had by and large been forgotten by international donors. As one donor put it during an interview: 'But with the ISIS crisis, the numbers [of Iraqi refugees] started to increase again, and with everyone's focus on the Syrian refugees, people forgot about the Iraqis.'[47] In fact, Iraqi refugees were mentioned only six times in UN OCHA's Financial Tracking System – which tracks world-wide humanitarian aid flows – among hundreds of projects dedicated to Syrian refugees in 2013.

Moreover, the first three UN pledging conferences – the UN's response to sudden and unexpected emergencies – barely raised enough funding to ensure the minimum survival of Syrian refugees in their host countries (Lenner, 2016). In particular, interviews with donors revealed a general lack of interest in countries categorized as 'middle-income' by the World Bank, which are often left to respond to the arrival of refugees with minimal overseas assistance. As one European donor explained its organizational policy: 'There is a debate on whether middle-income countries should be getting funding. They are not poor, but they also don't have enough to provide for everyone. We don't have a policy for these countries so they often lose out.'[48] Such a tepid appraisal of Jordan's position as a refugee host country makes for a stark comparison to the sudden shift in donor policies after 2015. As I argue in the following section, it was only after the arrival of more than 1 million Syrian refugees in Europe that donors began to perceive the refugee presence as hitting closer to home or, in the words of a commentator at the time, as 'Europe's problems too'. In particular, I contend that the progressive framing of Syrian refugees as security threats in Europe brought about a considerable increase in financing to Jordan.

Donor policies after 2015: when Syrian refugees became 'Europe's problems too'.

After a lacklustre response to the first three UN pledging conferences, donor policies evolved considerably after 2015. When the U.K., Germany, Kuwait, Norway and the UN co-

[47] Interview with donor, Amman, [date withheld]

[48] Interview with donor, [date and location withheld]

hosted the 'Supporting Syria and the Region' conference – also known as the London Conference – they raised more than US$ 12 billion in pledges to 'support humanitarian, resilience and development activities' in Syria and refugee hosting countries for the following four years (UK Government Web Archive, 2018). In addition, several bilateral donors and multilateral development banks such as the World Bank and the European Bank of Reconstruction and Development announced up to US$ 41 billion in loans, including a small percentage available on concessional terms. More specifically to Jordan, the London Conference brought an influx of US$ 2.66 billion in grants and concessional financing (European Council, 2017). So what had changed since the previous years?

Initially, media coverage of Syrian refugees arriving – and often dying – on European shores in 2015 and 2016 brought the horrors of the war in Syria to the doorstep of European donors and, especially, of their constituents (Wallace, 2018). A new public consciousness and outrage over the suffering of refugees was accompanied by a brief period of support in which some European countries such as Germany welcomed hundreds of thousands of asylum seekers (Traub, 2017). Such inclusive policies, however, were soon followed by a widespread political backlash characterized by the resurgence of nationalist and populist movements. In particular, several events which occurred in rapid succession in 2015 and early 2016 contributed to the construction – and widespread public acceptance – of refugees as threats to the stability of states across Europe and the U.S.

First, a series of attacks in Paris in November 2015 – for which ISIS claimed responsibility – killed 130 people and injured hundreds more. The fact that one of the suspects falsely claimed to be a Syrian asylum seeker produced a deep-rooted fear of terrorists masking as refugees among western constituents. Around the world, reactions to the attacks were swift and decisive. French President François Hollande denounced the violence as an 'act of war' that must be countered 'mercilessly' (Henleyand & Chrisafis, 2015). Soon thereafter, 31 U.S. state governors endorsed the narrative of refugees as potential terror threats and publicly opposed President Barack Obama's plans to resettle 10,000 Syrian refugees in the U.S. the following year. 'After full consideration of this weekend's attacks of terror on innocent citizens in Paris, I will oppose any attempt to relocate Syrian refugees to Alabama through

the U.S. Refugee Admissions Program,' Alabama Governor Robert Bentley declared in a statement (Fantz & Brumfield, 2015).

The second event which further cemented the widespread perception of refugees as a security threat occurred in Germany, a state which had welcomed the largest number of refugees of any country in Europe. Here, reports of between 500 and 1,000 men of 'Arab and North African origin' robbing and sexually assaulting women during the 2015 New Year's celebrations in Cologne were largely ascribed to the presence of refugees and asylum seekers (Connolly, 2016). As scholars have pointed out, the New Year's events in Cologne mark a pivotal point in Germany's refugee policies (Greussing & Boomgaarden, 2017). Narratives surrounding the presence of refugees soon began to focus on irreconcilable 'cultural differences' between German citizens and refugees from the Arab world (Greussing & Boomgaarden, 2017). Overall, the perception of refugees and, in particular, of refugee men as a threat to Germany's national identity and security led to a plunge in public support for the integration of refugees (Heisbourg, 2015). Third, in March 2016, a series of coordinated suicide bombings at the airport and at a metro station in Brussels were widely condemned as 'the bloodiest attack since World War II' (Higgins & Freytas-Tamura, 2016). Despite the fact that several of the perpetrators were second generation immigrants and thus Belgian citizens (Counter Extremism Project, 2020), a commentator after the event put it succinctly to the BBC: 'the problems of a fragmenting Middle East are fast-becoming Europe's problems too' (Marcus, 2016).

Amid heightened anxieties over national security, EU member states responded by tightening their national borders and through an increased engagement with the situation of refugees in the Middle East (Düvell, 2018; Heisbourg, 2015). Unsurprisingly, at the time of the London Conference in February 2016, the most generous donors, namely Germany, the European Commission, the U.S., and the U.K., were also some of the countries with the greatest vested interest in keeping Syrian refugees from arriving in their territories – albeit

with slightly differing agendas.[49] For Germany, one of the policy priorities at the conference was to stem the arrival of further refugees to the country (Lenner, 2016). For the UK, the overall strategy was to maintain high levels of support for refugees in host countries, while denying entry to substantial numbers of refugees within their territories (Lenner, 2016). In the case of the U.S., the mission statement of its Bureau of Population, Refugees, and Migration clearly states: 'We maintain our enduring humanitarian commitments by working to assist refugees and other displaced people *as close to their home countries as possible* until they can safely and voluntarily return (U.S. Department of State, 2020).'[50]

At the London Conference, these objectives were plainly stated in the co-hosts' declaration: 'We must support the efforts of the neighbouring countries so that Syrians see a future for themselves and their children *in the region*, rather than risking their lives by fleeing even further from their homes' (UK Government Web Archive, 2016)[51]. Clearly, the intent of the largest donors at the conference was to prioritize the security and integrity of their national borders by restricting the mobility of Syrian refugees and by supporting host countries in keeping refugees within their territories.

Interviews with donors in Jordan further supported these views. Indeed, donors confirmed that a critical aim of proposed policy solutions was the local integration of Syrian refugees into their respective host countries. As one EU donor put it:

> Integration is what we defend from a humanitarian perspective but that is a political issue, that is for the EU to discuss. The best approach is to either return [to the country of origin] or get integrated into the host community. Beyond two to four years, what is the point? There are children out of school waiting to go back and they end up losing the most important years of their lives. How many years is it acceptable to live out of humanitarian assistance for the dignity

[49] These countries pledged the following amounts: Germany - US$ 2.5 billion; the European Commission - US$ 2.3 billion; the U.S. - US$ 891 million; the UK - US$ 730 million.

[50] Emphasis added

[51] Emphasis added

> of the person?[52]

While this interviewee framed local integration as a 'humanitarian' issue which affects the 'dignity of the person', other representatives from donor organizations were more candid in their assessment of their government's objectives. In fact, in a climate of increasing hostility towards refugees in Europe, several donors admitted that they had a vested interest in supporting local integration and in maintaining refugees in their host communities. More specifically, the populations most likely to be affected by these supranational concerns were generally young men, who tended to be targeted and monitored as security risks (Turner, 2019). As one official from a European donor clearly described the organization's priorities: 'The focus is on youth because they are the ones that get into trouble, especially young men between the ages of 17 and 25.'[53]

Significantly, a second watershed outcome of the London Conference was the commitment of host countries to accept the limited integration of refugees into their national labour markets – a move that host countries such as Jordan and Lebanon had strongly and emphatically resisted for years. Labour integration, as many countries had learned from experience, meant acknowledging that refugees were likely to remain in their host countries for an indefinite period of time. In exchange, the donor community agreed to treat Jordan as a 'crisis' country and to disburse billions of dollars in concessional loans. As a senior official from UNDP put it:

> After the Kuwait appeal what changed radically was the next, the London Conference in 2016, where we saw seismic shifts. It was chaired by Angela Merkel, David Cameron, the PM [prime minister] of Norway, and the Secretary-General [of the UN]. And not only did that result in an appeal of US$ 10.9 billion in funds, but also US$ 40 billion in grants and loans, including in concessional financing. They made the business case that because Lebanon and Jordan have a 15% increase in net population – Lebanon has a 30% increase – with this

[52] Donor organization, Amman [date withheld]

[53] Donor organization, [date and location withheld]

> increase in population your GDP goes down. As a consequence of a lower GDP per capita you should, if we follow the World Bank's module, with this decline you should be available for concessional loans.[54]

Matters came further to a head after the 2016 suicide attack in proximity of the Rukban refugee camp. Defined as 'sovereign procedures', the Government of Jordan's response included designating border areas with Syria as 'military zones', halting the expansion of refugee camps, and effectively banning any border crossings from Syria. 'We call upon the international community to understand our sovereign measures and to understand the need for us to take these measures in order to maintain our security and stability,' Mohammad al-Momani, Jordan's minister of state for media matters, said at a press conference (Karadsheh & Hume, 2016). With borders effectively shuttered to Syrian refugees in Jordan and among heightened fears of a further increase in arrivals of refugees in Europe, EU member states responded with increased financial assistance.

[54] UNDP, Amman, September 2017

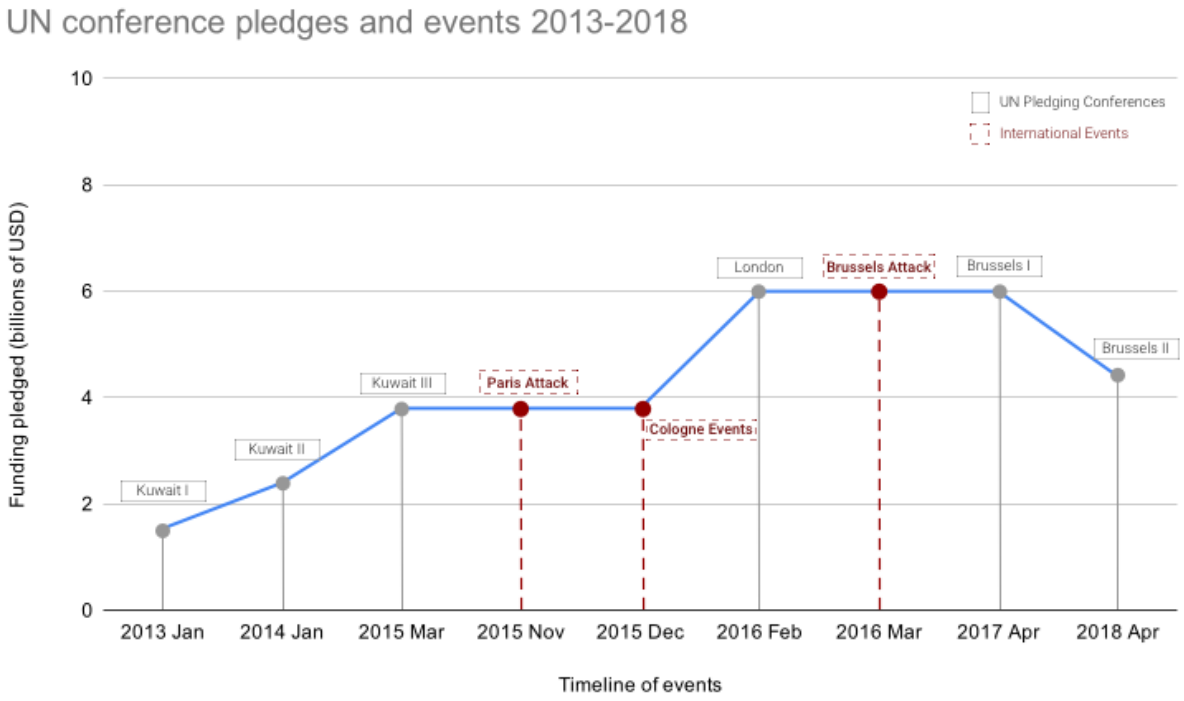

Figure 7: Timeline of security events and amounts pledged at donor conferences (2013-2018)

Source: Compiled by the author

As can be seen by tracking the trajectory of external funding to Jordan (see Figure 7), data show that international interest in Jordan's refugees from the part of bilateral organizations has not necessarily corresponded to the magnitude or the severity of any given crisis. In fact, donor interest in refugees in Jordan has corresponded to a combination of factors, including the perception of closeness to the crisis, and a vested interest in keeping refugees in place in the Middle East. In a climate of increasing hostility towards refugees in Europe, the closure of Jordan's borders could very well mean an increase of asylum seekers on European shores. This was a risk many donors – and their constituents – were not prepared to take. As a large European donor stated frankly during an interview on funding priorities for Syrian refugees: 'We continue to provide because we don't want refugees on our doorstep…There is a conflict between politics and humanitarianism.'[55]

[55] Donor organization [location and date withheld]

As I have argued in this section, an increased securitization of the presence of Syrian refugees in the Global North led to an increase in border externalization policies from the part of EU member states. At the same time, donors proved to be particularly receptive to the demands of Jordanian authorities. To the extent that negotiations between donors and the Government of Jordan resulted in the adoption of 'extraordinary' measures to respond to the presence of Syrian refugees. Such measures include the provision of unprecedented amounts of overseas development assistance – as compared to the previous decade and the previous 'refugee crisis' – and of the disbursement of World Bank concessional loans usually only reserved for low-income countries. The significance of Jordan's policies towards Syrian refugees from a foreign policy perspective has not been entirely lost on observers working in the humanitarian sector. As a medical officer at UNRWA observed about the results of Jordan's policies affecting Syrian refugees:

> Jordan has become politically more important in the global arena and in Western society. When I joined UNRWA seven years ago, none of the donors were interested in Jordan – none of them really. But now we have quite a good number of donors who want to help us in Jordan. And I think it is the same for the Jordanian government, since, along with the influx of Syrians, this country becomes more important, not only for humanitarian support, but also for political stability.[56]

In other words, the presence of Syrian refugees and their need for health care services have been gradually instrumentalized to project a position of power on the international stage. In what follows, I address the funding and policy trajectories among donors in the aftermath of the large-scale mobilization of resources aimed at countering the Syrian refugee 'crisis' in Jordan. Overall, the reduction in the number of arrivals of Syrian refugees in Europe and elsewhere led to subsequent attempts at a withdrawal or 'exit' from Jordan from the part of major donors. However, evidence shows that such attempts have only been partially successful.

[56] UNRWA, Amman, November 2017

Donor investment in 2017-2018: the transition to a 'protracted crisis'

By 2017 and 2018, in the face of what was becoming a 'protracted crisis', western perceptions of the presence of Syrian refugees in Jordan began to shift. The number of Syrian refugees arriving by sea in Europe or seeking asylum in other donor states had dropped considerably and – along with it – the sense of urgency in alleviating the so-called 'refugee crisis'. European border externalization policies had led to an arrangement, known as the 2016 EU-Turkey deal, in which Turkey was promised significant amounts of aid in exchange for hosting refugees. Similar deals with Lebanon and Jordan (such as the Jordan Compact mentioned earlier) further helped reduce the number of Syrian refugees seeking asylum elsewhere.

In 2017, some donors continued to recognize the precarious living conditions of Syrian refugees in Jordan and the potentially catastrophic consequences of downgrading the perception of a 'crisis'. As one donor underlined the political implications of the crisis label for funding and for the future of Syrian refugees residing in Jordan: 'If Syria is downgraded from a Level 3 emergency, then the funding will disappear. It may be downgraded in the next four-five months. It will be a big political battle. And what about forced returnees? There are already deportations.'[57] In the absence of a shared understanding of a 'crisis', donors recognized that many refugees would be forced to return to their country of origin – with deportations already occurring unofficially in Lebanon and, according to some sources, in Jordan (Human Rights Watch, 2017).

By and large, however, interviews increasingly showed a faltering conviction among donors about the crisis narrative surrounding the presence of Syrian refugees in Jordan. Indeed, subdivisions of bilateral organizations with a humanitarian mandate had even begun discussing 'exit strategies' and 'handovers' to agencies concerned with development. As one donor put it, an eventual exit from a protracted crisis was widely regarded as being in the best interest of the donor's constituents:

[57] Interview with donor, [location withheld], 2017

> We have a commitment to the European taxpayers' money, and we have to be consistent to this commitment. At the same time, we also want to try and find a way to step out whenever it is needed, and we don't want to be into a crisis for too long. The more you stay in a crisis, the more heavy and complicated it gets.[58]

Moreover, donor representatives expressed scepticism about the extraordinary measures which the presence of refugees had engendered. More than eight years since the arrival of Syrian refugees in Jordan, what emerged from conversations with donors was a relative perplexity over whether the situation warranted the label of a 'crisis'. Moreover, donors complained that sustained emergency measures were stretching the mandate of organizations focusing on humanitarian financing and blurring the boundaries between humanitarianism and development. 'It is not clear where to draw the line between humanitarian and development,' one donor explained. 'For example, education is a long-term investment…for example, solar power outside Za'atari [refugee camp]…'[59] Donors with a humanitarian mandate emphasised that their mission did not include institutional or health systems strengthening, but rather a focus on maintaining a comparable health status among the general population to before the 'crisis' and avoiding excess mortality. As one European donor explained: 'The health care needs are no longer urgent and are the same as the health care needs of Jordanians. We would want to integrate the needs and not have parallel services. So we need to strengthen the public services, but this is not us because we cannot fund local governments.'[60]

Similarly, several bilateral organizations had misgivings about the necessity and appropriateness of providing humanitarian and development assistance to a country still classified as 'middle-income' by the World Bank. Indeed, donors complained that the government was allocating international financing to its national population to the exclusion of refugees. Moreover, donors recognized the inherently political nature of the

[58] European donor, Amman, 2017

[59] Interview with donor, Amman, 2017

[60] Interview with donor (health expert), Amman, 2017

government's reporting of the numbers of Syrian refugees in the country: 'The Jordanian government to get resources is exaggerating. I feel like that a bit. They are always taking advantage of their geographic position…' [61]

Despite such considerations, however, international assistance pledged at the first Brussels Conference 'Supporting the Future of Syria and the Region' in April 2017 continued to surpass expectations with a total of US$ 9.7 billion in grants for 2017–2020 (UK Government Web Archive, 2016). In the declaration signed by Germany, Kuwait, Norway, Qatar, the U.K., the EU, and the UN, the conference hosts applauded Jordan's apparent commitment to integrating refugees within the labour market:

> The co-chairs and others acknowledged the need for support for the economic development of Jordan and Lebanon to address the impact of the protracted crisis as well as opportunities for Syrians to secure their livelihoods. They welcomed progress in opening labour markets to refugees and agreed to support job creation programmes aligned with the host country governments' social and economic development strategies (European Council, 2017).

In 2018, the second Brussels Conference co-chaired by the EU and the UN continued to show donor support for Syria and the region with a total funding commitment of US$ 7.9 billion in grants, and US$ 21.2 billion in loans from international financial institutions and individual governments (European Council, 2018). By August 2018, 95% of the pledged amount had been disbursed and 14 donors had even exceeded their promises (ibid.).

How to account for the discrepancy between stated priorities focusing on 'exit strategies' and continued high levels of financing for Syrian refugees in Jordan? Overall, despite an evident shift in priorities and discourses aimed at desecuritizing the refugee presence in Jordan, evidence shows that such attempts from the part of donors were only partially successful. Part of the reason lies in the continued geopolitical relevance of Jordan's position in the Middle East and, in part, as a result of Jordanian strategies aimed at

[61] Donor representative, Amman, 2017

maintaining the visibility of Syrian refugees. As one donor stated à propos a slightly decreasing budget for health financing in 2017: 'The attention is moving more towards inside Syria especially since the number of refugees in Jordan are shrinking. But since Jordan is an important partner we don't want [funding] to decrease noticeably.'[62] In other words, donor fears over Jordan's potential response to waning international support served in part to maintain a relatively stable amount of international financing. Moreover, when it comes to financing health and health care, donors acknowledged that financing was only marginally related to reported humanitarian needs. A representative from a U.S. donor organization explained a further increase in its funding for health in Jordan: 'The U.S. government knows we have a special relationship with Jordan, so the overall increase in the budget is not necessarily because there are more health needs.'

In sum, as can be seen by following external funding flows into Jordan during this time period, not all crises and not all refugees are created equal. Despite recurrent and significant refugee presence in Jordan over the past two decades – especially of Iraqi refugees after 2003 – no recent 'crisis' in the country has come close to garnering the level of attention and funding reserved for the arrival of Syrian refugees. In fact, though the Hashemite Kingdom of Jordan has been classified by the World Bank as a middle-income country with a stable government and a relatively strong public health sector – especially compared to other countries in the Middle East region – international donors have invested heavily in infrastructure and in the provision of services. To the extent that, between 2015 and 2016, Jordan became the eighth largest recipient of all Official Development Funding world-wide (OECD, 2018). As donors openly stated in interviews, Jordan and the Syrian 'refugee crisis' have enjoyed a particular status among the donor community and within the popular imagination of western constituents. As an officer at an international NGO in Amman put it: 'You need to accept that some crises get more money than others and maybe

[62] EU donor, phone interview, 2017

comparing is not fair. The closer you feel to the crisis, the more you will pay and you have to accept that this is the way the system works.'[63]

5.3 Conclusion

As can be seen by tracking the amount of external overseas development financing flowing into Jordan from 2012 to the present date, there has been sustained international interest in what has now become a protracted refugee situation. Despite the continued presence of bilateral and multilateral organizations providing services and funding, however, government officials frequently complain of the limits of international cooperation and of a perceived abandonment from the part of the international community. While an analysis of the real or perceived grievances of the host state is beyond the scope of this discussion, what becomes apparent in tracing evolving national health policies is a progressive marginalization of the health needs of the Syrian population. In fact, beginning in 2014, the Jordanian state has engaged in a progressive abandonment of its responsibilities towards providing health services to refugees. As I have argued in this chapter, such policies have served multiple purposes: that of appeasing Jordanian citizens in the face of increasing austerity measures, improving Jordan's ability to negotiate international assistance, and to resist the long-term integration of Syrian refugees.

From the perspective of international donors, findings reveal that investment in humanitarian and development assistance in Jordan is closely tied to the perception of relative *closeness* or political proximity to the crisis. In other words, decisions to invest in refugees and health are steeped in political considerations which, in particular, include concerns over the national security of the governments they represent. As donors stated in interviews, the fear of refugees 'on their doorstep' served as a strong incentive for their continued support to Jordan. As a result, despite donor scepticism over the appropriateness of providing humanitarian funding and assistance to Jordan's 'refugee crisis', international assistance to Jordan has remained much higher than what would usually be available to a

[63] NGO representative, Amman, November 2017

middle-income country. Moreover, a relatively weakened position among EU donors in the face of political paralysis and populist backlash among member states means that donors appeared particularly amenable to fulfilling Jordan's terms and conditions for hosting Syrian refugees. In what follows, I turn to an analysis of the preferences of the international humanitarian and development actors tasked with implementing health policies and allocating resources to refugees.

Chapter 6 | BETWEEN COOPERATION AND CONTROL: HOW NON-STATE ACTORS NEGOTIATE ACCESS TO THE HUMANITARIAN SPACE

In the previous chapter I analysed the factors which influence the decisions of international and domestic state actors to invest in refugees and health care in Jordan. What emerged from my analysis is that health policies affecting Syrian refugees are highly politicized and largely reflect the preferences and interests of the actors that formulate them. I now turn to an analysis of the ways in which humanitarian non-state actors react to the limitations posed by powerful donors and government authorities. As discussed in Chapter 4, the retrenchment of the Jordanian state as the main service provider has left a vacuum, which has been filled in part by non-state actors involved in financing, providing, and regulating services, including for health. Over the past few decades, growing numbers of non-governmental and multilateral organizations have thus coexisted in a context of both cooperation and competition for funding and resources. In what has become an increasingly crowded 'humanitarian marketplace', this chapter answers the research question: How do non-state actors negotiate and legitimize access to the humanitarian space?

Drawing on IR scholarship on regime complexity, this chapter investigates how the rapid proliferation of institutions in the wake of the arrival of Syrian refugees served as a catalyst for the rapid expansion of the aid market. By 2020, as many as 17 UN agencies and programmes, and 59 international NGOs, which receive an estimated 80% of all humanitarian financing (UNOCHA, 2020), were involved in the regulation, allocation, and delivery of humanitarian assistance (JIF, 2020; UN, 2020). As a result, I argue that a densely populated humanitarian space has strongly influenced the behaviours and strategies of both state and non-state actors. On the one hand, the large number of humanitarian and development actors confers an advantage to donors and government authorities who can select – or 'shop' for – partners and fora based on their strategic preferences and interests (Alter & Meunier, 2009; Drezner, 2009). On the other hand, non-state actors find

themselves compelled to behave strategically to maintain relevance and legitimacy in an increasingly crowded arena (Betts, 2013).

This chapter is divided as follows. I begin by examining the ways in which state actors such as donors and the Government of Jordan engage in 'forum shopping' by financing and regulating non-state actors based on their strategic interests. Consequently, I argue that non-state actors employ three fundamental strategies which allow them to maintain their relevance and legitimize their activities in the 'humanitarian marketplace'. These strategies include (a) attempting to influence state preferences by providing technical assistance and expertise within national policymaking; (b) promoting 'crisis' and 'emergency' narratives; and (c) adapting their discourses to conform to the expectations of donors and national authorities.

Lastly, I investigate some of the effects that these strategies have on collaboration among actors and on the overall priorities of the health response. In a context which both expands and limits the scope for cooperation, some non-state actors have expanded their mandates, while others have considerably narrowed the scope of their operations. As a result, struggles over authority, legitimacy and power contribute to the neglect of some health causes and of the needs of some refugee groups. Overall, a complex coordination structure comprised of large numbers of actors means that there is little accountability when humanitarian objectives fall through the cracks.

6.1 State actors and the delimitation of humanitarian activities

Scholars theorizing on regime complexity – defined as the 'way in which two or more international institutions intersect in scope and purpose' (Betts, 2013, p. 61) – have observed the effects of the proliferation of institutions on the behaviour of state actors (Orchard, 2017; Orsini, et al., 2013). In Jordan, the wide availability of competing service providers, organizations, and fora has allowed donors and government authorities to strategically select international venues and service providers that are most sympathetic to their policy preferences. In what has been defined as 'forum shopping' or 'regime shifting', state actors exert a considerable amount of control over the activities of international non-state actors

(Morse & Keohane, 2014). In what follows, I turn to the ways in which the behaviour of state actors increasingly restricts and constrains access to the humanitarian space.

Donor priorities in the humanitarian marketplace

In line with observations on the growing 'bilateralisation' of humanitarian aid (Macrae, et al., 2002), donors in Jordan have been increasingly involved in humanitarian activities and decision-making. Discussions with donor representatives revealed a tightening of the reins over the activities of international NGOs as a means for subsuming humanitarian objectives within the remit of domestic and foreign policy aims. In a first instance, donor organizations delimited access to the humanitarian space through the selective allocation of funding. This occurred mainly through calls for proposals which encouraged funding applications from INGOs and pre-established implementing partners. As donors discussed in interviews, the allocation of resources to partner organizations was not only largely contingent on the selection of projects that conformed to specific criteria, but also entirely at the discretion of the individual donor. According to a UK donor representative, this selection procedure is highly strategic:

> We have a strategic component based on DFID's and UK strategy, and how well a project conforms to the overall strategy and how relevant it is. Then there is the programme component and the beneficiary selection process and the value for money. There is a high weight on the programme and the organization's ability to monitor and evaluate.[64]

As described in the interview excerpt above, donors stated that they were willing to invest in a project or programme based on several criteria: an organization's ability to conform to the donor's strategic priorities and the selection of 'beneficiaries' or recipients. Moreover, funding decisions were based on an organization's ability to 'monitor and evaluate' results, demonstrate the 'impact' of its activities, and comply with criteria such as 'value for money' (discussed in more depth in Chapter 7).

[64] Donor organization, Amman, August 2017

Failure to conform to donor preferences, as I observed during my fieldwork, could have dire consequences even for larger international organizations. In 2017, for instance, the U.S. State Department announced that it would cut all funding to the United Nations Population Fund (UNFPA). The stated reason was that UNFPA allegedly 'supports, or participates in the management of, a programme of coercive abortion or involuntary sterilisation' (Ford & Khomami, 2017). While UNFPA supports universal access to 'voluntary family planning', the organization vehemently denied the allegations (UNFPA, 2019). Funding, however, has remained unavailable for the past three years. 'When [U.S. President] Trump won, he reduced the funding provided for UNFPA,' an official from the agency lamented in an interview. 'They decreased our funding maybe by 30% because of the family planning issue.'[65] As a result, UNFPA has had to adjust its priorities and reduce the provision of certain services to Syrian refugees.

Shortly thereafter, the U.S. announced a cut to its funding to UNRWA, the UN agency providing assistance and health care services to more than 1 million Palestinian refugees and their descendants in Jordan; a population which the U.S. State Department defined as an 'endlessly and exponentially expanding community of entitled beneficiaries' (Beaumont & Holmes, 2018). The move was seen by many as a means to delegitimize the refugee status of Palestinians in the Middle East and to aggressively push for the acceptance of a U.S.-brokered peace plan (Beaumont & Holmes, 2018). As a result, with one-third of its budget slashed, UNRWA has been struggling to fund its school programmes and to provide food support to its target population (Reinl, 2019).

In both cases, abrupt funding cuts from the world's largest donor affected significant proportions of these agencies' budgets, severely restricting their ability to provide services. In many ways, the defunding of UNFPA and UNRWA provides a cautionary tale to UN agencies and NGOs about the high price that comes with pursuing an independent agenda. Within the complex dynamics of the humanitarian system, a single donor such as the U.S. can wield a disproportionate amount of power over the financing, the provision of services,

[65] UN agency, Amman, August 2017

and even the principles and values of particular organizations. Indeed, conversations with donors revealed a concerted effort to influence and guide the overall humanitarian response according to organizational preferences. As one donor put it succinctly: 'In the donor coordination meetings, we try to establish our common position so we as donors try to speak with one voice or a confirmed common position. This gives us stronger backing and influence over the UN.'[66]

Despite the clear conditions placed on funding and on the operations of their implementing partners, donors were quick to minimize their involvement in humanitarian activities, and to point out that their relationships with implementing agencies remained fundamentally unaltered. As one donor specified in an interview: 'Nothing has changed with our relationship with the UNHCR, *we are just asking more questions*. So if they're sending money to Jordan, we would like to know how much money is being sent.'[67] Indeed, donors preferred to describe their increased involvement in guiding and regulating humanitarian activities as a necessary measure for ensuring greater transparency and improving the overall efficiency of the humanitarian response. By and large, donors I spoke to envisioned their roles as demonstrating 'value for money' to the taxpayers of their respective governments. As an EU donor put it: 'Because it's European taxpayers' money there is a lot of expectations of transparency, and also they [taxpayers] want the best use possible of their money.'[68] In other words, donors unsurprisingly viewed European taxpayers – rather than refugees – as the ultimate arbiters of the 'value' and overall success of their investments.

As has been observed in other contexts (Macrae, et al., 2002), donors justified their involvement as a necessity to compensate for a perceived failure among humanitarian agencies to demonstrate the impact of their programmes and to fulfil accountability criteria. Indeed, donors showed a considerable amount of distrust towards implementing

[66] EU donor, (phone interview), November 2017

[67] Donor organization, Amman, September 2017, emphasis added

[68] Donor organization, Amman, November 2017

agencies and, in particular, towards national NGOs. Donor scepticism vis-à-vis operational organizations directly translated into a greater amount of earmarked funding – as opposed to unallocated funding through UN appeals – and in the purposeful exclusion of national organizations from international funding.[69] This shift towards a greater monitoring of NGO activities was presented as a necessity to counter a perceived lack of experience among NGO workers. According to one donor: 'The disaster response has tended to attract younger workers for whom this is a first experience. There are inexperienced people making decisions on a humanitarian crisis, which is the largest we've seen in our time.'[70] When it comes to national NGOs, these were perceived as being unable to fulfil both accountability and branding criteria due to a lack of capacity and potential corruptibility. Put differently, donors were wary of being associated with organizations which might not share their strategic objectives or might be perceived as damaging to their reputation.

Overall, the large number of international NGOs and organizations providing services to refugees has allowed donors to engage in instances of 'forum shopping', by funding or defunding organizations which are most – or least – sympathetic to their interests and preferences. A combination of such donor strategies, along with the increasing politicization of humanitarian assistance discussed in the previous chapter, has placed considerable constraints upon the breadth and scope of humanitarian activities. 'Usually what should happen is that the programme drives the budget, but with this situation the budget is driving the programme,'[71] an NGO representative acknowledged in an interview.

Over the past few years, humanitarian funding to Jordan has begun to show signs of decreasing, which has set many NGOs further on edge. As a UN public health officer commented on the impact of funding cuts on the humanitarian system's ability to continue to provide for Syrian refugees and vulnerable Jordanians:

[69] Health advisor, donor, (location withheld), 2017

[70] Donor, [location withheld], 2017

[71] NGO representative, November, 2017

> We all know there is a reduction globally in the funding for Jordan, not only to Jordan, but the MENA region…We experienced a 10% reduction in the budget…And this indeed negatively impacted the refugees and their access to health care services.[72]

In a situation of protracted displacement, NGOs are exceedingly aware of the conditional and temporary nature of international funding. Furthermore, as I address in the following paragraphs, the perception among national authorities of the politicized nature of international assistance has led to further restrictions on humanitarian activities. With humanitarian action increasingly becoming an integral part of donor strategies (Mawdsley, 2017), NGOs and UN agencies are largely viewed by the Government of Jordan as representing the interests of their (mainly) western funders.

Government regulation of foreign funding

Since 2014, the Government of Jordan has taken the lead in coordinating and regulating the Syrian refugee response. For all intents and purposes, access to the humanitarian space can only be negotiated through government authorities who hold the power to legitimize or delegitimize the presence of NGOs and international organizations within the country. Stringent government control over the refugee response means that all NGO projects must not only align with the priorities explicitly stated in the JRP (see Chapter 4), but must also be registered for prior government approval. As a donor explained the procedure:

> So, through this JRP process, every NGO and programme has to get registered and get approval from the MOP [Ministry of Planning and International Cooperation] because they want to know how much money is coming, where from, and how much of it is spent, which is understandable, you know, it is their right as it's their country.[73]

[72] Public Health Officer, UN agency, October 2017

[73] Donor organization, Amman, September 2017

Failure to align with government priorities would severely curtail the ability of international organizations to operate in the country (Human Rights Watch, 2012; Human Rights Watch, 2016). Moreover, since 2009, amendments to Jordan's Law on Associations have placed greater restrictions on NGO activities – which are frequently perceived to be politically motivated – and foreign funding. Though revisions to the law have improved access to registration for non-governmental organizations, they have also increased the authority of officials over individual projects, which now require cabinet-level approval for foreign funding (Human Rights Watch, 2012). Amendments include the broad prohibition of any groups that pursue 'political objectives' or violate 'public order'. This has led to the dismissal of several civil society organizations which, for instance, supported the rights of migrants or the legal right for women to transfer their nationality to their children (Human Rights Watch, 2016).

In 2016, several amendments added further restrictions, including to the registration of groups violating 'national security, public safety, public health, public order, public morals, or the rights and freedom of others' (Human Rights Watch, 2016). These amendments also expanded the right of the government to reject funding proposals without justification, restrict the operations of international NGOs and the flow of foreign funding, and reject applications for registration by simply not responding within 60 days (ibid.).

When it comes to collaboration with the government, relations between NGOs and Jordanian officials were marked by frustration and apprehension. Representatives from NGOs often pointed out the limited communication and exchange between UN-led working groups and government-led task forces (see Chapter 4). The government remained recurrently absent from working group meetings and international NGOs regularly did not participate in task force meetings. A frequent complaint from the part of NGOs was that the government remained inflexible and intractable in setting priorities and regulations, which were not necessarily aligned with the most urgent needs. A representative from an NGO providing medical services expressed frustration with the strict government oversight of the medical response:

> They come almost weekly to our hospital to check our standards, for example the distance between beds, our waste management, they check our infection control, our staff, and overall they are extremely active and caring about this. The more they care about the technical aspects…the less they regard the quality of our care…This does not interest them. For example, with non-communicable diseases, the Ministry of Health has no protocol that all doctors are supposed to follow. I know that they are working on it with WHO, but for months now they haven't met. So that means that people can get very different quality of care depending on what doctor they meet and where they meet the doctor and so on.[74]

Other challenges in cooperation with the government include diverging conceptualizations of which categories of citizens and non-citizens should be included in the 'resilience' financing section of the Jordan Response Plan. With more than half of total budget requests seeking support for 'resilience', definitions of this term have been a cause for attrition. According to the government, resilience financing should strengthen institutions and support the domestic population referred to in policy documents as 'host communities' and 'vulnerable Jordanians'. According to representatives from UNDP, however, 'resilience' financing is meant to support the sustainability of humanitarian and development interventions, which may or may not include supporting government institutions and Jordanian host communities.[75] Government sources privately complained during interviews that only 30% of funding supported 'vulnerable Jordanians' with all remaining funding dedicated to Syrian refugees.[76] In reality, the most recent iterations of the JRP consistently requested greater amounts of 'resilience' financing as compared to funding dedicated to refugees (Ministry of Planning and International Cooperation, 2018).

[74] Director of an NGO focusing on the medical humanitarian response, November 2017

[75] UNDP, Amman, September 2017

[76] Ministry of Health, Amman, December 2017

As discussed in this section, the Government of Jordan and powerful donors such as the U.S. wield a considerable amount of control over the mandates and operations of organizations providing health care to refugees. On the one hand, donors often view international NGOs as instruments of foreign policy (Calhoun, 2010). On the other hand, national governments perceive the presence of international humanitarian and development organizations as an intrusion on national sovereignty. In what follows, I analyse the strategies undertaken by international NGOs and other non-state actors which allow them to overcome some of the strict limitations imposed by state actors.

6.2 Negotiating access and legitimacy in a crowded humanitarian space

In their seminal article on the power and pathologies of international organizations, Barnett and Finnemore (1999) identified two expressions of power which are applicable to the Jordanian context. First, international organizations are involved in the diffusion of norms which influence national policies and set standards for 'good behaviour' (Barnett & Finnemore, 1999). Second, international organizations legitimize their interventions and set boundaries for what is considered to be 'acceptable action' by 'fixing meanings' (Barnett & Finnemore, 1999). It is to these two expressions of power that I turn to in this section: influencing national norms and policies, and setting boundaries for acceptable action. Building on these concepts, I add an additional strategy through which non-state actors negotiate access to the humanitarian space: adapting their discourses to the interests of powerful state actors.

Influencing national policies[77]

To overcome some of the restrictions imposed by donors and government authorities, non-state actors seek to maximize their authority by setting standards for 'good behaviour' (Barnett & Finnemore, 1999). Interviews with NGOs revealed frequent attempts from the part of larger and well-established organizations to shape the values and principles guiding

[77] Some of the arguments in this section are based on a draft of an article published in *Global Social Policy*

national health agendas. Such values included establishing health as a human right and advocating for universal health coverage (discussed in Chapter 5). Over the past two decades, international non-state actors have been increasingly involved in providing technical expertise in drafting national strategies and health plans, and in knowledge production. In 2006 and 2011, for instance, the WHO financed and produced the two main publicly available reports describing the workings and financing of the Jordanian health care system (Verme, et al., 2016; WHO, 2006; Ajlouni, 2011).

Significantly, over the past 10 years alone, all national agendas and health strategies have been drafted in collaboration with UN partners and other international organizations. Recent collaboration between the government and international NGOs has included efforts to align Jordan's national health policies with the objectives charted out by the UN's Sustainable Development Goals. In 2017, for instance, the government reached out to several of its international partners, including the WHO, the World Bank, and USAID, for assistance in drafting an updated version of the 'Ministry of Health Strategic Plan 2013-2017'. According to a WHO press release at the time, the main objective of the new plan was to attain Sustainable Development Goal 3.8 or, more specifically, to 'achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all' by 2030 (WHO, 2017).

Though strategies supporting the expansion of health coverage to the entire national population had been espoused by several successive governments for decades, it was only in 2014 – at the height of the arrival of Syrian refugees – that language pertaining to human rights began to feature in national health policies. An excerpt from a speech by King Abdullah II stated that: '…to improve the quality of life of each citizen requires attention to *Healthcare as a right for each citizen*. The healthy reassured citizen for his health and the health of his children is able to work and produce [sic.]' (High Health Council, 2016, emphasis added). As all documents since 2014 have been explicitly drafted in collaboration with external humanitarian and development actors, and supported by major donors such as USAID, the development of explicit human rights language – absent from earlier national

strategies – suggests an increasing alignment with international values. Indeed, the notion of health as a fundamental human right is repeated several times throughout subsequent policy reports as a framework and justification for the implementation of universal health coverage and the expansion of health care services.

While a comprehensive analysis of the influence of external actors on domestic policymaking and policy transfer is beyond the scope of this chapter, data suggest that a long-standing collaboration between government ministries and international organizations has played a significant role in influencing the policies and priorities of government policymaking for health. In the specific case of health policy formulation, the presence of international organizations and their close collaboration with the government in agenda-setting and policymaking have led to the transfer and dissemination of international values, frameworks and policy reform models to the national level over an extended period of time (Harrigan, et al., 2006; Lupieri & Frisina Doetter, 2020). In this context, some of the activities undertaken by international organizations can be seen as an expression of global governance processes which have far-reaching effects on the shaping and formulating of domestic policies (Kaasch, 2015). In what follows, I address a second strategy largely employed by international actors: the 'fixing of meanings' so as to set boundaries for acceptable action (Barnett, 2012).

Who defines a crisis?

In the face of flagging donor interest and concerns over dwindling resources, constructions and definitions of 'crises' and 'health crises' among actors involved in the health response are not only vague and opaque, but also serve a particular purpose – that of legitimizing their continued presence in Jordan. As discussed in interviews, the vague nature of the terminology, in which 'crisis', 'disaster' and 'emergency' are used interchangeably, obscures the relative mundaneness of the presence of refugees within the historical context in Jordan (see Chapter 4) and serves to heighten the need for immediate action (Calhoun, 2010; De Genova, et al., 2018). As highlighted by Watson, 'humanitarianism, like security, is a powerful discourse that legitimized marshalling a vast amount of resources in the implementation of emergency measures' (Watson, 2011, p. 4). In other words, by

emphasising human suffering, the emergency imagery promoted by the media, the state, and international organizations presents an exceptional condition which requires an exceptional response (Brun, 2016; De Genova, et al., 2018).

In 2013, a report by Médecins Sans Frontières (MSF) criticised the participation of non-state actors in 'catastrophizing' the presence of Syrian refugees. As the authors of the report wrote: 'Overall, it appears that the international reading of the situation inside Jordan, and especially inside Za'atari [refugee camp], is worse than it is in reality, and humanitarian agencies have contributed to the creation of that' (Healy & Tiller, 2013, p. 19). Indeed, the report emphasised how competition among actors over international visibility had led to a considerable amount of publicity on the living conditions in refugee camps, often at the expense of the visibility of refugees residing in urban areas (ibid.). Though vulnerability assessments clearly indicated a greater need for support to the majority of Syrian refugees living in Jordan's host communities, well-known celebrities such as Angelina Jolie, who visited the Za'atari refugee camp in 2012 and 2018 (Reuters, 2018), continued to point the spotlight on the needs of refugees living in camps.

As the years that refugees spend in exile wear on, the 'crisis' nature of their presence has been increasingly called into question – at times by humanitarians themselves. Indeed, the presence of non-state actors involved in financing, regulating and delivering health care in Jordan has not only led to parallel systems of health governance, but also to competing definitions of what constitutes a 'crisis', an 'emergency' or a 'protracted crisis'. On the one hand, interviewees noted that the pressure on state health care services brought about by the arrival of Syrian refugees constituted an emergency in its own right.[78] On the other hand, NGO staff members voiced their frustration with a system which appeared to overwhelmingly incentivise a focus on emergencies. The majority of interviewees emphasised the strong correlation between labelling a situation an 'emergency' and the amount of funding that NGOs and UN agencies could expect to receive from international donors:

[78] International medical NGO, Amman, November 2017

> On the one hand everyone wants to cry wolf and wants to call it an emergency because it's so sexy and it's what everyone wants to hear – so much better to say 'I am working on an emergency', than to say 'I am working on resilience and development'…But whether a substantial long-term influx of people – whether that you can still call an emergency – I'm not sure.[79]

According to some actors, the presence of Syrian refugees in Jordan had gradually become 'the new normal' and labelling the situation an emergency would only serve to detract from 'real' emergencies. 'It is still labelled as an emergency, but you need to ask yourself: is it really an emergency?' a public health officer from a UN agency questioned during an interview. 'I keep saying to partners in meetings: "let's move away from this emergency thinking and accept it for what it is." If everything is an emergency, then the emergency mechanisms will not work anymore.'[80]

By 2017 and 2018 many Syrian refugees living in Jordan had been in exile for more than five years – a time limit which, in the humanitarian space, differentiates an 'acute' from a 'protracted' crisis (UNHCR ExCom, 2009). 'I saw people come into Jordan barefoot, just with a plastic bag. So people, over the years, you know their vulnerability has increased,' said a representative from a donor organization focusing on the humanitarian response.[81] Despite the growing long-term needs of a population which has over time depleted its resources, NGOs reported facing resistance from both donors and the government in recognizing the protracted nature of the refugee presence in Jordan. According to frustrated staff members at various NGOs, part of the responsibility lies with international donors who 'don't want to see protracted crises as protracted so they just give short tranches of funding.'[82] According to UNDP, which has long advocated for including

[79] UN Agency, Public Health Officer, Amman, September 2017

[80] UN Agency, Public Health Officer, Amman, September 2017

[81] Donor, Amman, September 2017

[82] International NGO (Skype call, US), August 2017

development planning from the outset of any given emergency, government bureaucracies have resisted efforts to acknowledge a 'development-humanitarian nexus'.[83] As one exasperated UN official noted: 'That people are living here is a fact that we need to admit, and we need to provide them with care because it is a human right. They should be treated with respect and they need to be given what they need after they have been deprived of their home.'[84]

The protracted nature of the displacement of Syrian refugees has raised fears over potential 'donor fatigue' and a subsequent decrease in funding. [85] With new crises emerging in other parts of the world and diverting the attention of the media and international donors in 2017 and 2018, the need for international NGOs to maintain legitimacy and justify their presence in Jordan had become as pressing as ever. As a UN public health officer summed up the dilemma: 'You get more money as soon as you call something an emergency…' [86] In other words, international humanitarian and development organizations not only fix the meanings of such notions as 'crisis', 'emergency', and 'protracted emergency', but at the same time also delineate the appropriateness of the response (Calhoun, 2010). A focus on crisis narratives has had the clear advantage of legitimizing the presence and activities of large numbers of humanitarian and development actors, and warranting the disbursement of exceptional amounts of funding. In what follows, I turn to a third strategy undertaken by non-state actors to maintain their legitimacy and relevance: adapting their discourses to conform to the expectations of state actors.

Adapting discourses

As scholars have suggested, the ability of international organizations to conform to donor and state preferences can greatly enhance their success in securing funding and approval in a competitive and crowded humanitarian space (Alter & Raustiala, 2018; Asad & Kay,

[83] UNDP, Amman, September 2017

[84] UNFPA, Amman, August 2017

[85] Medical NGO, Amman, December 2017

[86] UN Agency, Public Health Officer, Amman, September 2017

2014). With the risk of 'donor fatigue' looming at every UN funding appeal, and the threat of countries reneging on their pledges, it thus comes as no surprise that NGOs often find themselves catering to the priorities of powerful donors and government authorities. As illustrated in the following two examples, some actors have engaged in the use of 'issue-linkages', which promote causal relationships between refugee protection and the priorities of state actors (Betts, 2013). Others, have espoused depoliticised and neutral discourses to maximize their chances of receiving government approval.

In the face of mounting concern among state actors over national security, evidence shows that international humanitarian and development organizations have at times created causal links between development objectives and the attainment of national security objectives. In other words, the protection of refugees has been frequently embedded within wider narratives supporting terrorist prevention activities. A UNDP project from 2017 is a case in point. Under the banner of 'psychosocial support', 'livelihoods integration' and 'women's empowerment', the project had the explicit objective of providing 'support to counter-terrorism, stabilization, and counter-radicalization in Jordan' (UNDP, 2017, p. 1). As part of its efforts to 'mitigate the impact of the Syrian refugee crisis through support to host communities', the project's stated aim was to '…employ a comprehensive multi-sectoral approach to support national efforts to stabilize the country and immunize it against any possible spread of violent extremism' (UNDP, 2017, p. 1). According to the project description, tackling the 'root causes' of extremism included a myriad of interlinked interventions ranging from such vague objectives as 'community empowerment' to improving the responsiveness of state organizations to the needs of citizens, and 'creating youth employment'.

While couched in technical language, the project created a subtle but pernicious link between the arrival of Syrian refugees from ISIS-controlled areas and their potential to conduct terrorist activities in Jordan. In this context, Jordan was depicted as a fundamentally stable country whose citizens were threatened by the temptation posed by extremist ideologies. As the writers of the project document put it:

> Syria has now become the training ground of choice for today's violent extremists. Extremists [sic] groups operating from Syria have become increasingly good at the recruitment of fighters from all over the Arab region and the world, including from Jordan, through campaigns often relating to sectarian issues and using the cyber space. Though Jordan is one of the few countries in the region still blessed with stability, some Jordanians are actively contributing to the growth of fighters in neighbouring countries (UNDP, 2017, p. 3).

As evidenced in the excerpt above, rather than presenting refugees as *at risk* populations, the project document depicted refugees as *a risk* to the national population (Gray & Franck, 2019). Of particular interest is the gender dimension of the project. Though women generally tend to be depicted as helpless and 'vulnerable' (see Chapter 7) within humanitarian discourse (Johnson, 2011), the project document reflects a more ambivalent stance. Here, female refugees are called upon to contribute to the economy through their participation in the labour market. At the same time, however, the project attributed some of the root causes of violent extremism to youth being rendered 'vulnerable' by an absent mother or father. More specifically to women, the document stated that 'as the "bread-winning" responsibilities fall on the mother, she may have less time and attention to dedicate directly to her children.' A follow up interview with a representative working on the project confirmed that women were considered to be at the heart of campaigns to eradicate violent extremism.[87] Women, largely identified as 'mothers' and 'caregivers', were thus perceived as not only bearing responsibility for the upbringing of their (male) children, but as pliant receptacles for internalizing and transmitting values and behaviours tied to peace and non-violence.

As this example shows, the securitization of Syrian refugees is not only the domain of state actors. In fact, scholarship has recognized the ways in which humanitarian projects aimed at altering the behaviour and attitudes of recipients can devolve into the dangerous

[87] UNDP, Skype Interview, August 2016

regulation of the lives of refugees (Brown, 2014). By constructing refugee populations as traumatized, dysfunctional, or prone to terrorist activities, such issue-linkages merge humanitarian and social concerns with the national security concerns of donor states (Gray & Franck, 2019).

In the absence of an ability to create issue-linkages or influence state preferences, smaller, less-established non-state actors acknowledged that they frequently adjusted their narratives to avoid offending donor and government sensibilities. Such adjustments consisted in submitting applications for projects couched in apolitical language so as to speed up an otherwise lengthy approval process and reduce the likelihood of rejection. As a representative from an NGO delivering health services explained:

> The government plays a large role in determining the priorities and the research on health. For example, when making an assessment, all organizations have to take government sensitivities into account as any action has to have government approval and all projects have to be registered with the government. This means that many organizations *have to make charity-based arguments rather than getting involved in the politics of inequality and impoverishment* among refugees as time passes.[88]

As explained in the interview excerpt above, proposals for funding for health projects frequently favour the neutral appearance of charity-based arguments and eschew human rights discourses that might imply government criticism. In contrast to assumptions about the political role of 'new humanitarians', many non-state actors negotiate access to the humanitarian space by presenting themselves as neutral and apolitical actors (Orchard, 2017).

In sum, non-state actors respond to the limitations placed on access to the humanitarian space through several strategies, including influencing national agendas and frameworks, espousing narratives that focus on emergencies, and adapting their discourse to state

[88] UNHCR, Amman, September 2017

preferences. Interestingly, the strategies adopted by international non-state actors closely relate to an organization's status within the humanitarian system. Larger, well-established actors tended to exert power and authority by attempting to influence actor preferences or create linkages among issue areas. Smaller actors with more limited budgets tended to adapt their discourses to conform to the preferences of powerful state actors. In what follows, I examine some of the effects and unintended outcomes of such strategies on the mandates, partnerships, and activities of the overall humanitarian and development response.

6.3 The UN's 'borderline dictatorship' and other unintended outcomes

In this section I investigate the ways in which institutional proliferation – and the strategies which arise from it – has induced greater competition for resources and thus hampered effective collaboration. Described in terms of 'challenged' and 'reinforced' institutions (Betts, 2013), findings show that some organizations have been able to exert authority and dominate the refugee and health response. Others, have been effectively side-lined and have reduced the scope of their operations to focus on narrow, specialized issues and target groups. When it comes to health care, increased competition, a focus on emergency narratives, and adaptation to state preferences have rarely resulted in more efficient or more equitable service provision. To the contrary, cross-sectoral issues which require wide-ranging collaboration – such as the management of NCDs or the particular needs of older persons – often fall through the cracks. As scholars have pointed out, the vast and complex amalgam of institutions, rules and actors which make up regime complexes translate into reduced accountability towards refugees (Alter & Raustiala, 2018).

Expanding and narrowing mandates

For several months during my fieldwork, I attended the Health Sector Working Group (HSWG) meetings held at the UNHCR office, a squat, concrete building along the dusty, traffic-clogged Wasfi At-Tall Street in the outskirts of Amman. I joined 20 or so representatives from UN agencies, the Ministry of Health, and international NGOs who met regularly to discuss sharing data, ongoing projects, and successes and failures. As part

of the HSWG, five official sub-groups addressed specific focus areas: reproductive health, mental and psychosocial support, nutrition, community health, and non-communicable diseases. Though the meetings appeared collegial and well-attended, individual interviews with members of the working group exposed tensions related to collaboration among health actors and, in particular, among international NGOs and UN agencies. What emerged from interviews is that this large and often bureaucratic cooperation mechanism has tested the limits of these partnerships, which remain based on a combination of competing interests, mutual distrust, and co-dependency.

Collaboration between the UN and other international NGOs was often fraught. Fears over a monopoly of the coordination mechanism by the UN led to some large NGOs avoiding the meetings altogether and referring to the running of the HSWG as a 'UN dictatorship'. This view is corroborated by the fact that, since the inception of the health working group, the chairs have consistently been representatives from the WHO and UNHCR. According to the WHO and UNHCR, however, the main reason for the lack of rotation among chairs is that no other organization has shown an interest in taking over this responsibility. An interview with a UN representative revealed awareness of the resentment caused by UN leadership in the refugee response: 'I do think we need to get away from this borderline dictatorship where the UN is dictating to the NGOs what to do and how to do it…As the UN we should not be coming there with fixed ideas and telling people what to do.'[89]

At the same time, several NGOs expressed a lack of interest in attending the coordination meetings citing such reasons as an excessive number of meetings, a lack of time to attend, and staff shortages. One representative from a large NGO officially affiliated with the Health Sector Working Group stated simply: 'I don't think [our] involvement in the Health Working Group is very high because I am actually supposed to go with the health coordinator to these meetings and she never goes. So I don't know how much she is actually doing in terms of bilateral coordination with other NGOs that are doing health.'[90]

[89] UN Public Health Officer, Amman, September 2017

[90] Health advisor at NGO (Skype call), August 2017

Moreover, some NGOs raised concerns about corruption scandals which emerged in relation to one of UNHCR's partners: the nationally run Jordan Health Aid Society (JHAS). 'UNHCR has had a lot of corruption issues with their provider organization for medical services, JHAS,' an NGO staff member explained, citing multiple scandals which allegedly implicated UNHCR and IOM partners across Jordan and Turkey. 'Because JHAS has had tons of corruption issues, UNHCR is looking for other health partners and JHAS is getting side-lined. JHAS also has government connections so it's a sticky one.'[91]

Though unwilling to comment directly on any corruption issues, UNHCR officials explained that they were in the process of launching a call for expressions of interest for new implementing partners to deliver health services to refugee camps and urban settings. 'The idea of this new launching of this call for expression of interest for health programmes is to have new partners, to have what we call "partnership diversity", not to put all the eggs in one basket,'[92] an official explained. This, the official continued, would widen opportunities for partnerships with 'qualified' local organizations and would, in turn, ensure the long-term sustainability of the UNHCR health programme.

Other organizations, however, remained unconvinced. In a context of limited funding and resources, UN agencies and NGOs have been struggling to maintain their relevance among a large pool of actors delivering similar services in a protracted refugee setting. In addition to mistrust among actors and occasional disinterest in coordination efforts, disputes over mandates among UN organizations, which frequently devolved into competition and turf wars, were further hampering coordination efforts. Interviewees complained that organizations with more funding, resources, and overall capacity were able to expand their mandates and thus access to the humanitarian space. This was especially true of UNHCR, an organization that many NGOs and even other UN agencies perceived as having overstepped its mandate. As a representative from a UN organization working on health complained bitterly:

[91] Health advisor at NGO (Skype call), August 2017

[92] UNHCR, Amman, October 2017

> UNHCR is here with about 700 people, UNICEF is here with about 500 people…I always say that in the beginning because people are always asking why is [name of organization withheld] not doing this and why is it not doing that and I have to say: 'sorry, I am the only international technical staff here and we can do as much work as four people can do'. But we can never go into competition with an organisation that has 700 people they can send to every single meeting in the country and cover every single specialty and functional area.[93]

The health officer then continued to explain how ongoing disputes over mandates resulted in an effective UNHCR monopoly: 'We've pretty much left the space to UNHCR in terms of providing the health care needs of refugees…UNHCR is being very protective of their refugee mandate and maybe wanting to take care of all of the sector responses including health for refugees.'[94]

Similarly, the IOM – currently the newest member to join the UN system – reported a considerable degree of convergence with UNHCR over the definition of its target beneficiaries. In fact, an IOM representative described the organization's mandate as 'related to the movement of people'[95] and encompassing refugee protection. While my interviewee stated that such an overlap with UNHCR's mandate was not considered to be a particular challenge within the organization, data show that ambiguity and unclear mandates make it difficult to avoid duplicating services and to clearly demarcate where responsibilities lie within the refugee response. As a UN health officer observed in an interview: 'It is not that clear anymore, the mandates are shifting. It's not anymore WHO/health and UNHCR/refugees. The mandates of other organisations are broadening as well.'[96]

[93] UN Public Health Officer, September 2017

[94] WHO, (Skype call), September 2017

[95] IOM, Amman, November 2017

[96] Public Health Officer, UN, September 2017

Though the presence of a well-developed coordination structure has brought about greater information sharing and transparency through online platforms and accountability mechanisms, these insights indicate that internal disagreements over mandates, competition over funding, and tense collaboration among NGOs and the UN have hampered effective cooperation. UNHCR emerges as an example of a 'reinforced' (Betts, 2013) organization which has not only expanded its target population to include IDPs (see Chapter 2), but has also encroached upon the health mandate of the WHO. As the lead agency in charge of protecting the rights of refugees, UNHCR has now taken the lead on issues that lie at the intersection between the refugee and the global health regimes. In the case of the WHO, the agency has largely ceded the field to other actors such as UNHCR and has, in some ways, become less relevant to the overall health response.

Smaller organizations have similarly adjusted their mandates to focus on narrower issue areas and target populations. In some cases, efforts to lay claim to specific, specialized issues has led to exclusive – rather than inclusive – advocacy efforts. A particularly poignant example of such efforts arose in an interview with the director of an NGO:

> Where I work (off the record) we're an agency that specifically works to promote the rights of women and girls. And in a number of cases that means advocating against the inclusion of other marginalized groups. For example, in the GBV [gender-based violence] group there is a shift in the sector to address the needs of men and boys who can also experience GBV. We actively lobby against that. I think there is a case to be made that women and girls are more discriminated against and have fewer opportunities and different needs from men and boys, but it makes our advocacy quite exclusive rather than inclusive. So the idea that we might add older men and women to the discussion is not even on the table because we are so focused on women and girls.[97]

[97] Skype interview, NGO consultant, August 2017

As my interviewee acknowledged in the excerpt above, skewed power dynamics within the overall refugee response have led to a disproportionate focus on refugees and health causes considered 'popular' among donors and government authorities. As a result, certain health causes and certain target populations are frequently overlooked, or purposefully excluded, within the humanitarian and development response.

Accounting for gaps in services

The neglect of chronic and non-communicable diseases exemplifies one of the unintended outcomes of power negotiations and strategic behaviour among non-state actors. Despite a documented need for services focusing on preventing and managing NCDs among Syrian refugees, studies show that considerable gaps remain in providing funding and treatment for chronic, life-threatening diseases such as cancer, kidney diseases, and hypertension (Akik, et al., 2019; Doocy, et al., 2015). Yet UNHCR's online portal, which provides publicly available meeting minutes and activity reports, indicated that the sub-sector working group on NCDs had only convened twice since the beginning of the Syrian refugee crisis: in 2014 and in early 2015. Interviewees also separately confirmed that the working group on NCDs was no longer active in 2017 and 2018.

When asked about the reasons for these discrepancies, representatives from international NGOs and UN agencies were unable to provide a clear answer. Some indicated that the overwhelming focus on crisis and emergency narratives detracted from a focus on chronic conditions requiring more complex, long-term medical care.[98] As an interviewee working for a large, international NGO stated:

> It's all Band-Aids rather than real, long-term solutions. And again it leads back to this idea that everything has to be lifesaving. And I'm like no, it's not lifesaving in the sense that I'm going to be dead on the floor in five minutes if this doesn't happen, but it's lifesaving in the sense that in 20 years that

[98] UN agency, Amman, September 2017

> person will say 'thank you for saving my life'. It's a different kind of life saving.[99]

Other representatives echoed similar sentiments and stressed the need to cater to longer-term health concerns. However, with the spotlight pointed firmly on the crisis response, interviewees stressed the difficulties in transitioning to a narrative which emphasised the need for longer-term interventions and programmes, and for a concerted response strategy among various actors. Several NGO workers pointed to the humanitarian system's lack of adaptability to differing contexts and needs:

> I think what was fascinating in the beginning of the Syria crisis, lots of agencies turned up having basically been responding in sub-Saharan Africa for the last 20 years and they have very set ideas about the needs they were going to find, and it took quite a long time to recognize that for example older people were present in the population, that NCDs were a major concern, that untreated NCDs were killing lots of people. That was when MSF came out and said that this silent death in the Syria crisis was killing people. I think there was recognition in those six years that something needed to be done, but my sense is that didn't turn into a robust, cross-sectoral response…[100]

Interestingly, the majority of NGO workers I interviewed had developed their professional expertise in low-income settings with a particular focus on sub-Saharan Africa. Without discounting the transferability and generalizability of such technical knowledge, scholarship on the culture and behaviour of international organizations has revealed how forms of 'bureaucratic universalism' tend to generate universally applicable rules and categories which frequently fail to account for contextual and pluralistic concerns (Barnett

[99] Catholic Relief Services, Skype, August 2017

[100] Skype interview, NGO consultant, August 2017

& Finnemore, 1999). In many cases, this has led to a failure to adapt organizational priorities to better reflect the specific health needs of Syrian refugees in Jordan.

Indeed, UN representatives emphasised the marked mismatch between the expectations of refugee populations from middle-income countries – as in the case of Iraqi and Syrian refugees – and the delivery of humanitarian assistance. As an interviewee pointed out, refugees from middle-income countries that boasted advanced and sophisticated health systems frequently expressed indignation over the perceived poor quality of health services offered by humanitarian responses. 'I do remember from 10 years back when I was with MSF working in Iraq with our standard drugs and packages, people were upset,' a UN public health officer recalled. 'They said: "go away with your rubbish African health care standards here." Iraq had some of the best universities and some of the best trained doctors…and it's the same here [in Jordan]'.[101] Though relatively recent crises in Iraq and elsewhere had already emphasised the need for more tailored approaches to responding to the complex health needs of populations from middle-income countries, the humanitarian response in Jordan has struggled to keep up.

While recognizing the gaps in services especially in regard to the management of NCDs, many interviewees shifted the blame to other organizations and pointed to an overall lack of leadership. As a UN public health officer focusing specifically on NCDs stated: 'Maybe WHO are not buying the idea of NCDs. There were many discussions with them that they will advocate the idea. I don't know why they don't see it as a priority to coordinate NCDs within the country."[102] In addition to criticizing the WHO's lack of initiative, NGO representatives pointed to the fractured and competitive nature of the humanitarian and development response. As a representative from an NGO explained:

> You just have to look at the humanitarian environment: HelpAge doesn't get along well with Handicap International; Handicap International Development didn't speak with Handicap International Emergency; and it

[101] UN agency, Amman, September 2017

[102] Public Health Officer, UN agency, October 2017

> goes on, so it's a very funny environment that we work in. This might be historical and things are better now, but there are still lots of challenges…These are things that nobody likes to talk about, but this is what reality is.[103]

In the absence of an established hierarchy to resolve disputes over mandates and priorities, the overall lack of effective leadership was attributed by many to UNHCR's inability to project its authority over the refugee response. As a caustic report on the failures and inefficiencies of the Syrian refugee response in 2013 put it:

> What's more concerning is the capacity of the UNHCR to lead and to strategize. In the specific case of Jordan, this is not for lack of capacity or vision – the UNHCR has been clear-eyed in Jordan throughout about where the needs and gaps are. Rather, the agency has simply not been very successful in influencing the course of events. (Healy & Tiller, 2013, p. 20)

In other words, though UNHCR may very well have expanded its operations and mandate across issue-areas and regimes, this has not necessarily resulted in a greater projection of authority and leadership. To the contrary, such an expansion appears to have in some ways weakened the organization's effectiveness in advocating for the rights of refugees across various fora and platforms. Moreover, according to the MSF report, competition and a lack of leadership frequently engendered the duplication of efforts and an overall lack of efficiency (Healy & Tiller, 2013, p. 19).

As we have seen in this section, the strategies enacted by humanitarian and development actors have strongly influenced the priorities of the refugee health response. In particular, health governance has become a contested space in which international non-state actors vie for visibility and compete to outbid one another for funding. As will be analysed further in the following chapters, the growing complexity of global governance processes has contributed to reducing the accountability of the humanitarian system towards refugees.

[103] Senior Adviser at an NGO, (Skype), October 2017

6.4 Conclusion

This chapter investigated how the presence of regime complexes and institutional proliferation has fundamentally altered the politics of humanitarian and development assistance for health. In response to 'forum shopping' among state actors, international non-state actors have implemented certain strategies which allow them to legitimize their presence in Jordan. These include influencing the values and priorities of state actors within national policymaking, constructing crisis narratives that justify extraordinary amounts of funding, and linking their discourses to perceived state interests. Overall, the large number of non-state actors has led to a large and relatively new mechanism for collaboration across actors, issue areas, and regimes. At the same time, however, humanitarian strategies have undermined the quality of health services and resulted in the widespread neglect of some issues and refugee groups. In the absence of an established hierarchy and leadership among institutions, there is little accountability when humanitarian priorities fall through the cracks (Alter & Raustiala, 2018; Gómez-Mera, et al., 2020).

In this chapter I have provided a more nuanced perspective on the role and agency of non-state actors involved in humanitarian and development responses. While IR and global health scholarship tend to relegate the position of NGOs to that of subaltern actors within the politics of humanitarian action, I have shown that non-state actors can be both dependent and empowered actors. On the one hand, international NGOs and UN agencies are highly dependent on the financing provided by major donors, and on the goodwill of the governments on whose territories they operate. As we have seen in this chapter, diverging too far from the values and priorities espoused by state actors can have severe effects on funding and on an organization's very existence. On the other hand, the increasing politicization of humanitarian aid has made non-state actors powerful players within refugee responses. As I discuss in the following chapter, NGOs and UN agencies are conferred with a growing authority to select the most 'vulnerable' recipients of humanitarian assistance – to the exclusion of others – while making life and death decisions on behalf of refugees.

Chapter 7 | RESILIENT REFUGEES OR HAPLESS BENEFICIARIES? CONSTRUCTIONS OF VULNERABILITY IN THE REFUGEE RESPONSE

In the previous chapters I examined the political factors which influence the strategies and priorities of state and non-state actors involved in the Syrian refugee response. I now turn to an analysis of the concept of 'vulnerability', which has come to play a central role as an organizing principle across humanitarian and development responses in crisis settings (Flegar, 2018; Janmyr & Mourad, 2018). In particular, this chapter asks: How is 'vulnerability' constructed in the refugee health response? In recent years, increasingly sophisticated indicators and vulnerability assessments have been designed to guide humanitarian actors towards the 'greatest needs' and serve as supposedly impartial tools for evaluating eligibility for humanitarian assistance (Brown, et al., 2019; Brun, 2016). What actually constitutes vulnerability and what defines a vulnerable person in times of crisis, however, is a matter of contention among scholars and humanitarian actors. Indeed, there has been little critical reflection on the diverse and at times ambiguous constructions of 'vulnerability' in refugee settings, and on the repercussions of such constructions on the 'life chances' of refugees (Flegar, 2018; Glasman, 2019; Janmyr & Mourad, 2018). As some have, more ominously, pointed out, notions of vulnerability can support arguments for the greater protection of refugees on the one hand, or become mechanisms for social control on the other (Brown, 2011; Flegar, 2018).

In Jordan, the health response has enthusiastically embraced the use of means-tested approaches to determine the greatest 'vulnerability' and 'need' among Syrian refugees, and, subsequently, to guide priorities for the allocation of resources. Since 2014, UNHCR and several other UN agencies, NGOs, and donor organizations have taken the lead in designing the Vulnerability Assessment Framework (VAF), a multidimensional tool designed to establish a profile of vulnerability among Syrian refugee households, target assistance based on common vulnerability criteria, and strengthen coordination and decision-making in delivering humanitarian assistance (UNHCR, 2017). Despite the increasing

sophistication and complexity of such assessments embodied in Jordan's VAF, in this chapter findings show that the concept of 'vulnerability' is not only highly politicised, but is also produced and socially constructed in ways which largely mirror the requirements, biases, and power dynamics of the humanitarian response. More specifically, I argue that constructions of vulnerability serve a dual purpose: that of increasing the cost-effectiveness of the humanitarian response, and of justifying the 'bureaucratic exclusion' of certain population groups. As a result, I contend that some groups – mainly women and children – are championed by certain powerful actors, while other groups within the same refugee population – such as older people – are consistently overlooked.

This chapter is organized as follows. I begin by arguing that UNHCR's recently established VAF constructs 'vulnerability' as a mathematical problem, which can be solved through the use of algorithms and complex technical criteria. A subsequent analysis of the discourses and practices in regard to conceptualizations of vulnerability among the main actors involved in the health response reveals four main trends. First, gendered and racialized interpretations of vulnerability and an emphasis on security have led to a disproportionate focus on certain categories of beneficiaries: predominantly women and children, and refugees with disabilities. Second, the conflation of health and security within donor discourses has privileged the allocation of resources to treating and containing communicable diseases. This has often come at the expense of non-communicable diseases, which not only tend to affect a greater proportion of older refugees, but also account for 78% of deaths in Jordan (WHO, 2018). Third, one of the main factors driving constructions of 'vulnerability' among actors is the desire to selectively allocate resources to 'real' and, by extension, 'deserving' refugees. Fourth, constructions of 'vulnerability are strongly influenced by the principle of 'value for money', which permeates the refugee response. In the final section of this chapter I address the refugee groups that are conspicuously absent from the humanitarian agenda. These include men, older refugees, and unregistered refugees. I highlight the case of older Syrian refugees as a compelling example of a population which is considered vulnerable and yet is almost universally overlooked.

7.1 The Vulnerability Assessment Framework and the technicalities of exclusion

In the context of a perceived crisis and scarce resources, humanitarian and development actors are faced with determining which aspects of humanitarian assistance are negotiable for survival and which are not (Glasman, 2019). Especially when it comes to determining access to health care, such decisions have significant physical repercussions for individual recipients and can have life or death implications (ibid.). In this section I provide a critical look at the VAF in Jordan and analyse how it has been employed as an apparently neutral and objective tool which serves to process, categorize and select recipients who are eligible for assistance. On the one hand, the perception of the VAF as a fair, neutral and technocratic methodology for assessing the greatest needs and vulnerabilities reduces the concept of 'vulnerability' to a purely mathematical problem. According to this conceptualization, refugees can be counted, assessed, and, ultimately, selected based on universally accepted criteria which determine eligibility for humanitarian assistance. On the other hand, the complex and obscure calculations which make up the VAF translate into refugees being anonymized, ordered, and categorized with little regard for their personal needs and preferences. While useful in providing valuable information about the overall needs of Syrian refugees, the VAF has in many ways translated into a subtle form of paternalism which increases the inherent power differentials between refugees and the organizations that claim to represent them.

Since 2014, Jordan has seen the progressive retreat of the state as the main provider of services to Syrian refugees, leaving many refugees dependant on the resources provided by the humanitarian and development response (see Chapters 4 and 5). In response to an increase in demand, humanitarian and development actors have had to adapt their strategies and, in some cases, stretch their mandates to accommodate the complex long-term health needs of the Syrian population (see Chapter 6). As a UNHCR staff member stated when describing the aftermath of government cuts to health care for refugees: 'All of a sudden we had half a million who couldn't pay for health services' (Salmorbekova & Howe, 2016, p. 10).

The initial response to the arrival of Syrian refugees produced various incompatible and competing definitions and criteria for determining 'vulnerability' that frequently became conflated with more generic understandings of 'poverty' and 'helplessness' (UNHCR, 2015). In the face of a large-scale and multi-sectoral refugee response, it soon became apparent to humanitarian actors that a more unified response mechanism would be required to reach those with the 'greatest needs' and effectively monitor and evaluate project results (Verme, et al., 2016). The fact that the allocation of resources to certain selective groups of the refugee population countered humanitarian principles of universality and impartiality was not lost on interviewees. However, such contradictions were largely swept aside as lacking in pragmatism. As one interviewee put it:

> It's not about dividing the cake, it's about understanding the broad gamut of vulnerability and then applying resources accordingly. This is the principled argument, which only gets you so far because as soon as you've left the room, people are like: 'What do we do with that?' [104]

In the face of limited resources, a framework was required to create a 'household hardship formula' which would determine eligibility and the degree of humanitarian assistance an individual or a household was entitled to (Verme, et al., 2016, p. 23). As a UNHCR official explained the usefulness of the VAF for selecting recipients within the health response: 'As UNHCR, we cannot cover all Syrian refugees in the country. Based on that, we said we would cover the most vulnerable who cannot afford the non-insured rate [for health care].'[105]

According to the VAF, 'vulnerability' is defined as 'the risk of exposure of Syrian refugee households to harm, primarily in relation to protection threats, inability to meet basic needs, limited access to basic services, and food insecurity, and the ability of the population to cope with the consequences of this harm.' (UNHCR, 2017). In order to select which refugees are 'vulnerable', the VAF relies on indicators based on household dependency

[104] IRC, (Skype), August 2017

[105] Public Health Officer, NCD focal point, UN agency, October 2017

ratios, access to education for children, household expenditure, adequate shelter, access to health services, coping strategies, and food security among others. The combination of these indicators results in either 'low vulnerability', 'moderate vulnerability', 'high vulnerability', or 'severe vulnerability' (Brown & Winton, 2018). As an official involved in developing the VAF explained, the survey questionnaire is designed to collect detailed household data which are subsequently analysed with the intention of predicting a household's expenditure and, by extension, the quality of life of its members. As the official explained: 'You can get a good idea of the quality of life that someone has by where they are spending their money: whether on consumables or just food and rent.'[106] Since its development, the VAF has provided in-depth evaluations as to how the needs of refugees have changed over time.

When it comes to specific needs associated with health and access to health care, the early designers of the framework specified that the VAF 'focuses on factors that influence an individual's ability to mitigate health risks, rather than aiming to assess the extent of medical issues' (Brown, et al., 2019, p. 55). More specifically, the VAF identifies the following main factors as influencing health vulnerability: access and availability of health care, family composition, existing health conditions, and the proportion of expenditure on health-related items (ibid.). A UNHCR official involved in the initial development of the VAF explained the strong linkages between health and vulnerability. On the one hand, health can have a 'direct impact' on vulnerability when the 'head of the family' has a medical condition that does not allow them to work. Similarly, health can have an 'indirect impact' when a family member needs medical care and where the family spends some of their income to fulfil their needs.[107] Over time, the results of the various iterations of the VAF have highlighted the incidence of certain contextual factors which affect the relative vulnerability of Syrian refugees in Jordan. In 2016, for instance, the VAF emphasised the

[106] Interview with UNHCR, Amman, October 2017

[107] UN Public Health Officer, Amman October 2017

significant impact of NCDs on individual and household vulnerability and concluded that 55% of refugees were either 'highly' or 'severely vulnerable' (Brown, et al., 2019).

By 2018, the VAF had identified a significant increase in vulnerability across the refugee population, to the extent that 76% of refugees were considered to be 'highly' or 'severely' vulnerable (Brown, et al., 2019). In regard to health, more than half of respondents said they had noticed an increase in costs which led to greater financial strain. Moreover, with some Syrian refugees entering their ninth year in exile, the VAF highlighted a growing disparity between household expenditure and income. With limited access to the labour market, many refugees were found to have depleted their savings, sold their assets, and frequently resorted to what UNHCR defines as 'negative coping mechanisms'. These included pulling children from school and incurring high levels of debt (Brown, et al., 2019). With limited access to much-needed mental health services, 20% of refugees reported 'Feeling so hopeless that [they] did not want to carry on living' (Brown, et al., 2019, p. 62).

At the time of my fieldwork, the VAF had been adopted by more than 20 international organizations among NGOs and UN agencies to better determine eligibility for assistance programmes, and to identify and prioritize refugees in urgent need of assistance (UNHCR, 2017). To date, the VAF represents one of the most important mechanisms for the allocation of resources – including for health – in the refugee response, and has been lauded as a multidimensional and dynamic tool for profiling vulnerability (Brun, 2016). The rapid rise and diffusion of the VAF comes at the heels of an increasing reliance on quantitative data, including needs assessments and vulnerability indicators, within humanitarian and development responses (Glasman, 2019). By definition, the VAF is presented as an objective and neutral tool which serves to select recipients of humanitarian assistance (UNHCR, 2017).

Though the majority of interviewees strongly supported the use of the VAF, several representatives from NGOs expressed a certain unease with increasingly narrow interpretations of 'vulnerability' espoused by the VAF. As a representative from an NGO reflected in an interview: 'The VAF is a good tool…but it's too focused on the economic

aspect rather than the complexity of vulnerability.'[108] In particular, NGO workers stressed the limitations of what some considered to be a 'medical model' employed by UNHCR, which fails to account for the complexity and multi-dimensionality of situational vulnerability. Indeed, critics pointed out that the expansive VAF questionnaire failed to capture important biographical data such as place of origin and the movement of refugees within Jordan, the gendered power dynamics within households, or the role of social capital and networks in affecting quality of life (Brun, 2016). For instance, NGO workers stressed that technically rigorous criteria failed to account for the needs and vulnerabilities of individuals with caregiving responsibilities. 'The point system is quite fair, but the reality is that if you look at an older person alone, then you have fewer points than a family with six children,' a protection advisor explained. 'But then older people living alone or with a partner, they are also caregivers for the partner. In terms of vulnerability, dependency and access to services are not taken into consideration in the analysis.'[109]

Others still questioned whether the VAF would be able to successfully capture the degree to which refugees may have exhausted all of their options, including the ability to employ so-called 'negative coping mechanisms'. As a representative from MEDAIR commented on the lack of sensitivity of the VAF to the most extreme forms of vulnerability: 'What if people have actually exhausted all of these negative coping skills, and then you're just so much more vulnerable?'[110]

In addition to critiquing its focus on economic principles, interviews with some NGOs revealed an unspecified discomfort with the depersonalized nature of the VAF. Here, refugees are anonymized, counted, and assessed through a series of points which are awarded or detracted according to complex technical criteria. For instance, as a disability advisor at a UN agency described the dehumanizing effects of this model on marginalized populations such as older people and people with disabilities:

[108] NGO Protection Advisor, Amman, September 2017

[109] NGO Protection advisor, Amman, September 2017

[110] Medair, Amman, November 2017

> In this case, older people or people with disabilities are seen as having specific needs and, particularly, specific medical needs, rather than being seen as also needing the same as everybody else: education, livelihood, access to information about opportunities to participate in decision making. *They're not seen as a whole person*, but just as a person that has a specific need and that is vulnerable.[111]

Indeed, what emerged from interviews is that the opaqueness of the questionnaire was purposefully designed to circumvent the 'subjective biases' expressed by refugees when asked to assess their circumstances. As a UNHCR officer explained: 'When refugees learned that they are getting asked questions about money stuff, if they say they are not making very much then they are more likely to receive cash assistance.'[112] In other words, the complex calculations of the VAF are designed to thwart any attempts from the part of refugees to influence the outcomes of their assessments and, consequently, their access to resources. As the UNHCR officer continued:

> We use a regression model to level out the distribution of expenditures based on the other information that [refugees] provide us. So, for example, if they have a large house with large rooms they are more likely to be more affluent and less poor than a highly house-crowded family…*So we are able to correct the data*.[113]

In sum, interviews with the creators of the VAF revealed that opaqueness is an integral part of vulnerability assessments and is designed to eliminate the possibility for individuals to enact 'performative dimensions' of vulnerability, and to claim the label to their advantage (Malkki, 1996). As my interviewee stated in the excerpt above, the VAF serves to 'correct'

[111] UNHCR (Skype), October 2017, emphasis added

[112] UNHCR, Amman, October 2017

[113] UNHCR, Amman, October 2017, emphasis added

the collected data and, ultimately, to prevent refugees from speaking for themselves and articulating their needs.

So far, we have seen how the highly technical methods of the VAF serve to reduce the complexities of individual vulnerability and of the situational contexts in which refugees exist to a mathematically derived common denominator. As scholars have noted, the global rise of 'evidence-based humanitarianism' has not only led to the proliferation of complex measurements, standards, and classifications, but has also condensed 'vulnerability' and 'need' into a 'bookkeeping of human suffering on a world scale' (Glasman, 2019, p. 2). In Jordan, I argue that an overwhelmingly uncritical reliance on the VAF across the humanitarian system has reduced the complexity of human 'vulnerability' to a technicality which can be measured and addressed through supposedly 'objective' mathematical tools and calculations. Ultimately, the impersonal and technocratic nature of the VAF has considerable implications for the ways in which refugees – and their agency – are perceived among humanitarian actors and for the increasing divide between 'beneficiaries' and 'benefactors'.

As I examine in the following sections, the widespread acclaim and often acritical use of the VAF within the medical humanitarian response has largely disguised the wide array of subjective constructions and preferences which make up notions of vulnerability. As an interviewee from an international medical NGO summed up the dilemma succinctly: 'Vulnerability is not a set thing, it's not either "yes" or "no".'[114] In other words, the concept of 'vulnerability' itself, while useful in assessing humanitarian needs, is purposefully vague and open to interpretation. An advisor at a large NGO eloquently commented on the weaknesses embedded in the assessment process:

> The question then is that the assessment is only the beginning, then what do you do with the findings and how do you analyse them? Our former colleagues did an evaluation of the assessments by UNHCR and there was a

[114] International medical NGO, Amman, November 2017

> relatively light link between what was found during the assessment and the programmes that were actually implemented.[115]

Beyond the operative definitions promoted by the VAF, how do health actors in Jordan imagine vulnerable people? And, as a result, which groups of refugees and which health causes are championed – and which are not – within the health response? In what follows I turn to the various ways in which humanitarian and development organizations, donors, and government actors construct who is vulnerable and, ultimately, which groups of refugees receive particular access to resources, and which groups remain largely invisible within the refugee response.

7.2 The humanitarian system and constructions of the 'helpless refugee'

Interviews with donors, government officials, and members of the UN-led Health Sector Working Group revealed that explicit and implicit biases permeated all levels of the humanitarian and development response, especially in regard to health. Across state and non-state actors, preconceived notions and stereotypes not only circumscribe certain groups of refugees as inherently vulnerable, but in many cases even contradict the official assessments of the VAF. More often than not, notions of vulnerability described in interviews reflected organizational mandates and fell back on gendered and racialized views as to which refugees are vulnerable and which are not. As a result, certain refugee groups have gained particular prominence and visibility within the humanitarian response. Others remain invisible or unaccounted for. In what follows, I analyse the main frameworks which underlie constructions of vulnerability among the largest and, arguably, most powerful organizations involved in the refugee response for health.

'Womenandchildren' and refugees with disabilities

When it comes to the preferences of humanitarian and development actors, a closer analysis of the target beneficiaries identified by NGO representatives reveals how

[115] NGO consultant (Skype), August 2017

vulnerability is imagined in the field. As evidenced in Figure 8 below, women and children emerged as a privileged example of groups considered a priori vulnerable within the refugee population. Indeed, 52% of NGO representatives involved in the health response in Jordan agreed that women – in particular pregnant women, widows, and female heads of households – and children were the most vulnerable groups of refugees. For women, perceptions of vulnerability appeared to be closely tied to their reproductive roles and to motherhood, with a majority of organizations expending a significant proportion of their resources on reproductive health and maternal care. 'Coming to why maternal care, well of course these are our target group,' an NGO staff member said. 'It's very difficult for women to find employment and so they don't have money to approach the health services, drugs or paediatricians. In terms of sustainability, it's clearly not sustainable for them.'[116]

[116] NGO, Amman, November 2017

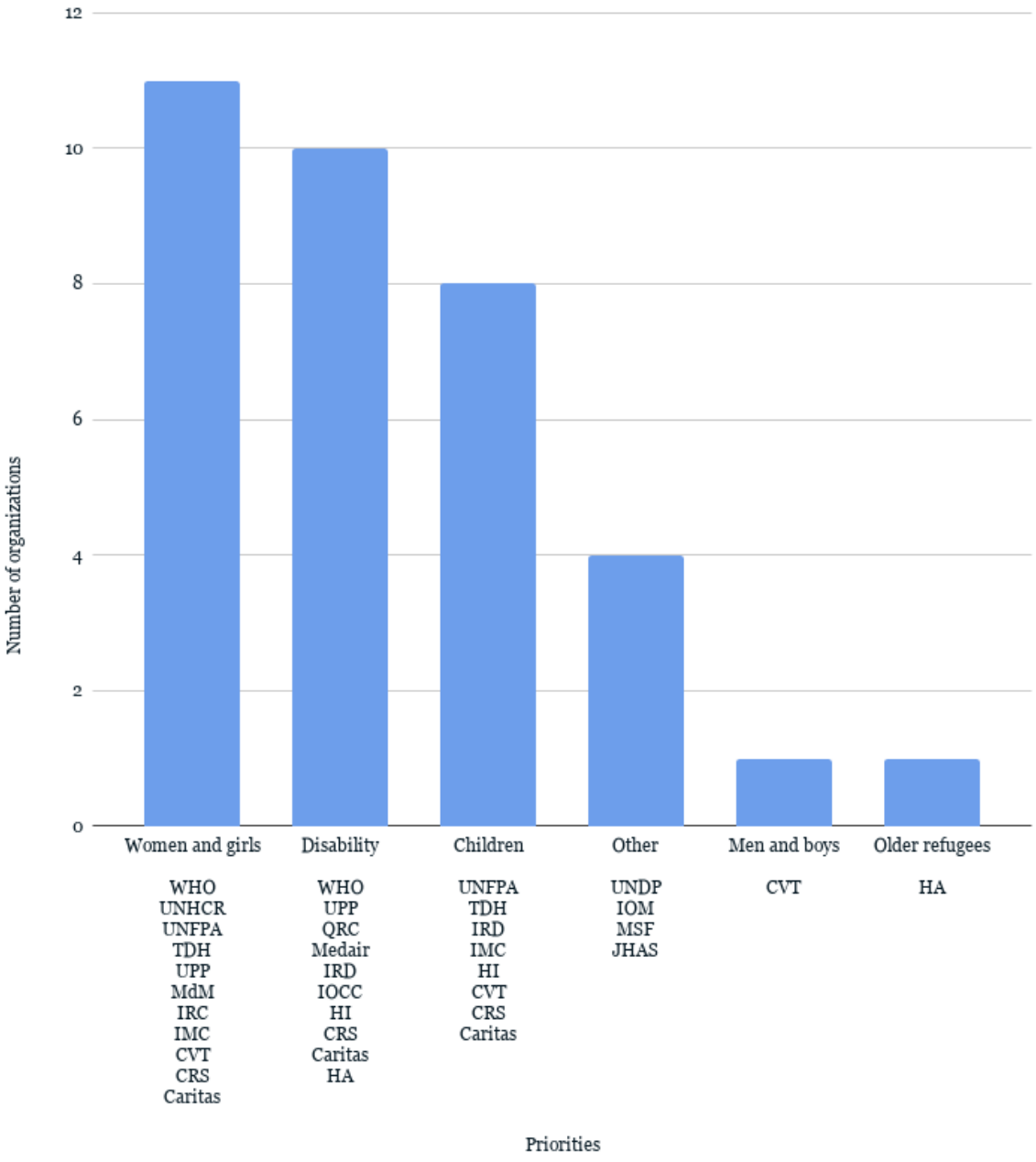

Figure 8: Self-reported priorities among non-state actors involved in the health response

Source: Interviews conducted by the author with members of the Health Sector Working Group (for a full list see Appendix B)

Donors I interviewed largely echoed a preference for groups considered a priori vulnerable:

mainly children and pregnant women.[117] NGOs working in the field confirmed the implicit priorities supported by donors, which more often than not focused exclusively on perceptions of 'needs' and 'life-saving measures'. 'Because donors, when they come, they are interested in such a crisis situation to be dealing with people who are most in need,' a UN health advisor explained. 'This is their target, which is women and children. So most of the donors put their money in life-saving measures.'[118] As in the case of many NGOs and UN agencies, donor representatives stressed the importance of focusing on women in relation to their reproductive roles and to the exclusion of older women.

While women and children face demonstrated disadvantages and vulnerabilities during displacement (Hales & Gelsthorpe, 2012; Johnson, 2011; Mehta, 2009), several interviewees were critical of what they felt was an overwhelming attention dedicated to women and children at the expense of other refugee groups. 'Most agencies are focusing on women and gender-based violence because this is like a fashion', an NGO advisor lamented. '[This] is linked to violence, pregnancy and lactating, and then vulnerability.'[119] According to some, the narrow attention dedicated to women and children was closely tied to a reliance on preconceived notions of vulnerability and a lack of understanding of the needs of marginalized groups. As an advisor at an NGO explained eloquently:

> The humanitarian sector when they all arrive and they start responding, they come with preconceived notions of what vulnerability is and who is vulnerable and they start delivering programmes – because you need to start saving lives immediately – based on those preconceived notions. And then the idea is that they refine that understanding based on further assessments. But actually assessment methodologies often don't provide much of an insight into the needs of these marginalized groups and that reinforces this

[117] Humanitarian Adviser, donor organization, Amman, August 2017

[118] Reproductive Health Advisor, UN agency, August 2017

[119] HelpAge International, Amman, August 2017

> concept of who is vulnerable and who needs assistance and that translates into funding applications, project design, evaluation of response.[120]

Frequently, perceptions surrounding women's specific vulnerabilities are divorced from the context-specific nature of forced displacement and linked to a gendered perception of 'femininity' presupposing weakness and dependency. In particular, the conflation of women and their reproductive roles, as well as perceptions of women as victims of gender-based violence, have influenced constructions of vulnerability which are independent from the findings of vulnerability assessments.

A second group which stands out among NGO and donor priorities are refugees with a disability, which were considered particularly vulnerable by 31% of respondents (see Figure 8). In line with a greater international focus on the needs of persons with disabilities, strengthened by the ratification of the UN Convention on the Rights of Persons with Disabilities in 2006, approximately half of the surveyed organizations reported that refugees with disabilities constituted one of their target groups. Interviewees frequently mentioned the particular needs of persons with disabilities and highlighted the efforts of various organizations to procure mobility devices such as crutches and wheelchairs, and the challenges of identifying less visible and frequently stigmatized mental impairments. As one donor representative put it: 'When we come to mental disability it is even more complicated because there is a reluctance to accept it, acknowledge it, and deal with it. So if it's complicated in camps, it's nearly impossible outside camps.'[121]

Despite these efforts, however, when it comes to responding to the actual needs of refugees with disabilities, outcomes appeared mixed. As advocates for the needs of persons with disabilities observed, there is a marked discrepancy between the priorities stated by humanitarian actors and the implementation of the rights of refugees with disabilities:

[120] Adviser, International NGO (Skype) August 2017

[121] European donor organization, Amman, November 2017

> I think people don't really have a clear understanding of what's being said at the policy level and what that actually means in practice, because I would go into the settings and people would completely agree that people with disabilities have equal rights and they would agree with all the principles, but then when it came to translating them into practice it wasn't really understood, and people didn't really feel they were doing something wrong.[122]

In addition to a gap in the understanding about how to implement the rights of persons with disabilities outlined in UN conventions, a disability advisor at UNHCR suggested that one of the issues lies with how results are reported in follow-up assessments. Without the data on access to services disaggregated by disability status, interviewees pointed to challenges in monitoring results: 'There's a lot of talk about people with disabilities having equal rights, but the systems are not set up in a way for us to be able to ensure that it actually happens.'[123]

At the same time, all actors involved in the response appeared to shift the blame for the lack of services for refugees with disabilities. In particular, while donors largely pointed the finger to government actors for stigmatizing and overlooking persons with disabilities, government authorities underlined the lack of donor interest in providing funding for services for persons with disabilities. 'It's not very attractive for donors,' one interviewee stated. 'Donors are interested in children and battered women. Refugees come from wars and many are disabled.'[124] At the same time, however, interviews with donors appear to contradict these accounts in that not only are persons with disabilities considered a priority among vulnerable groups, but donors have complained about the sub-standard conditions faced by persons with mental and physical disabilities in Jordan. In fact, a representative from a donor organization stated: 'Jordan may be the best case [in the Middle East] but

[122] UNHCR (Skype, Geneva), October 2017

[123] UNHCR (Skype, Geneva), October 2017

[124] Ministry of Social Development, Amman, May 2018

there are neglected issues such as mental health and people with disabilities. It is appalling. It's neglected, it's like it doesn't exist. They don't know what the needs are so there are no services.'[125] Unlike the preferential treatment afforded to women and children, the narratives and discourses surrounding the needs of refugees with disabilities highlight their intrinsic vulnerability, but do not necessarily translate into improved services.

Refugees as carriers of diseases

Global health scholars have observed the ways in which the securitization of diseases has in many ways influenced public health responses. In many cases, the allocation of international resources is less tied to the actual level of the health threat, but rather to the level of fear the threat induces (Yuk-ping & Thomas, 2010). An example of this can be observed in the amount of funding and expertise mobilized to contain the Ebola outbreak in West Africa in 2014 amid fears of a global epidemic defined by the UN Security Council as a 'threat to international peace and security' (BBC, 2014). Just as in the case of the H1N1 influenza virus in 2009, the heightened security response of the WHO, which called for a state of emergency governance, drew widespread criticism in the aftermath of the outbreaks which caused far lower mortality and morbidity rates than had been anticipated (Hanrieder & Kreuder-Sonnen, 2014).[126]

In Jordan, donor priorities include a disproportionate amount of attention dedicated to treating and containing communicable diseases such as tuberculosis and polio, often at the expense of chronic or non-communicable diseases such as heart disease and diabetes. While the arrival of Syrian refugees in Jordan presented a heightened risk of the spread of communicable diseases due to lower vaccination rates and overcrowding among the Syrian population, evidence clearly points to higher levels of morbidity and mortality caused by NCDs both among Jordanians and Syrians (Akik, et al., 2019; Doocy, et al., 2015). Moreover, donors pointed to 'the berm' as a humanitarian crisis and, indirectly, as the spatial

[125] Health Expert, European donor, Amman, November 2017

[126] For a brief discussion on the implications of the ongoing COVID-19 pandemic for global health and politics, see Chapter 9.

embodiment of national and international fears over security and the spread of diseases across national boundaries. Since Jordan's closed border policy with Syria in 2016, tens of thousands of refugees have remained stranded on this inhospitable strip of land, living in makeshift shelters with limited access to clean water, sanitation, and medical care (Awad, 2019; Hajzmanova, 2017). 'The Sphere Handbook says that you should have access to a minimum of 20 litres of water per day, but in the berm they were hardly reaching 12 litres of water per day so it was below the minimum standards,'[127] explained a health expert at a large European donor organization.

According to one donor, rumours of terrorists masking as refugees to gain entry into Jordan soon became conflated with a narrative of refugees as carriers of communicable diseases. 'The berm is the border where people are dying,' the donor representative explained in an interview. 'It's frustrating because it's linked and wrapped up into a global isolationist view and austerity based on fear. For example, the fear of the spread of disease such as anti-microbial resistance among Syrian refugees'.[128] As mentioned above, the arrival of Syrian refugees in Jordan may indeed have presented a heightened risk of the spread of communicable diseases. Yet I argue that the sense of urgency that accompanies communicable diseases coupled with fears of international or even global pandemics, far outweighs concerns for chronic diseases. For older people in particular, this means limited access to health care and treatments for chronic conditions. As one academic focusing on Syrian refugees and health put it:

> You can spend billions on eradicating polio – which is almost eradicated in the region – and then people over 50 suffer from chronic diseases and behavioural diseases. Sixty percent of cancer cases are [among people] above the age of 60…Heart disease is also a major issue. Huge stress leads to a dramatic increase in smoking.[129]

[127] Health Expert, European donor, Amman, November 2017

[128] Interview with donor [date and location withheld]

[129] Academic at the American University of Beirut, Beirut, September 2017

Jordanian authorities similarly expressed particular concerns over the costs associated with subsidized medical care for chronic conditions. Amid fears of international abandonment in the face of what has become a protracted refugee setting, officials worried about having to shoulder the burden of high rates of NCDs among the Syrian population. As an official working in the health sector emphasised the particular impact of certain 'expensive' diseases:

> It's a big challenge for NCDs [among] Syrian refugees because the medications are very expensive…We also have to take into consideration cancer, which costs because the doctor has to investigate. For Jordanians it is free of charge, but for Syrians it is different, there is a referral system. In all cases it is impacting [the health care system] together with kidney dialysis.[130]

According to NGOs in Jordan, haemodialysis is in fact a significant concern among Syrian refugees as the treatment is expensive and requires specialized medical equipment. As a government official focusing on health explained the many competing priorities for the national health response, and the lack of adequate support:

> We have more than 120 Syrians who need [haemodialysis] three times a week. They need care in this regard. Also we need help with the government vaccination campaign. It is very important for us also. Also there are eye problems, cataracts and Hepatitis C. The prevalence [among refugees] is six times higher than among Jordanians and no one has raised this issue despite discussions with NGOs. They tell me it is costly, but now we have medicines that can treat Hepatitis C.[131]

Despite the focus on NCDs as one of the most important health concerns in the Jordan Response Plan, the Government of Jordan has been hesitant in providing funding for what are considered to be costly and potentially long-term treatments. In fact, government

[130] Ministry of Health, Amman, November 2017

[131] Ministry of Health, Amman, November 2017

involvement in health appears to have acquired the expressed aim of protecting the national population from potential communicable diseases spread by Syrian refugees. And while successful vaccination campaigns have reduced many of these risks, life-threatening diseases such as cancer or kidney failure are often not a priority.

7.3 'Deceitful' refugees

When discussing how donors imagined 'vulnerability', what emerged from conversations was a lack of a unified vision or definition of the concept. Indeed, understandings of vulnerability ranged from a focus on women and children, undocumented or unregistered refugees, refugees living in urban areas, and, more generally, anyone whose life might be at risk. As one donor defined the organizations' target population: 'The poor, the poorest of the poor and the vulnerable.'[132] Another representative from a bilateral organization explained how vulnerability assessments, though reliable, were fragmented across various partner NGOs, and discussed the difficulties associated with identifying what was vaguely referred to as 'the most vulnerable':

> Each NGO or organization has its own set of standards either in line with VAF or other guidelines which are robust. We are quite pushy about understanding the selection process of beneficiaries during monitoring and evaluation quarterly meetings. We have to be clear that we are working with the *most vulnerable*.[133]

Beyond such broad conceptualizations, however, findings show that 'vulnerability' was largely employed as a benchmark for excluding 'undeserving' refugees who were perceived as taking advantage of humanitarian assistance. As one donor representative put it:

> Three years ago, we started [to] provide not a blanket cover of services, but to target the vulnerable of the refugees. Because there are people who can afford living here in Jordan. Three-four years ago, people [would] bring

[132] Interview with donor, Amman, August 2017

[133] Interview with donor, Amman, [date withheld] emphasis added

> examples and say 'I met a Syrian woman at the supermarket and she looked well-to-do but still [she] felt like she needed the bread'. It was like [she thought it was] *her right to be fed*, but she didn't need it. So we started asking the UNHCR and other active players, *to be smart enough to target the most vulnerable*.[134]

As evidenced in the interview excerpt above, donors were considerably preoccupied with excluding 'undeserving' and 'deceitful' refugees who might claim benefits to their advantage. According to my interviewee, rumours of a supposedly well-to-do woman claiming free bread was a compelling enough reason to call upon non-state actors such as UNHCR to 'be smart' and to only target those who are truly 'vulnerable'. The mere *appearance* of being 'well-to-do' appeared sufficient for my interviewee to claim that many refugees could not only afford to live in Jordan, but that many also deviously claimed a right to assistance which they were not entitled to. Indeed, according to many donors I spoke to, humanitarian assistance is not an entitlement and all refugees clearly do not have a 'right to be fed'.

Similarly, interviews showed that government officials did not necessarily view Syrian refugees as particularly vulnerable or 'deserving' of financial assistance. This became apparent when analysing the discrepancy between priorities stated in government-led policy documents and the reality of funding allocations. In addition to being viewed as a threat, refugees are frequently seen as undeserving recipients of aid who not only divert resources from the national population, but also take advantage of the generosity of the national government and of international assistance. As one official claimed:

> They say Syrians live better than Jordanians because they take money from the UN agencies and they can move anywhere they like, and because they receive money as refugees for rent agreements. Often they take an apartment

[134] Interview with donor, Amman, [date withheld] emphasis added

> and then sublet it for a higher rate, and get cash assistance and they work.[135]

In this case, compared to the suffering of the national population, refugees as a whole are viewed as duplicitous and undeserving of the assistance they receive.

7.4 Value for money

Publicized as an expression of improved efficiency, the principle of 'value for money' and notions surrounding 'returns on investments' emerged on several occasions during discussions about humanitarian financing in Jordan. In particular, findings show that 'value for money' is an ambiguous and vague catchphrase which has become synonymous with 'cost-effectiveness'. Moreover, interviews revealed that the concept has been frequently applied not only to determine the value or cost-effectiveness of humanitarian programmes, but also as a rationalisation for championing certain groups of refugees over others. In other words, refugees are considered 'deserving' if, in addition to being 'vulnerable', they can also demonstrate 'value for money' in the form of labour and the ability to contribute to the economy. As a representative from an NGO put it:

> There is this whole piece missing around what it is to be an inclusive society and it is very much seen through an economic lens: you get refugees to integrate by putting them to work. But it doesn't look at the fact that some of the refugees are highly vulnerable and can't be integrated into the workplace or need different sorts of work if they are going to work. It's a major disconnect.[136]

In this context, within the touted framework of 'value for money'[137] promoted by many large European donors, women and children emerged as the 'ideal' recipients of humanitarian assistance as they are perceived as being concomitantly 'vulnerable' and a worthwhile 'investment'. For instance, interviewees noted that donors were always willing to invest in children because this target population would bring a 'return' on their investment in the

[135] Interview with government official, Amman

[136] IRC, (Skype, London), August 2017

[137] Donor interview, Amman, 2017

form of future participation in the labour market. In the case of women, humanitarian actors frequently alluded to their roles in the domestic sphere as providers of (free) childcare and household labour. As a representative from an NGO noted: 'Donors are making sure that if they put money on the table it should be used in a *sustainable* way and that there are *good outcomes* from it.' [138]

Unsurprisingly, within this framework based on 'sustainability' and 'outcomes' intended in predominantly economic terms, older refugees and their health care needs are largely overlooked. A striking example of the narratives espoused by donors with regard to populations considered a poor investment came from a former employee at HelpAge International who had moved on to a senior position at another NGO. During our conversation, my interviewee stressed the importance of economic factors in determining the low priority awarded to older refugees:

> They can get good outcomes from older people only if they invest in them, but [donors] will not target this cohort of people that maybe will die in a couple of years and so it *isn't worth to invest* in them. If it's a five-year project they will not invest in people around 70-75 because they know in five years they will die or something might happen to them, so they invest their money in children or the younger generation so they can help them and give them a *return*.[139]

In other words, the perception of older refugees' reduced lifespan and lack of economic contributions are determining factors in the exclusion of this demographic from targeted donor assistance. Moreover, the sense of 'deservingness' usually attributed to women and children as blameless and apolitical victims somehow eludes the narrative (if there is one) surrounding older refugees. The dilemma between humanitarian principles and 'value for money' came to the fore in discussions surrounding perceptions of the vulnerability of children vis-à-vis older people. As the director of an organization delivering health services

[138] HelpAge International, Amman, August 2017

[139] HelpAge International, Amman, September 2017

explained:

> There was once a very contentious disability task force meeting about the treatment of children versus elderly. One of the arguments was that we all know that we have limited resources and you want to address the needs where you're going to have most impact. And we felt that where we're going to have most impact is in assisting children and getting them into schools and integrated into the community. If we had endless amounts of resources we would obviously have covered the full population, but because we're trying to make the most impact with whatever resources we have that's why there is this focus on addressing the needs of children in particular. [140]

Measuring the 'most impact', however, is a fundamentally political decision. Certain groups considered vulnerable attract research, funding, and lobby groups which advocate on their behalf. In particular, the dependence of NGOs on international funding from donors means that particular groups generally acknowledged to be vulnerable tend to attract the most amount of funding. One staff member explained that 'it is an easy way to get funding as the tools and methodologies are already there. There is lobbying on reproductive health and violence, and children have a very strong lobby.'[141]

In the case of older people, few lobbies are taking up their cause. And those that do, such as HelpAge International, have found themselves compelled to conform to 'value for money' discourses. As a result, advocacy efforts frequently argue that older persons can make significant financial contributions to households and society as a whole. '[Older people] can be a massive workforce in the family and in the society,' an advisor at HelpAge International explained. 'The World Bank estimated that even above the age of 60 and 70 they can still contribute huge kinds of economic benefits and they estimated that they can add to 10% of the national GDP.'[142] Such contributions to society include free childcare

[140] IRC, Amman, September 2019

[141] HelpAge International, Amman, August 2017

[142] NGO, Health and Care Adviser (Skype, London), October 2017

which, the argument goes, allows parents – and especially women – to fully participate in the workforce. At the same time, advocates for older people stressed that interventions for this demographic, including information written in large print or in pictorial form for those who are illiterate, would benefit the population as a whole. Ultimately, what it comes down to, is convincing donors of the value of such investments. As an NGO representative put it: 'I think the pragmatic argument is to say "look there's loads of interventions that would improve the lives of older people that aren't expensive."'[143]

Within the context of providing medical assistance to refugees, the principle of 'value for money' emerged as an implicit and insidious justification for selecting – and excluding – refugees from costly treatments for chronic and non-communicable diseases. The case of cancer treatments provided a compelling example of how perceptions surrounding the value and worth of human life infuse the humanitarian system and, in particular, the medical response. Following the pathways of available cancer treatments and funding provides an informative glimpse not only into the logic underpinning the allocation of health services, but also into the particular constructions of who is vulnerable and how these influence access to life-saving treatments and care.

In the context of the health response, VAF criteria are often employed to determine eligibility for access to life-saving treatment and care, especially for chronic and non-communicable diseases. Particularly in the wake of cuts to health care services, many patients are referred to special committees which determine their eligibility for treatment on a case-by-case basis. 'In the beginning of the crisis refugees had free access to public facilities,' said a representative from Caritas. 'With the new regulation then the load came to Caritas and other NGOs, and then we had to set up the medical committee and the referral system."[144] With the increase in workload and a simultaneous 10% reduction in international funding, Caritas was struggling to cover the gaps in services, especially for diseases such as cancer. A staff member at a UN agency stressed the lack of options for

[143] NGO, (Skype), August 2017

[144] Caritas, Amman, October, 2017

Syrian refugees with life-limiting diseases residing both in camps and among host communities:

> The other thing is that we do the screening for breast cancer, but the issue is that when we discover a case with such cancer, what can you do? You cannot do anything…What is the benefit of doing breast cancer screening and awareness raising and when the lady or the old woman comes and I find a lump in the breast, what do I do? I cannot offer any management beyond that."[145]

In many cases a cancer diagnosis spells financial disaster for individual refugees and their households. For treatments costing above a certain threshold, usually US$ 2,000, refugees have to apply to specialized committees to gain approval for treatments (Doocy, et al., 2015; Spiegel, et al., 2014). While some larger NGOs, such as Caritas mentioned above, have their own committees which approve or reject patients depending on the availability of funding, others refer refugees to UNHCR's Exceptional Care Committee (ECC). According to sources at UNHCR,[146] the ECC is made up of two external health specialists and is chaired by a UNHCR public health officer. The committee members meet on a monthly basis to review all cases in need of referrals for secondary and tertiary health services.

The criteria for decisions about financing are based on an applicant's diagnosis, prognosis, cost of treatment, and vulnerability – which is in turn based on recommendations put forth by the VAF. What happens next is a decision which has a significant impact on the lives of refugees seeking treatment. 'Then the committee takes a painful decision, when the prognosis is not good or the prognosis is poor, maybe the patient needs only palliative care,' a UNHCR official explained. 'For example, a cancer case – late stage cancer – you know that chemotherapy and other therapy is very costly. So rather than "okaying" each refugee as having the right to access health services, unfortunately there are limited funds.' [147]

[145] UN agency, Amman, August 2017

[146] Based on interviews with public health officers at UNHCR in Amman

[147] UN Public Health Officer, Amman, September 2017

Even if a case is accepted for referral and funding, a patient's ability to complete a course of treatment is far from guaranteed as funds are limited to a ceiling of JD 8,000 (approximately US$ 12,000) per year. As the UNHCR official quoted above explained, treatment for breast cancer can cost upwards of US$ 35,000 per patient per year. In such cases, UNHCR might make an exception, mostly in cases involving younger patients with a good prognosis, or choose to partially support treatment and refer the patient to a partner or a charity in the hopes of securing the remaining funding. As one public health officer put it: 'It's hard when we reach the point where you would put 10,000 JD[148] on a congenital heart disease of a baby versus a cancer patient who by giving him the chemo you would extend his life for four months only. From a public health perspective, it's not cost effective."[149]

As a last resort, some patients may be recommended for third-country resettlement on medical grounds as part of the current package of 'durable solutions'. And while some countries accept medical cases, this is becoming less frequent in particular with the introduction of stringent quotas and more restrictive US resettlement policies (Yuhas, 2018). With few options available, many cancer patients turn to the charity-based King Hussein Cancer Center in Amman, where waiting lists are often long. Other charities offer free services, but also have differing standards and criteria for taking on a case.[150] [151] For those with a bad prognosis, palliative care is still in its infancy in Jordan. While some initiatives have been launched at the King Hussein Cancer Center, these mainly target the national population to the exclusion of refugees. Recently, some organizations have begun to offer training for doctors and other medical personnel on how to provide end-of-life support for those patients who have run out of options. However, strict government

[148] The equivalent of approximately US$ 14,100 as of 10 March, 2020

[149] Public Health Officer (with a focus on NCDs), UN agency, Amman, October 2017

[150] UN Public Health Officer, Amman, September 2017

[151] Public Health Officer, UN agency, Amman, October 2017

regulations regarding the use of opioids used to relieve pain among cancer patients often limit the access and use of such medications.[152]

In sum, though assessments in Jordan clearly indicate that chronic diseases have a significant impact on the vulnerability of the refugee population, interviewees frequently cited a lack of 'value for money' of such health interventions. While determining assistance for refugees with cancer and other diseases based on *prognosis*, or projected outlook, makes sense from a public health perspective, this inevitably leads to a distribution of resources based on the values and assumptions promoted by individual NGO committees and, on a larger scale, of the ECC. In many cases, interviewees from UNHCR confirmed, certain groups such as older refugees face greater difficulty in accessing costly treatments based on a grimmer appraisal of their life chances and, by extension, on implicit biases surrounding the value of human life across life stages. Moreover, the perception of older refugees' reduced lifespan and lack of economic contributions are determining factors in the exclusion of this demographic from targeted assistance. Overall, interviews revealed that the complex combination of political pressures and security concerns from the part of predominantly Western donors has privileged certain categories of beneficiaries to the detriment of others. Children and women in their reproductive ages are considered a priority by all donors, and, to a certain extent, policy level shifts have ensured the greater inclusion of refugees with disabilities among the list of the 'vulnerable'

7.5 Excluded refugees

With more than 70% of organizations stating that women, children, and refugees with disabilities were 'vulnerable' groups within the refugee response, what stands out is a marked lack of interest in the particular needs of other groups of refugees. These include the needs and vulnerabilities of boys and men, older persons, and the largely invisible category of 'unregistered refugees'.

Men and boys

[152] Public Health Officer (with a focus on NCDs), UN agency, Amman, October 2017

While 'boys' are to some extent included in the more general and well-represented group of 'children', many organizations cited the particular needs of 'women and girls' without mentioning vulnerabilities which may be specific to men and boys. On an anecdotal level, medical professionals noted the large number of war wounds inflicted on young men, which frequently led to permanent disabilities. As one representative from an NGO focusing on the physical and psychosocial rehabilitation of Syrian refugees suffering from war wounds noted, the patterns of injuries appeared strategic and aimed specifically at this demographic:

> There is this war technique in which the snipers target the spine and we have, for example, only in our project 18 guys from the 17-32 age group, all of whom have been shot in the spine and they have been made disabled….It's the spine they target, so it is a war technique especially inflicted on young guys.[153]

Despite the gender-specific violence encountered by young Syrian men, a single organization in the health response focused on the particular health-related needs of men and boys. Though men may very well occupy a privileged space within programmes focusing on livelihoods - which in turn strengthens perceptions of men as primary breadwinners - within the health response few programmes cater to the specific needs and vulnerabilities of men and boys (Janmyr & Mourad, 2018). An academic focusing on refugee responses for health in the Middle East commented:

> The humanitarian system is focusing on women and children as the most vulnerable. That's right, but it's just part of the problem. In a protracted crisis, when the Syrian crisis started, 16- to 25-year-olds left school, came here, and now they cannot work and cannot contribute. They are not children, there is no programme, nothing for them. The only thing left to do is to work illegally and be exploited or throw themselves into the Mediterranean to get to

[153] Italian NGO, Amman, November 2017

> Europe. They will live another 40 years in the future in miserable conditions.[154]

Men, young men, and older people are conspicuously absent from the agenda. In the case of young men, stereotypes in regard to the inherent 'dangerousness' of this demographic (discussed in part in Chapter 5) means that they are rarely seen as vulnerable or deserving of particular assistance (Turner, 2019). If anything, men are identified as perpetrators of domestic violence, potential converts to extremist causes, and a population which is largely seen as a risk rather than *at* risk (Johnson, 2011).

Older refugees

When asked about the specific health care needs of older refugees, interviewees expressed surprise at the question and stated that they were unaware of the particular needs of older people. Among the organizations I interviewed, only HelpAge International had a particular focus on the needs of older people. A particularly emblematic response as to why older refugees were not being considered came from a disability advisor working at an international NGO. Here, the advisor stressed the perception that older refugees do not contribute financially to households and, by extension, the economy:

> I think it's a mix, on the one hand there's the perception of older people not being vulnerable because they're not children in a very simplistic way, but then on the other hand they're saying that they're not contributing. I really don't know, I think it's just something that is never considered and I don't know why.[155]

Though most NGO representatives agreed in principle that older people could be considered particularly vulnerable, few were able to pinpoint specific interventions which would improve the living conditions of older persons. One of the reasons for a lack of attention to the needs of older people appeared to be an emphasis of the refugee response

[154] Academic, American University Beirut, Beirut, September 2017

[155] Disability Adviser (Skype), October 2017

on emergency interventions which eschew at times simple, but not life-saving services. As a director of an NGO described a particularly poignant case of a vulnerable older refugee:

> Old age brings a double vulnerability because you are old and you are a refugee…I remember an old person, around 70, blind, who lived alone in a tent. His children had left for opportunities in Europe. He barely moved to an external toilet which was six meters outside his tent. This was his only journey in three years. He had cataracts. It's a 15-minute surgery, not expensive and would have taken care of everything. This is one example among many. These people are outside the mentality of humanitarian aid because they do not have…acute diseases and do not fit into a category.[156]

In the case outlined in the interview excerpt above, a disproportionate focus on emergency, life-saving interventions across the health response comes at the expense of relatively cost-effective treatments which would greatly improve the lives of older refugees and refugees with disabilities.

When it comes to the specific health needs of older refugees, all interviewed donors agreed that older people were a particularly vulnerable category. These statements, however, are contradicted by the absence of any mention of older refugees in the planning and allocation of health care financing. Among all donors interviewed, none listed older refugees as a priority. When asked directly about older persons, donors expressed surprise and either assumed that older people had remained in Syria or were being taken care of by their families in Jordan. As a result, much of my analysis is based on interpreting what was not stated in interviews with international donors and the silence surrounding this forgotten demographic.

The lack of interest in the particular needs and vulnerabilities of older refugees has been in part exacerbated by – and in part a further source of – the exclusion of this demographic from data collection, especially in regard to health. A case in point is the Demographic and

[156] Director, NGO, Amman, September 2017

Health Survey supported by USAID, which provides comparative indicators on population, health and nutrition across 90 countries around the world (DHSProgram, 2018). The survey, which was conducted in Jordan in 2007, 2012 and, more recently, in 2017-18, only includes women and men between the ages of 15 and 49 (Department of Statistics and ICF, 2018). Anyone above the age of 49 is not represented among the wide-ranging survey topics including HIV prevalence, domestic violence, household wealth, family planning, and household characteristics. According to a USAID representative, the rationale behind the exclusion of older adults is that the survey focuses on reproductive health and includes questions on fertility, sexuality, sexual practices and behaviours, household expenditure, and gender-based violence.[157] And while older men and women are often at high risk of abuse and sexual and gender-based violence from family members (Wells, 2005), the lack of awareness of and interest in the experiences of older refugees translates into a portion of the population being uncounted and, as a consequence, unaccounted for. As a health adviser from a donor organization stated when asked whether the needs of older refugees were considered in health care financing decisions: 'There is a perception that older people are being taken care of by their families, and there is a lack of data. And what would we do in particular?'[158]

Similarly, national budget requests for the Syrian refugee response largely reflect government priorities and considerations, and reveal a marked discrepancy with the priorities stated in official policy documents. In 2019 for instance, the section of the JRP which outlined the overall health situation in the country specifically mentioned high out-of-pocket expenses and the prevalence of NCDs as major challenges facing the health care system. In terms of specific priority groups within the health response, the JRP mentioned older refugees among the populations considered most vulnerable in Jordan. As stated in the document: 'Women and children, disabled, war-wounded, and *older refugees' needs* also present significant challenges. These vulnerable groups require wide range of costly

[157] USAID, Amman, November 2017

[158] Donor organization [date and location withheld]

health services for long time"[159] (MOPIC, 2018).

The marked disinterest in older people as a category became apparent in interviews with government officials at ministries dealing with health and, more specifically, with the welfare of older persons. 'Older people are not a problem, we deal with them as [if they were] Jordanians,' one official stated. He then continued: 'We are dealing with all age groups the same and the elderly the same. Maybe 90% of them are being treated free of charge and given drugs free of charge."[160] According to yet another official, older people are either not present among the population or well-taken care of: 'Older people are a problem if you have elderly,' she said, 'But there is the Emirates Camp[161] which has mostly elderly and children and they are taken care of like in a five star hotel."[162] And, lastly, an official focusing on affairs relating to older people at one of the ministries replied curtly: 'We don't have any information about older refugees."[163]

Overall, when it comes to older refugees, a conflict between politics and humanitarianism translates into the neglect of older age as a determining factor capturing the attention of international donors. Interviews with donors showed that, almost paradoxically, older refugees' lack of mobility and lack of threat to stability and international security have placed this age group at the very bottom of the donor agenda. As one donor summed it up: 'TB and communicable diseases still get us out of bed. But older people do not spread communicable diseases, they are largely immobile."[164]

Unregistered refugees

[159] Emphasis added

[160] Government Official, Ministry of Health, Amman, December 2017

[161] The Mrajeeb Al Fhood refugee camp, also known as the Emirati Camp, was opened in 2013 and is funded by the UAE

[162] Government Official, Ministry of Social Development, Amman, May 2018

[163] Government Official, Ministry of Health, Amman, December 2017

[164] Donor organization [date and location withheld]

A last group which emerged from my analysis as particularly 'vulnerable' and yet entirely excluded from the refugee health response is represented by an unspecified and unknown number of 'unregistered' refugees. A lack of registration can be due to several factors including a lack of the necessary documentation to register, the fear of political repression, or a wish to elude government control over the movement of refugees within the country. 'People prefer to not be registered because they do not want to be tracked because they are political refugees or people [who] ran away from the camp,' a UN officer explained. 'If they try to go to register they will be taken back to the camp.'[165] While estimates of the number of unregistered refugees vary widely among humanitarian actors, little is known about the needs and vulnerabilities of this group. Excluded from UNHCR assessments, unregistered refugees living in Jordan are rendered almost completely invisible within the refugee response. According to NGO workers, refugees who are not registered face some of the most severe vulnerabilities:

> Ultimately the unregistered [refugees] are considered the most vulnerable…and because they are not registered they can't get any assistance from the UNHCR, so then they just really fall through the cracks…our teams have been shocked by certain conditions that people are living in.[166]

Overall, the selective allocation of resources to certain groups of refugees deemed 'vulnerable' has served in part to exclude refugees considered less 'deserving- or less 'desirable' from access to services. In a context in which resources are scarce, constructions of vulnerability reinforce identities rooted in gendered and racialized stereotypes of 'deserving' refugees, and based on neoliberal rationalities of 'value for money'. On the one hand, refugees who are prioritized within the response are those who are able to conform to images of victimhood and helplessness, while at the same time representing the potential to provide – often unpaid – services and labour. On the other hand, those who are considered to be dangerous and threatening, such as men and young men, or those

[165] Catholic Relief Services (Skype), August 2017

[166] Medair, Amman, November 2017

whose economic 'usefulness' is questioned, as in the case of older refugees, are frequently overlooked. The case of 'unregistered' refugees remains under-explored as there is little information pertaining to this population.

7.6 Conclusion

In this chapter I examined the ways in which humanitarian and development organizations, major international donors, and national authorities involved in the health response construct definitions of 'vulnerable' refugees. In this context, the classification and labelling of refugees as 'vulnerable' represents a powerful tool which on the one hand extends the range of international assistance afforded to the refugees who need it the most, but on the other hand excludes certain refugee groups from humanitarian assistance. I contend that the uncritical use of 'vulnerability' presented as an objective and apolitical tool for status assessment obfuscates its inherent political constructions. First, strong preferences for certain groups of refugees and certain health causes include the prioritization of women, children and, to some extent, refugees with disabilities. While this in many ways reflects the challenges and vulnerabilities faced by these demographics, it also represents a highly gendered understanding of who is 'vulnerable' and thus 'deserving' of humanitarian assistance. For women and children, who are often conflated into a single, undifferentiated category, such categorizations can indeed improve access to assistance. At the same time, however, scholars have observed how such distinctions can reduce women to agency-less objects of humanitarian pity (Gray & Franck, 2019; Johnson, 2011). In many ways, the selective ordering of recipients for access to assistance masks the failures of the humanitarian system and the state to accommodate the needs of the majority of refugees. As such, the methods employed to select refugees serve to absolve state actors from the responsibility to uphold the right to health of refugees.

Refugees who are largely neglected within the refugee health response reflect a larger discourse based on securitized and neoliberal rationalities predominantly espoused by state actors. My analysis has revealed how some groups, such as older refugees, do not appear to fulfil any of the indirectly stated criteria for donor funding. As a largely immobile

population, older refugees do not represent a security threat. Moreover, their health care needs tend to revolve around non-communicable diseases which, as they are often chronic, are considered to be expensive to treat and of little consequence to the threat of global pandemics. The absence of older refugees in popular discourse and imagination, and the predominance of the 'women and children' narrative means that older refugees also serve little to increase donor visibility and influence. Ultimately, when it comes to providing 'value for money', older refugees appear to fail the test—at least in the eyes of donors. At the same time, young men emerge as a highly securitized population, which is seen as highly mobile and a threat to the stability of international order.

Overall, dominant representations of refugees in Jordan are based on constructions of vulnerability which reduce refugees to agency-less objects of humanitarian intervention who are rarely consulted on decisions which may deeply affect their life chances. The complex and purposefully opaque design of the VAF further restricts the agency of refugees who are on the one hand required to emphasise and enact their vulnerability to gain access to services, while on the other hand are kept in the dark as to the criteria they need to fulfil to be considered a 'real' and 'deserving' refugee. In this chapter, I have demonstrated how the evidence collected from the VAF is not only inherently political, but also allows for a considerable degree of interpretation and, in some cases, manipulation to reflect larger preferences and interests. Ultimately, how health actors imagine and conceptualize vulnerable people not only shapes their everyday practices, but also affects the chances of survival of the refugees who are in many ways (rendered) dependent on humanitarian assistance.

Chapter 8 | DISCUSSION: SYRIAN REFUGEES AND THE POLITICS OF HEALTH

The world of refugees and human movement is steeped in politics. In this thesis, policy decisions on health and health care are seen as an expression not only of global governance processes theorized by International Relations and global health scholarship, but also of political and securitization processes emphasized by forced migration and security studies discourses. Scholarship on migration diplomacy emphasises how the presence of refugees on a territory can be instrumentalized by self-interested state actors for material or political gain. Yet so far there has been little acknowledgement of the effects of such foreign policy negotiations on other policy spheres, including health care.

Taking health care as a vantage point to analyse how migration diplomacy affects responses in refugee settings, I answer the research question: **How has the increasing politicization of both refugee movements and global health influenced the priorities of the Syrian refugee health response in Jordan?** I contribute a new framework for understanding the ways in which foreign policy agendas and political interests in refugee settings not only affect apparently unrelated policy spheres such as health, but also shape the spending priorities of health responses on the ground.

In this chapter, I situate my findings within the wider political context of the international refugee regime and the humanitarian system. First, I find that the refugee health response has contributed to exposing some of the fundamental limitations of the international refugee regime, including an overwhelming focus on national security, unequal power dynamics among states, and a fragile commitment to international responsibility-sharing. Such power asymmetries have led to the instrumentalization of refugees and health policies as tools for intra-state bargaining. Second, I demonstrate how the increased politicization of the humanitarian system shakes the terrain in which non-state actors involved in the health response operate. I illuminate how humanitarian and development actors have to negotiate and legitimize their access to the humanitarian space, fomenting discourses and practices that frequently influence priorities on the ground. Third, my research uncovers

the political constructions that underpin the 'humanitarian methodologies', employed to select and order refugees based on their 'vulnerability'. In a context in which resources are scarce, my findings show that constructions of who is 'vulnerable' and who is not are strongly influenced by the principle of 'value for money', and a reliance on gendered and stereotyped notions of vulnerability. As a result, I argue that the refugee response in Jordan has constructed three main groups of refugees with differing access to services and resources: refugees who are 'deserving', 'securitized', or 'invisible'. Lastly, I address the implications of my research for both theory and practice in refugee settings before outlining recommendations for further research.

8.1 Power and politics in an unequal refugee system

What emerges from my analysis is that the priorities and preferences of state actors are intertwined in a complex dynamic of mutual influence and interdependence. Chapter 5 addressed the research question: *have health care policies become instruments of migration diplomacy and, if so, how*? Evidence from Jordan shows that health policies affecting refugees have been largely subsumed within the national and foreign policy agendas of donor governments and the Government of Jordan. Indeed, findings reveal that health policies have not only been increasingly linked with national security concerns, but also wielded as instruments of diplomacy.

Syrian refugees and health as security threats[167]

When Syrian refugees began arriving in Jordan, they were hailed as 'brothers and sisters' and offered free access to public services including education and health care (Ministry of Planning and International Cooperation, 2013). Since 2014 to the present date, Jordan's policy strategies towards refugees have included a gradual curtailment of services, especially when it comes to health care. From free health care services for Syrian 'brothers and sisters', in early 2018 refugees were required to pay a two-to-four times more expensive

[167] Some sections and arguments presented in this chapter are based on the following article: Lupieri, S., 2020. When 'brothers and sisters' become 'foreigners': Syrian refugees and the politics of healthcare in Jordan, *Third World Quarterly*, 41(6), 958-975.

'foreigner rate' with often catastrophic consequences on household expenditure (Jaffery, 2018). After years of relatively generous policies towards refugees, findings show that health policies have become the battleground where intrinsic tensions and power dynamics between donors, multilateral institutions, and the host state emerge.

At critical junctures in time, and in response to internal social, economic and political pressures, health policies towards refugees have served the purpose of maintaining the attention of international donors and upholding a precarious sense of 'crisis'. Amid fears over 'donor fatigue' and 'exit strategies', the catastrophisation of the presence of refugees has become a significant tool for maintaining attention and humanitarian and development support. Based in part on theories developed by Wæver and others at the Copenhagen School (Buzan, et al., 1998; Wæver, 2011; Yuk-ping & Thomas, 2010), I argue that the increasing securitization of the presence of Syrian refugees and of infectious diseases within state and non-state discourses has led to a wider public acceptance of health and refugees as a security threat.

Throughout this thesis, health and health care policies emerge as highly contested and politicized aspects of national and global social policy. Health indicators, such as maternal mortality and life expectancy at birth, are used by various actors for various purposes – from justifying requests for funding and international aid, to highlighting successful public health campaigns and projects. Based on the logic of securitization, health intended as the containment of illness and disease is also fraught with political meaning. In fact, the process of securitizing health threats (or perceived health threats) is often influenced by non-medical considerations such as economic opportunities and political legitimacy (Wenham, 2019; Yuk-ping & Thomas, 2010). Moreover, the response to the threat and the allocation of international resources is less tied to the actual level of the health threat, but rather to the level of existential fear the threat induces (ibid). As Enemark put it, 'the best candidates for securitization are those infectious disease threats that inspire particular human dread, and which therefore generate a level of societal disruption disproportionate to the morbidity and mortality burden they pose' (Enemark, 2007, p. 131). In Jordan, the overarching focus on the securitization of the borders of wealthier donor countries has had

an impact on which diseases and categories of people donors focus on. In many cases, non-communicable diseases, which tend to affect a larger proportion of the population, are not considered a priority due to the lack of threat that NCDs pose to national and international security concerns.

From the perspective of national state actors, interviews with representatives from the Jordanian government reveal how health indicators represent a politicized tool used to underline the negative impact of the arrival of Syrian refugees who are held responsible for rising birth rates and declining life expectancy. Indeed, Syrian refugees are widely regarded as an overarching threat to the economic, health and moral security of the country. As a result, health policies promoted by the government have the explicit aim of protecting the national population from communicable diseases emerging among the Syrian refugee population, which has been exposed to years of unsanitary conditions and inadequate health care. The lack of interest in non-communicable diseases, which are a leading cause of death in Jordan and tend to disproportionately affect older persons (Rehr, et al., 2018), can be explained in part as a lack of international concern for illnesses that do not pose a security threat and do not spread across national borders.

In this context, the Government of Jordan emerges as an important actor that uses its power and agency to shape global agendas, especially when it comes to health policies for refugees. In particular, findings show that the government has a vested interest in maintaining a state of 'health crisis' or 'health catastrophe', and in ensuring a continued flow of funding into the country. The perception of a crisis is used as an important 'bargaining chip' not only to maintain donor interest, but also to exert control and influence over otherwise prescriptive policies and conditions imposed by international creditors such as the World Bank, the IMF and bilateral donors. The sudden government announcement of its intention of cutting all subsidized health services to Syrian refugees three months in advance of the 2018 Brussels Conference is a case in point. Sources confirmed that the Government of Jordan hoped that the exclusion of Syrian refugees from access to health care would increase the visibility of the refugee population and put pressure on donors to increase international aid.

Overall, I have argued that the heightened portrayal of the presence of refugees in Jordan as a crisis has served in part as a means to mobilize international financial resources. In particular, findings show that the perception of a health crisis has been used as an important tool not only to maintain donor investment in Jordan, but also to exert control over the unequal power dynamics inherent in the global refugee system.

Syrian refugees and health diplomacy

Collaboration between the government and international donors has been one of both tension and cooperation. On the one hand, cooperation has included one of the first and most comprehensive nationally led humanitarian and development agendas – the Jordan Response Plan – which has been an effective mechanism for the coordination of the refugee response. The JRP also presented an important development in that it included budgeting and planning for the 'development' and 'resilience' of Jordanian host communities in addition to humanitarian support to refugees. On the other hand, however, tension has formed over the fundamental, intrinsic divergence in aims and objectives between the government and international donors. While the former aims to reap the benefits of international assistance to strengthen its infrastructure and support its citizens, the latter are resistant to supporting infrastructure projects for a middle income country and want to see funding channelled in support of Syrian refugees.

Overall, Jordan's at times volatile and unpredictable health policies affecting Syrian refugees can be viewed as attempts to leverage the country's dependency on foreign aid and to expand its negotiating capacities within the international refugee system. More specifically, the progressive exclusion of Syrian refugees from the national health care system served to exert pressure on powerful donors already grappling with concerns over regional instability in the Middle East and the threat of refugees arriving in Europe. As donors stated in interviews, the fear of refugees arriving 'on their doorstep' served as a strong incentive for their continued support to the country. I argue that Jordanian state authorities and donor governments, along with other non-state actors, have engaged in forms of 'health diplomacy', understood as a process through which states use health concepts in negotiations to achieve other political, economic, or social objectives' (Katz, et

al., 2011; Ruckert, et al., 2016).

Indeed, research shows that a perceived 'closeness' of the Syrian refugee crisis – with significant numbers of Syrian refugees seeking asylum in Europe and other countries in the west – contributed to the considerable amount of funding and donor interest dedicated to Jordan and other host states. A combination of Europe's weakened political position and Jordan's strategic instrumentalization of migration and health as a bargaining strategy have in part subverted the starkly asymmetrical power dynamics between states in the Global North and refugee host states in the Middle East region. At a time when thousands of Syrian refugees were arriving daily at Europe's borders, studies suggest that Jordan and other host countries in the Middle East were able to exploit the widespread panic and political inertia among EU officials to leverage their respective positions within the global refugee system (Natter, 2020; Norman, 2020; Tsourapas, 2019). To the extent that 2015 – a year in which Europe was in the midst of a 'migration crisis' and ensuing political crisis – can be considered a turning point within the complex power differentials between Jordan and members of the European Union (Lenner & Turner, 2018).

Findings indicate that a combination of 'migration diplomacy' and 'health diplomacy' from the part of the Jordanian government have been partially successful in achieving two main foreign policy goals: maintaining international investment, and resisting the integration of Syrian refugees. In particular, as suggested by Norman, since 2015 Jordan has been emboldened by the political paralysis and willingness to 'throw money at the problem' exhibited by several powerful European donors (Norman, 2019). On the one hand, donors have complained that the government is allocating international financing to its national population to the exclusion of refugees. On the other hand, however, despite such misgivings, donor investment in Jordan has remained higher than average, especially in the context of what has now become a protracted crisis. In 2016, the London Pledging Summit resulted in a deal called the Jordan Compact, in which donors agreed to invest more heavily in the Jordan Response Plan (Ministry of Planning and International Cooperation, 2018). Moreover, the World Bank's Jordan Emergency Health Project provided a $150 million loan as an exceptional measure (The World Bank, 2017).

Interestingly, the instrumentalization of health and health care policies to achieve foreign policy objectives, including greater financing, appeared abundantly clear to donors. For instance, the Jordan Compact not only committed donors to investing billions of dollars in grants and loans, but also embraced the narrative of transforming the Syrian 'refugee crisis' into a 'development opportunity' for Jordan. In contrast to the reluctant and cautious attitudes of government officials, donors largely viewed Jordan as a testing ground for new approaches to managing crises and containing refugees in their host countries (Lenner, 2016). A significant component of the 'local integration' of refugees in Jordan involved the highly disputed integration of Syrian refugees into the labour market. Despite strong objections from the Government of Jordan in the face of already astronomic unemployment figures among Jordanian citizens, the Jordan Compact paved the way for access to work permits for an estimated 200,000 Syrian refugees.

Policy outcomes of the Jordan Compact have been mixed (Agulhas Applied Knowledge, 2019). On the one hand, actual international funding has repeatedly fallen short of pledged amounts. On the other hand, work permits have fallen short of expectations, with many refugees unable to fulfil the application requirements or afford the application fees, and reports of multiple work permits being issued to individual applicants. Moreover, rather than competing for jobs with the national population, studies highlight that Syrian refugees have largely displaced the large population of migrant labourers from Egypt (Hartnett, 2018). Furthermore, reports suggest that Jordan has continued its covert practice of forcibly repatriating hundreds of Syrian refugees every month since 2017 (Içduygu & Nimer, 2020; Su & Laub, 2017).

In this section I have analysed how power dynamics among state and non-state actors reveal some of the global undercurrents of dominance and control which play out in refugee settings, particularly in relation to the allocation of health care resources. In the face of uncertain and inconsistent international funding, and a lack of negative consequences for returning refugees, I argue that Jordan has to some extent succeeded in levelling the playing field of an otherwise vastly asymmetrical refugee regime. At the same time, the increased securitization of forced migration over the past decades has further

weakened commitments to burden-sharing within the international refugee regime (Arar, 2017; Goodwin-Gill, 2019; Hammerstad, 2011). The conflation of refugees with terrorists and criminals has not only led to a lack of political will among states in the Global North and South to fulfil their obligations towards refugee protection, but has also framed forced migration as a 'zero-sum game' in which some states benefit at the cost of others (Gray & Franck, 2019; Hathaway, 2019). I now examine the factors at play in influencing the preferences of non-state actors – mainly international NGOs and UN agencies – in the implementation of health care policies affecting refugees.

8.2 Negotiating access to the humanitarian space

Among rising numbers of refugees in need of assistance and dwindling popular and political support for humanitarian action world-wide, access to resources – including health care – for refugees has become not only one of the most politicised, but also one of the most pressing concerns for actors involved in refugee responses. As scholars have pointed out, the presence of 'regime complexity' means that large numbers of institutions find themselves competing for authority and legitimacy in a crowded humanitarian space (Drezner, 2009; Harman & Wenham, 2018). In the absence of an established hierarchy among regimes and institutions, non-state actors find themselves having to navigate and interpret 'a set of overlapping and perhaps even contradictory regimes that share a common forum' (Alter & Raustiala, 2018, p. 330). In response to an unstable environment characterized by fluctuating funding and donor preferences, findings show that international non-state actors have employed several strategies which allow them to operate in Jordan. As I questioned in Chapter 6, *how do non-state actors negotiate and legitimize access to the humanitarian space*?

Humanitarian actors and regime complexity

Data reveal that the actions of international organizations are partially constrained by those of other state and non-state actors involved in the health response. On the one hand, NGOs are compelled to abide by the regulations and political sensitivities of the Jordanian government. All individual projects run by NGOs and UN agencies must not only be

aligned with the priorities outlined in the JRP, but also obtain prior government approval. In addition to limiting the range of their activities, the pressure to obtain more rapid government approvals for time-sensitive projects means that NGOs frequently self-select and tailor their proposals to better conform to expectations. Failure to align with government priorities would severely curtail the ability of such organizations to operate in the country (Human Rights Watch, 2012; Human Rights Watch, 2016).

On the other hand, NGOs are heavily dependent on financing from international donor governments. As we have seen in the cases of UNRWA and UNFPA (see Chapter 6), a lack of compliance with donor agendas and priorities could have disastrous financial consequences even for larger, well-established non-governmental organizations. As scholars have suggested, the ability of international organizations to conform to donor and state preferences can greatly enhance their success in securing funding and approvals in a competitive and often crowded humanitarian space (Asad & Kay, 2014). Despite such constraints, however, findings reveal that international non-state actors not only exercise considerable autonomy, but should also be considered powerful actors in their own right.

First, data show that international organizations in Jordan have taken on an increasingly political role which at times blurs the boundaries between state and non-state actions. In Chapters 4 and 5 I discussed how, over time, government policies towards Syrian refugees have curtailed access to subsidized health care and deepened the divide between the level of assistance awarded to citizens vis-à-vis the refugee population. In the face of a marked retrenchment of the state as the main provider of health services to refugees, international non-state actors have had to step in to fill the gaps and provide services to both refugees and Jordanians considered 'vulnerable'. Moreover, evidence shows that the significant presence of NGOs and other international actors in Jordan has inevitably led to the influence of external actors on the national health care system, on knowledge production, and, ultimately on decisions over the allocation of resources (Lupieri & Frisina Doetter, 2020).

Second, findings show that non-state actors are able to negotiate access to the humanitarian space by advancing discourses and narratives in support of 'extraordinary

measures'. As we have seen in Chapter 6, international organizations such as the WHO and UNHCR are tasked with determining the parameters of a 'health crisis' or a 'refugee crisis'. Senior policy officials working at these organizations in Jordan acknowledged that announcing the existence of a 'crisis' or an 'emergency' can have powerful effects on the amounts of funding and level of attention dedicated to a particular issue. As elite decision makers confided in interviews, a crisis not only suggests the need for exceptional responses such as increased international assistance, but also legitimizes the presence and actions of humanitarian and development organizations. To paraphrase Barnett, the 'productive power' of international organizations lies in their ability to define reality and to influence and legitimize future action. In other words, when international organizations declare an emergency, they also authorize their own actions and interventions (Barnett, 2012).

Third, in agreement with IR literature, findings show that humanitarian and development actors attempt to persuade state actors to invest or prioritize certain issues by creating discursive, causal relationships between humanitarian and development needs and the perceived interests of state actors. In other words, such 'issue-linkages' serve to persuade national and international state actors of the importance and validity of certain humanitarian actions (Alter & Raustiala, 2018; Betts, 2013). In Jordan, we have seen how organizations frequently conflate health and longer-term development gains with security issues. The implicit – and often explicit – narrative which justifies the need for funding for such projects inevitably constructs refugees as security threats. Within such mainstream narratives, the Jordanian state and its citizens are depicted as 'at risk' and in need of protection from the corrupting and subversive influence of the refugee population.

Institutional proliferation and the priorities of the health response

The strategies adopted by non-state actors to access the humanitarian space have had several ramifications for the overall priorities of the refugee response. First, in a context of institutional proliferation, the preferences and priorities of non-state actors are shaped in part and (mutually) constituted by the actions and mandates of other non-state actors. As theorized by Alexander Betts, competition can lead to institutions being 'challenged' or 'reinforced', depending on their mandates and their ability to strategize access to the

humanitarian space (Betts, 2013). Findings in Jordan show that, within the humanitarian system, asymmetrical power dynamics have led to the dominance of the UN in directing and coordinating the response, and to the marginalization of smaller NGOs and national non-state actors. Within a crowded humanitarian space based on competition for limited material resources, some powerful actors such as UNHCR have vastly expanded their mandates, while other less powerful actors have found themselves having to lobby for specific narrow interest groups to maintain their relevance and funding.

The primacy of emergency and short-term planning among humanitarian actors has also contributed to a further narrowing of their scope of operations. The pervasive reliance on short-term funding cycles has led to a prevalence of NGO projects which aim to achieve immediate results and tangible benefits. This often comes at the expense of providing support for NCDs and chronic diseases which require consistent funding and management, and often do not yield immediate results. Moreover, the short-term mandates of many medical humanitarian organizations have limited the amount of time that such organizations can operate in the field. Interviewees frequently emphasised feeling unprepared for the challenges presented by a 'protracted crisis' in a middle-income country such as Jordan, which possesses sophisticated infrastructure and a complex health care system. Faced with an older refugee population accustomed to advanced levels of health care, policy makers and practitioners said they struggled to adapt their priorities to reflect the needs on the ground. Scholarship on the culture and behaviour of international organizations has revealed how forms of 'bureaucratic universalism' tend to generate universally applicable rules and categories which frequently fail to account for contextual and pluralistic concerns (Barnett & Finnemore, 1999). Among practitioners in Amman, findings reveal that a majority of humanitarian and development officials had developed their professional expertise in low-income settings with a particular focus on sub-Saharan Africa. Without discounting the transferability and generalizability of such technical knowledge, in many cases such 'bureaucratic universalism' led to a failure to adapt organizational priorities to better reflect the specific health needs of Syrian refugees in Jordan.

Overall, as demonstrated by the data, some objectives are neglected within the humanitarian health response. For instance, though NCDs are considered a priority by all actors, the extensive collaboration needed to implement interventions for managing NCDs – and the lack of immediate 'impact' of such interventions – means that services for chronic diseases are sorely overlooked. When confronted with blatant gaps in services, however, state and non-state actors point the finger elsewhere: to a lack of leadership from the part of the UN, to a lack of donor interest in the issue, or to government incompetence. In line with recent scholarship on regime complexity, findings show that the large number of service providers involved in the health response can lead to mixed outcomes. On the one hand, coordination mechanisms can increase the amount of available resources and create avenues for greater collaboration. On the other hand, such mechanisms frequently result in a lack of accountability when certain objectives fall through the cracks (Alter & Raustiala, 2018).

As we have seen in Jordan, the growing fuzziness of the boundaries between the roles of international organizations and domestic politics is not unproblematic, especially in regard to policies and practices related to health. Non-state actors are represented by unelected – and often foreign – officials who are not only unaccountable to the beneficiaries they represent, but are also depicted as impersonal, technocratic, and depoliticized actors engaged in the service of others in the name of an unspecified 'international community' (Glasman, 2019; Harrell-Bond, 2002). In other words, refugees have little recourse or ability to influence the decisions which are frequently taken on their behalf (Barnett, 2012). As such, the growing politicization of humanitarian and development assistance has not only influenced priorities on the ground, but has also further skewed the balance of starkly unequal power dynamics between international organizations and the Syrian refugees they are meant to represent.

8.3 'Vulnerability' and its political constructions

Despite the apparent neutrality and objectivity of vulnerability assessments, we have seen how the labels and criteria applied to Syrian refugees are far from neutral and apolitical

(see Chapter 7). As I argue in this thesis, collisions between international and supranational interests create a divide between expansive policy promises and the actual allocation of resources. In fact, the neglect of certain categories of refugees not only mirrors the unequal power dynamics among state and non-state actors involved in health, but also serves to unpack the profound political implications involved in health care delivery in Jordan. In Chapter 7, I answered the question: *how is 'vulnerability' constructed in the refugee health response*?

When 'vulnerability' becomes 'value for money'

In Jordan, findings show how life and death decisions about the implementation of health policies and guidelines frequently rely on the 'professional discretion' (Brown, 2011) of individual organizations involved in the refugee response. I argue that the power dynamics which play out in the labelling and categorizing of refugees should be viewed within a wider context of the politicisation of humanitarian and development assistance. Caught between political pressures from the Jordanian state and donor governments, and the need to allocate limited and unreliable resources to an increasingly impoverished refugee population, findings show that humanitarian and development actors tend to fall back on two main concepts: the principle of 'value for money', and notions of 'vulnerability'.

According to an OECD definition, the concept of 'value for money' is: 'The optimum combination of whole-life cost and quality (or fitness for purpose) to meet the user's requirement. It can be assessed using the criteria of economy, efficiency and effectiveness' (Jackson, 2012, p. 2). In theory, the notion of 'value for money' emerged to ensure greater transparency and accountability in the allocation and delivery of humanitarian aid, and to ensure that money that is spent also yields tangible results (Baker, et al., 2013). In other words, how can donors achieve the most 'humanitarian value' with limited resources? (Obrecht, 2017). In practice, however, the concept has been seen to increase the accountability of donors towards their taxpayers rather than to the actual recipients of humanitarian assistance (Jackson, 2012).

Publicized as an expression of improved efficiency, the principle of 'value for money' and

notions surrounding 'returns on investments' emerged on several occasions during discussions about humanitarian financing in Jordan. In particular, findings show that 'value for money' is an ambiguous and vague catchphrase which conveys notions of 'economy' and 'cost-effectiveness'. Moreover, interviews revealed that the concept has been frequently applied not only to determine the value or cost-effectiveness of humanitarian programmes, but also as a rationalisation for championing certain groups of refugees over others. For instance, interviewees noted that donors were always willing to invest in children because this target population would bring a 'return' on their investment (see Chapter 7).

Unsurprisingly, the principle of 'value for money' emerged in particular during discussions with donors and representatives from humanitarian organizations about financing medical assistance for chronic diseases and health services catering to the specific needs of older refugees. As we have seen in previous chapters (Chapter 4 and Chapter 7), though assessments in Jordan clearly indicate that chronic diseases have a significant impact on the 'vulnerability' of the refugee population, interviewees frequently cited a lack of 'value for money' of such health interventions. Moreover, the perception of older refugees' reduced lifespan and lack of economic contributions are determining factors in the exclusion of this demographic from targeted donor assistance. In sum, the principle of 'value for money' has at times become a more ominous tool for defining the 'value' of recipients of humanitarian assistance based on the potential value of their labour and contributions to the economy.

When it comes to 'vulnerability', from its inclusion in the Sphere Handbook of Humanitarian Standards to its mention within European asylum seeker guidelines, the notion is a central tenet of many laws and policies which govern the lives and rights of refugees. Its rise and popularity, defined by some as a 'vulnerability Zeitgeist' (Brown, 2014), have led to the concept now playing a dominant role in the allocation of resources in refugee settings. Despite its centrality, however, there has been little critical reflection on the diverse and at times ambiguous constructions of 'vulnerability' among humanitarian actors, and on the repercussions of such constructions on the life chances of refugees (Flegar, 2018; Janmyr & Mourad, 2018). As some have, more ominously, pointed out, notions

of vulnerability can support arguments for the greater protection of refugees on the one hand, or become mechanisms for social control on the other (Brown, 2011; Flegar, 2018).

As we have seen throughout this thesis, selecting 'the most vulnerable' is a far from transparent or straightforward process. While the increasing complexity of the VAF questionnaire in Jordan and its emphasis on the situational and structural factors which make up individual vulnerability is a welcome step forward, findings show that 'vulnerability' remains an ambiguous and ill-defined concept. In particular, I argue that the VAF, while useful in providing valuable information about the overall needs of Syrian refugees, has translated into a subtle form of paternalism which in many ways increases the inherent power differentials between refugees and the organizations that claim to represent them. Vested in 'moral' and 'expert' authority (Barnett, 2012), humanitarian and development actors speak on behalf of refugees by determining their 'vulnerabilities' and their 'greatest needs', and by making decisions on the allocation of resources. Indeed, the VAF's complex and opaque criteria for determining vulnerability stymies any ability that refugees may have to self-determine their needs and the assistance they are entitled to. Interviews with the creators of the VAF revealed that opaqueness is an integral part of vulnerability assessments and is designed to limit 'subjective interpretations' of self-reported vulnerability. In other words, the VAF eliminates the possibility for individuals to enact 'performative dimensions' of vulnerability and to claim the label to their advantage (Huschke, 2014).

In other words, the groups of refugees who gain prominence and visibility within the health response are those who fulfil two main criteria: demonstrated 'vulnerability' and 'value for money'. Moreover, we have seen how, within a framework of complex and at times ambiguous constructions of vulnerability, health actors frequently fall back on stereotyped and preconceived notions. More specifically, findings show that the humanitarian and development response indirectly orders refugees into three broad groups of recipients: 'vulnerable', 'securitized', and 'invisible'. In what follows, I turn to an analysis of the main determining features of these three groups before discussing the ramifications of such 'classification struggles' on the overall refugee response.

Vulnerable, securitized, and invisible refugees

First, women and children emerge as the uncontested recipients of humanitarian assistance in Jordan. Though the VAF does not necessarily consider these groups to be the 'most vulnerable', women and children are considered a priority by all actors involved in the response. As discussed in Chapter 7, the majority of actors involved in the health response mentioned women and children as the principal recipients of assistance and of specialized services. On the one hand, this trend can – and should – be viewed as a successful outcome of system-wide 'gender mainstreaming' processes within humanitarian and development responses. On the other hand, however, interviews revealed that, rather than focusing on the contextual factors which may increase the vulnerability of individual refugees, in most cases women and children are simply considered inherently vulnerable and 'helpless'. While being deemed 'vulnerable' can be an advantage in providing access to services and assistance, scholars have pointed out the risks associated with essentializing women as 'vulnerable victims' (Crawley, 2016; Freedman, 2019; Holmes & Castañeda, 2016). Indeed, such gendered and stereotyped categorizations not only confer an 'inferior' status to women, but also undermine their autonomy and severely limit their agency (Freedman, 2019). As Gelsthorpe writes on the ways in which the control of women is largely discursive: 'Social definitions of women and institutional arrangements are used to control women, often in such a way that women see them, not as control, but as part of everyday routines – part of the 'natural' order of things' (Gelsthorpe, 2010, p. 380).

Second, the group of 'securitized refugees' is predominantly comprised of men and boys, with a particular focus on the destabilizing potential of young men. For western donor governments, young men present the risk of cross-border mobility and subsequent threat to the integrity of national boundaries (Abbas, 2019; Turner, 2016). For the Jordanian state, heightened security concerns in a volatile region promote the image of young refugee men as potential converts to extremist ideologies and a risk to domestic stability. Despite facing particular vulnerabilities caused by greater exposure to war-related injuries, post-traumatic stress disorder, and exploitative labour practices, men are rarely considered vulnerable or in need of particular attention within the refugee response (Turner, 2019). To the contrary,

the presence of men and young men - viewed as potential breadwinners - within a household can adversely affect vulnerability assessments and diminish household entitlements to essential assistance and services. In sum, the health needs of men and, in particular, young men have been largely overlooked in the refugee response. Gendered stereotypes which equate masculinity with 'strength' and 'danger' have had damaging effects on perceptions of the needs and vulnerabilities of men and boys, especially in regard to health. Moreover, 'risk' and 'vulnerability' are predominantly constructed in relation to national populations in Jordan and the west (Johnson, 2011). Here, national populations – rather than refugees – are perceived as needing protection from the increasingly mobile and threatening presence of Syrian refugee men and boys (Gray & Franck, 2019).

Third, findings reveal the construction of a heterogeneous group of 'invisible refugees'. This group, predominantly made up of unregistered and older refugees, and, to some extent, of refugees with disabilities, is not only overlooked by the health response, but also largely unaccounted for. As discussed in Chapter 7, the category of 'unregistered refugees' is omitted from official statistics and vulnerability assessments, and is largely excluded from humanitarian assistance. Without an official registration status, an unknown number of refugees lives on the margins with little or no access to services.

Throughout this thesis, the case of older refugees has emerged as a prime example of a group which is generally deemed vulnerable, but has been largely overlooked by the refugee response. Over the last few decades, the right to health of older individuals has begun to figure more prominently within international conventions and treaties (Fineman, 2012). In 2002, the Madrid International Plan of Action on Ageing stressed the rights of older persons as well as their vulnerability in emergency situations, and set guidelines for policy making and humanitarian responses in the context of global population ageing. An increasing commitment to promoting the rights of older persons and persons with disabilities is reflected in the Sphere Project's *Handbook on Minimum Standards in Humanitarian Responses*, which includes guidelines on collecting disaggregated data based on sex, age and disability (Mazurana, et al., 2011).

Despite agreement among policymakers that older age can be a determining factor for greater vulnerability, however, older people themselves rarely capture the attention of international donors, the Jordanian government, and humanitarian and development agencies. Almost paradoxically, older refugees' lack of mobility and lack of threat to stability and international security have placed this age group at the bottom of humanitarian and development agendas. As representatives from NGOs complained in interviews, older people are rarely mentioned in appeals for funding. And when they are mentioned, they appear among a long list of vulnerable groups. When it comes to health care, interviewees pointed out that there is a pervasive bias against older people across all levels of delivery. As one interviewee explained, even when older refugees do manage to access services, they often face negative attitudes and poor treatment from the part of medical professionals who are dismissive and fail to take their complaints seriously.

So far I have discussed the main three categories of refugees which have emerged from the refugee response: 'vulnerable', 'securitized', and 'invisible' refugees. While these categories are necessarily general, they are by no means prescriptive. Indeed, several refugee groups do not fall neatly within these categories and occupy an indistinct space within the refugee response. The case of refugees with disabilities, for instance, is in some ways more ambiguous than that of older refugees. In recent years, discourses on the rights and vulnerabilities of persons with disabilities have gained prominence and recognition in policy circles. Yet, despite featuring among the priorities of donors and international organizations, in practice refugees with disabilities rarely receive the support that they require. In other words, refugees with disabilities have been integrated into mainstream discourses on vulnerability, but have yet to see changes in the actual allocation of services and resources on the ground. For the time being, this group occupies an interstitial space between a refugee group considered 'vulnerable' and one which is largely rendered 'invisible' in the health response.

Similarly, we have seen how inclusion in the category of 'vulnerable refugees' is largely based on gender and age. While women and children can be considered the principal recipients of humanitarian assistance, it is important to note that not all women are

included in this group. Indeed, older women are one of the most neglected demographics throughout the refugee response. As we have seen throughout this thesis, women above the age of 49 are frequently omitted from surveys and assessments, are rarely considered to be of particular concern for specialized health services, and are not perceived as potential victims of gender-based violence (see Chapter 7). In this respect, data suggest that inherent biases against older people and the lack of an intersectional approach to gender and age means that younger women in their reproductive years are considered 'deserving' of humanitarian assistance and specialized support, while older women are rendered largely invisible.

Ultimately, what emerged from interviews is a combination of various factors and influences which highlight the politicized nature of the medical humanitarian response. Within a complex mechanism for global health governance undertaken by international organizations in Jordan, the need to secure foreign funding and government approval, and maintain relevance and legitimacy within a saturated humanitarian space have led to a distortion of health priorities on the ground. In the following, final section of this chapter I turn to the implications of this research. I argue that, based on the case of Syrian refugees in Jordan, there are several lessons to be learned for both theory and practice in refugee settings. I then map out some recommendations for further research.

8.4 Implications for theory

In this thesis I contribute a new framework for understanding how foreign policy agendas and inter-state negotiations in refugee settings permeate humanitarian health responses. Through a critical analysis of the discourses of the main actors involved in allocating resources and providing health services in refugee responses, I distinguish two main steps through which 'migration diplomacy' ultimately shapes the spending priorities of health responses and produces and reproduces inequalities on the ground. First, I expand the concept of 'migration diplomacy' by bringing to the fore the strategic use of health care policies affecting refugees as a form of diplomacy within inter-state relations. I demonstrate the ways in which donor governments and refugee host states have instrumentalized the

presence of refugees – and their health needs – to further their agendas. Second, I investigate the effects of migration and health diplomacy on the distributional politics of the overall humanitarian health response. I find that political and foreign policy interests not only percolate across all levels of the health response, but also intertwine with gendered and racialized notions of 'vulnerability' and 'value for money' among humanitarian actors. In what follows, I analyse some of the main implications which have emerged from this research.

Health and politics in an asymmetrical refugee system

In a global context which appears to be increasingly shifting away from the internationalist, liberal world order of the post-World War II era, it should come as no surprise that international agreements on human movement have been frequently co-opted by national interests and state struggles for power and legitimacy (Doyle & Macklin, 2017; Gibney, 2015; Hathaway, 2019). My case study of Syrian refugees in Jordan clearly exemplifies the ways in which unequal power dynamics and unfavourable conditions imposed on refugee host states by the international refugee regime have shaped national policymaking. As I argue in this thesis, the failure of collective action at an international level to address the Syrian refugee crisis has led to the instrumentalization of refugees and health policies as bargaining tools within foreign policy agendas. Within the context of the complex politics of humanitarian intervention and a moral geography often determined by self-interest and power relations (Fassin & Pandolfi, 2010; Norman, 2019; Tsourapas, 2019), this section expands our understanding of how health care policies towards refugees can be used strategically by a host state to not only appease its national constituents, but also to leverage its position against more powerful, external state actors.

Recent scholarship has emphasised how donor governments and national authorities have successfully integrated health within national foreign policy goals and diplomatic strategies due to its interlinkage with global security concerns, economic interests, and principles relating to social justice (Anderson, 2018; Ruckert, et al., 2016). Yet little attention has been paid to an in-depth analysis of the politics of health and health care in a refugee setting. Chapter 5 revealed how the Jordanian state and donor organizations have selectively

supported health care policies for Syrian refugees depending largely on political and economic motivations rather than strictly humanitarian ones. Findings reveal that not only refugees, but also health policies have become politicized in the interest of achieving foreign policy objectives. On the one hand, the lack of binding commitments to responsibility-sharing among international actors has placed refugee hosting states at a marked disadvantage (Achiume, 2015). On the other hand, state actors from the Global South can at times exert a considerable amount of influence on international politics.

As we have seen in the case of Jordan, government health policies towards refugees have served as relatively effective tools in negotiating concessions and financing from donors in exchange for hosting refugees. In the face of a political paralysis among EU member states, host countries such as Jordan have been able to leverage their positions as 'refugee rentier states' to maximize benefits from a fundamentally unfair and unequal refugee regime (Arar, 2017; Tsourapas, 2019). At the same time, however, this thesis offers a more nuanced view of the extent to which the balance of power between Jordan and its donor governments has been subverted through attempts at health and migration diplomacy. Rather, I argue that Jordan's success in this respect has been mixed.

On the one hand, Jordan's policies of catastrophizing the presence of Syrian refugees has been relatively successful in painting the picture of a refugee and a health 'crisis'. Compared to the case of Iraqi refugees less than a decade earlier, a combination of encampment policies and policies excluding refugees from services have been considerably more successful in increasing the visibility of Syrian refugees and in securing international assistance. Moreover, Jordan's support for US foreign policies and its cooperation on the 'war on terror' has ensured a continuity of international assistance. On the other hand, however, securitization can be a double-edged sword. Discourses espoused by the Jordanian government which presented refugees as a catastrophe and as a security and health threat resonated strongly with western donor governments and publics. Indeed, the concomitant securitization of Syrian refugees in Europe and the US brought about more restrictive migration policies and greater attempts at border externalization policies (Crawley, 2016; Faist, 2018). While this may have provided a window of opportunity for host

states to leverage western fears over the arrival of refugees, such policies were followed by the effective closure of borders in the EU and a dramatic decrease of resettlement options for refugees in the West – particularly to the US. In the long run, though almost a decade has passed since the arrival of Syrian refugees in Jordan, Lebanon and Turkey, these countries are still hosting millions of Syrian refugees. In the meantime, international aid and interest in the refugee crisis in the Middle East are waning, and opportunities for resettling refugees to a third country or returning refugees to their country of origin are nearly non-existent.

For refugees living in Jordan, the results of such interlinkages between 'global security, economic and social justice agendas' (Ruckert, et al., 2016, p. 65) have rarely yielded more generous policies. The Jordan Compact, which promised 200,000 work permits for Syrian refugees has revealed mixed outcomes. In response to international pressures, Jordanian authorities, already grappling with one of the highest rates of unemployment in the world, have found less scrupulous ways to increase the numbers of work permits and fulfil their obligations under the Compact. These include issuing multiple permits to individual refugees and discriminating against the large number of Egyptian labour migrants already residing in Jordan (Hartnett, 2018). At the same time, under the guise of 'voluntary returns', Jordan has been accused of forcibly repatriating hundreds of Syrian refugees every month since 2017 (Su & Laub, 2017).

I argue for a stronger integration of scholarship relating to health, human movement, and world politics. To date International Relations scholarship has largely relegated health and migration to the realm of 'low politics' (Youde, 2016). I contend that the growing politicization of refugees and health policies calls for more trans-disciplinary and trans-theoretical research. More specifically, my analysis of the politics of migration and health in a highly strategic region such as the Middle East presents a strong case for forging stronger links between health policy and the politics of forced displacement. Indeed, this thesis argues for a more prominent positioning of global health diplomacy and migration diplomacy within the realm of 'high politics'.

Non-state actors and contested humanitarian principles

Since the end of the Cold War, scholars have observed a gradual shift in the principles and priorities of many humanitarian organizations, in particular when it comes to their wider engagement with international politics (Cuttitta, 2018; Hoffman & Weiss, 2017). From a focus on alleviating suffering in its most elemental forms, humanitarian objectives have evolved to include the responsibility to bear witness to atrocities and to advocating for the respect of human rights. Within the context of a shifting world order, the disengagement of western governments from the geopolitical peripheries after the end of the Cold War left many humanitarian and development actors as the sole representatives of western powers in non-strategic countries (Duffield, et al., 2001; Fox, 2001). As a result, scholars have noted a blurring of the distinction between politics, security, humanitarianism, and development assistance (De Lauri, 2016; Ticktin, 2014). Moreover, the linking of development with global security concerns within policy discourses over the past two decades has transformed the remit of many humanitarian and development organizations from one of minimizing suffering to one of bringing 'order' to 'disorder' (Duffield, et al., 2001). Critics of this shift contend that, over time, humanitarian organizations have become an integral component of the ambitions of western governments to bring about peace, stability and liberal development (Chimni, 1998; Duffield, et al., 2001).

The evolution of 'medical humanitarianism' has closely mirrored the development trajectory of 'new humanitarianism'. Here, a shift from 'disaster medicine' has included a growing focus on the interlinkages between the threat of pandemics and bioterrorism, and the national security of predominantly western countries (Wenham, 2019). Since 9/11, the institutionalization of disaster medicine has accelerated and now encompasses such wide-ranging objectives as responses to famine, wars, and refugee crises (Yamashita, 2015). In this context, the rise of a 'new humanitarianism' and, by extension, 'medical humanitarianism' has not only merged development assistance with politics, but also expanded the mandates of humanitarian organizations to a focus on broader political projects (Curtis, 2001; Hoffman & Weiss, 2017). These include attempts at influencing the behaviour and attitudes of recipient countries, and a more prominent role played by international organizations within domestic politics (Ticktin, 2014).

Some scholars argue that such political involvement among international organizations arises out of an historical necessity to compensate for the retrenchment of the state as the main provider of services (Slaughter & Crisp, 2009). Others contend that the increased presence of NGOs and other non-state actors delivering medical assistance has in part legitimized the retreat of the state as the main provider of services (Gottlieb, et al., 2012). In particular, the presence of external financing and especially of Development Assistance for Health has been correlated with a decrease in national health spending (Global Burden of Disease Health Financing Collaborator Network, 2019). For instance, though ministries of health may remain committed to strengthening national health systems, ministries of finance may cut budgets based on the presence of external financing (Lu, et al., 2010; Farag, et al., 2009). Overall, however, despite greater recognition of the political influence of non-state actors on the domestic policymaking of recipient countries, by and large IR scholarship has tended to relegate the role of international organizations to one of subservience to other, more powerful state actors (Khakee, 2018). In other words, humanitarian and development actors are frequently regarded as strategic manifestations of the power and influence of donor governments, and as a means for enhancing the national security and hegemony of the Global North (Donini, 2010; Duffield, 2014; Panebianco & Fontana, 2018).

I have provided a more nuanced perspective on the role and agency of non-state actors involved in humanitarian and development responses. While IR and global social policy scholarship tends to relegate the position of NGOs to that of subaltern actors within the politics of humanitarian action, I have shown that non-state actors can be both dependant and empowered actors. On the one hand, international NGOs and UN agencies are highly reliant on the financing provided by major donors, and on the goodwill of the states in which they operate. Indeed, as we have seen in Chapter 6, diverging too far from the values and priorities espoused by state actors can have severe consequences. On the other hand, however, the increasing politicization of humanitarian aid has made non-state actors powerful players within refugee responses. In particular, in the face of a rapid retreat of state responsibilities, humanitarian and development actors have expanded their mandates

to step in and provide basic services to the refugees under their remit. NGOs and UN agencies are thus bestowed with a growing authority to select the most 'vulnerable' recipients of humanitarian assistance – to the exclusion of others – while making life and death decisions on behalf of refugees. In this context, we have seen how non-state actors have not only become more powerful, but have also increased the divide between those in need of assistance and those in a position to bestow it.

What has emerged from my analysis is a fundamental discrepancy between the priorities of the government, donors, and non-state actors operating in Jordan. One the one hand, government authorities aim to maximize benefits for citizens to the gradual exclusion of refugees. Donor priorities, on the other hand, revolve around national security interests and maximizing the impact of humanitarian financing. Humanitarian and development actors, however, face the challenging prospect of catering to the needs of refugees while concomitantly securing funding, gaining government approval, and, increasingly, allocating and distributing health services. In line with a large number of IR scholars, I argue that it is thus unavoidable that non-state actors are strongly influenced by the priorities of donor governments. At the same time, however, I contend that within a context of sustained international assistance the vacuum left by the retrenchment of the recipient state has in part been filled by powerful international organizations. In contrast to the universalistic ambitions of the Jordanian state towards its citizens, however, NGOs and other international organizations are ill-equipped to provide indiscriminate, long-term support to the burgeoning population under their remit. To the contrary, as several representatives from NGOs pointed out in interviews, competition among actors has not only hampered effective coordination, but has also led to the neglect of groups of refugees and health causes which might not be considered 'popular' among donors.

The 'deserving' refugee

Scholarship has pointed to the fundamental role that labels play in influencing how we perceive refugees and migrants, and how we imagine their agency (Crawley & Skleparis, 2018; Zetter, 1991). In other words, the ways in which we envision certain categories of people determines how we engage with them and, ultimately, whom we accept as political

actors and participants in our world. From an historical perspective, how we imagine refugees in countries in the Global North has evolved considerably over the past decades (Johnson, 2011). At the height of the Cold War, 'typical' refugees were lone, heroic male figures fleeing persecution under communist regimes. Committed to building a new life for their families in the West, refugees were in many ways the embodiment and confirmation of the moral and ideological superiority of liberal western powers (Johnson, 2011).

By the time of the collapse of the Soviet Union and the emergence of long-term, internecine 'new wars' in the 1990s, the characteristics of refugees – and perceptions of forced displacement in the West – had evolved. Soon, the figure of the lone refugee fleeing political persecution was replaced by an image of 'huddled masses' of women and children from the Global South fleeing cycles of conflict, violence, and poverty (Johnson, 2011). Over time, constructions of the 'typical' refugee transitioned from an ideal of heroic self-reliance to becoming synonymous with dependency, victimhood, and vulnerability (Holzberg, et al., 2018). From political agents with the ability to determine their fates, refugees have been relegated to an image of anonymized and depoliticized masses with little power to shape their individual circumstances (Sözer, 2020).

In Jordan, the way Syrian refugees are imagined strongly influences the services that they are entitled to. In a crisis, there is recognition and acceptance of the fact that not all lives can be saved. But whose lives can legitimately be saved, and who gets to decide? As we have seen in this thesis, in the absence of universal access to health care, notions of 'vulnerability' serve to differentiate refugees and guide the distribution of limited resources to those who, supposedly, 'need them the most'. In this context, labels of 'vulnerability' carry certain advantages for some refugees, while also necessarily placing refugee groups in competition with one another (Holmes & Castañeda, 2016; Sözer, 2020). As Brown noted eloquently in the context of the UK welfare system: 'The prioritization of "the vulnerable" might be seen as sensible financial decision-making in an age of limited welfare resources, but how this strategy gives rise to competing interests for scarce resources should not go unnoticed.' (Brown, 2011, p. 49).

As we have seen in Chapter 7, vulnerability labels and assessments play a significant role in the allocation of resources in refugee responses. Recently, scholars have highlighted the rapid rise of 'evidence-based humanitarianism' centred on measuring and determining humanitarian needs, and labelling and classifying refugees (Crawley & Skleparis, 2018; Sözer, 2020). Increasingly, quantitative data have come to play a fundamental role in determining status assessments and 'needs' and, consequently, in influencing priorities for humanitarian aid (Glasman, 2019). So far, however, scholarly attention has largely overlooked the growing importance of 'vulnerability' as a central feature in determining the allocation and distribution of resources to refugees (Flegar, 2018; Janmyr & Mourad, 2018). As I discuss in this thesis, the ways in which 'vulnerability' is conceptualized by powerful actors in the refugee response has fundamental ramifications for refugees, their access to health services, and their overall 'life chances'.

Indeed, a more critical understanding of the politics which underpin constructions of 'vulnerability' in refugee contexts is needed to highlight the fundamental discrepancy between expansive global policy promises on the one hand and the restrictions of refugee rights on the other. Data show how the label of 'vulnerable', acquired through the VAF, can help to allocate resources to *some* refugees *some* of the time. Though a valuable tool for conducting rapid and comparative assessments across large populations, the impersonal and vague dimensions of the VAF fixes refugees within their social and spatial positions (Brun, 2016; Janmyr & Mourad, 2018). On the one hand, the humanitarian response and the financing of the crisis response in Jordan are aimed at relieving human suffering. On the other hand, however, such responses conceal the objective from the part of donor governments and the state of securing their ways of life from the ripple effects of large-scale refugee movements in an increasingly interconnected world. In other words, in line with definitions of 'paternalism', the VAF ultimately serves as a tool for speaking on behalf of refugees while claiming to represent their best interests (Barnett, 2012).

Vulnerability assessments not only obscure the gradual decrease in resources and services available to refugees, but also reflect a paternalistic form of welfare which has shifted the discourse on access to services and humanitarian assistance from that of an 'entitlement'

to that of a 'gift'. Moreover, we have seen how constructions of who is 'vulnerable' and who is not increasingly reinforce perceptions as to what a 'real' and 'deserving' refugee looks like (Crawley & Skleparis, 2018). According to the main actors involved in the refugee health response, 'real' refugees are those who are able to perform dependence and helplessness, while also contributing to the economy. In the following, final section of this chapter I turn to the implications of this research. I argue that, based on the case of Syrian refugees in Jordan, there are several policy lessons to be learned. I then map out some recommendations for further research.

8.5 Implications for policy

From a policy perspective, there are several lessons which have emerged from my research.

Refugees as a global responsibility

In response to new and emerging refugee movements, global policymaking has begun to call for fairer and more equitable mechanisms for responsibility-sharing. The 2018 Global Compact on Refugees, which called for stronger national commitments for refugee protection, has been widely regarded as a ground-breaking outcome of two years of negotiations among world leaders (Hansen, 2018). Backed by broad intergovernmental consensus, the objectives of the Refugee Compact are four-fold: to ease pressures on refugee host countries, to enhance the self-reliance of refugees, and to expand access to either third country resettlement options or to a safe return of refugees to their countries of origin (UN, 2018). Filippo Grandi, the UN High Commissioner of Refugees, called the compact 'a powerful expression of how we work together in today's fragmented world' and emphasised that 'no country should be left alone to respond to a huge influx of refugees' (Lederer, 2018).

Yet despite such international commitments, progress towards a more equitable refugee regime has been uncertain at best. In the case of the 2018 Refugee Compact, which called on states to (voluntarily) commit to greater responsibility-sharing, both the US and Hungary objected to the 'strong' terms of the compact and dropped out of the

consultations. Critical voices of the Compact's modest ambitions have gone as far as to define the Compact a 'Global Cop-Out on Refugees' (Hathaway, 2019). As Hathaway writes, the Compact 'is all about the process – a bureaucrat's dream perhaps, but nothing that even comes close to dependably addressing the operational deficits of the refugee regime' (Hathaway, 2019, p. 594). Indeed, the Compact has been largely faulted for failing to radically address the intrinsic power asymmetries of the refugee regime, in which the responsibility to protect refugees is based on geographic proximity to a crisis area (Betts, 2019; Doyle & Macklin, 2017).

At the same time, however, it is important to acknowledge the profound limitations imposed by the current political climate, increasingly characterized by nationalist populist movements, border closures, and anti-immigrant rhetoric. Indeed, such political constraints have severely hampered UNHCR's ability to build consensus around a long-term strategic vision (Betts, 2018). In this context, realistic solutions are needed to work within the constraints and the parameters of the current world order. On the one hand, the status quo is clearly not sustainable for host states in the Global South left to shoulder the responsibility for hundreds of thousands, if not millions, of refugees. Most importantly, it is not sustainable for those refugees who are left to wait in limbo for decades on end. On the other hand, however, the global community lacks sufficient solidarity to overcome collective action problems when individual states fail to meet their responsibilities (Doyle & Macklin, 2017).

More modest proposals advocating for incremental improvements may be what is feasible. As suggested by scholars from Columbia University, such proposals might include expanding and formalizing resettlement schemes and strengthening cooperative responsibility (Doyle & Macklin, 2017). This might generate a scheme which determines each state's share of global responsibility based on their respective capabilities. One way for determining capability might be through the EU formula which combines indicators such as population, GDP, unemployment, and past refugee loads (ibid.). Though the EU formula and its plan for responsibility-sharing of the Syrian 'refugee crisis' collapsed at the EU level, other pathways towards resettlement could include expanded visa schemes and

private sponsorship (Doyle & Macklin, 2017). Only when global human movement truly becomes a global responsibility, can the commodification of refugees – and the policies that affect them – become less prevalent. In the meantime, however, practical and incremental steps towards responsibility-sharing and a stronger commitment to the principles of the 1951 Refugee Convention may be the best we can hope for.

Building a more inclusive humanitarian system

Research in Jordan has emphasised the ways in which two significant actors are conspicuously absent from the refugee response: national civil society actors and the refugees themselves. In particular, interviews with international NGOs and donors reveal that local charities, Community Based Organizations and Jordanian NGOs are almost entirely excluded from coordination mechanisms and meetings. This is in part due to language barriers in that all meetings are conducted in English, and in part due to concerns over the 'capacity' and 'corruptibility' of national actors. Even more manifest is the exclusion of Syrian refugees from the decision-making processes of the refugee response. While paternalistic approaches to the allocation of services may be necessary in an emergency in which saving lives is a priority (Barnett, 2012), almost a decade since their arrival refugees are still not included in decision-making. This is a particularly blatant omission in the face of documented activism among Syrian refugees in Jordan (Khoury, 2017). Studies show that Syrians have engaged in forms of civilian mobilization for the Syrian cause in their host countries. Such instances of activism include fundraising, advocacy, and relief in both political and humanitarian arenas (ibid.). In many ways, however, security concerns among government officials combined with the exclusionary nature of the international response have largely marginalized the mobilization efforts of Syrian refugees in Jordan.

In this context, more efforts are needed to ensure the meaningful inclusion of national civil society actors and affected populations within refugee responses. In line with the recommendations of the Secretary-General's Outcome Report of the 2016 World Humanitarian Summit:

> Civil society, such as international and local non-governmental organizations, as well as faith-based groups, diaspora and migrant communities and others, must continue to fulfil their critical role in providing leadership, service delivery, advocacy and outreach, including through engagement with affected communities (UN General Assembly, 2016, p. 20).

As such, more efforts are needed to ensure that coordination meetings have local interpreters and that outcome documents are published not only in English, but also in local languages. Most importantly, refugees should be offered a seat at the table as decision-makers and active community representatives, rather than simply as 'vulnerable' individuals in need of assistance.

Towards a more critical understanding of vulnerability

In recent years, policymakers have begun to address the need for fairer and more equitable mechanisms for the allocation of resources to populations in need. In 2016, the World Humanitarian Summit, convened by former Secretary-General Ban Ki-moon, called on donor governments and international organizations to improve collaboration, and to 'transcend humanitarian and development divides' (UN, 2016). In particular, the outcome document stressed the vulnerability of certain populations, and the need for more inclusive policymaking. As one of the commitments in the document stated: '…children, young people, persons with disabilities, older people and other groups that are uniquely vulnerable in crises will be included to a greater degree in decision-making and will benefit from more targeted financing' (UN General Assembly, 2016, p. 3).

Scholars, policymakers, and international organizations, however, have highlighted that, despite the expansive promises of recent policies, little has changed on the ground (Röth, et al., 2017; Slama, et al., 2017; UNHCR, 2020). In Jordan, data indicate the marked exclusion of several populations and several diseases within the refugee health response. On the one hand, refugees considered dangerous or threatening are largely excluded by the global health regime, which focuses predominantly on women and children. On the other hand, infectious diseases considered dangerous and threatening to western populations for their

ability to cross borders tend to attract disproportionate attention and financing. In addition to recognizing the securitizing discourses and practices which underpin notions of 'vulnerability', the humanitarian system needs to adopt a more critical approach to the principle of 'value for money'. While improving the effectiveness of humanitarian programmes is both necessary and important, it is equally important to be cognizant of the biases and assumptions on the 'value' or 'worthiness' of individual lives which underpin such evaluations.

To paraphrase Mariam Ticktin, humanitarianisms is both a regime of care and violence, of inclusion and of exclusion (Ticktin, 2014). When faced with difficult decisions over the allocation of scarce resources, humanitarian and development actors necessarily engage with complex ethical and moral dilemmas. For instance, is it more ethical to provide expensive, life-saving treatment for a child or a vulnerable older person? From a more global perspective, is it ethical to spend tens of thousands of dollars on kidney dialysis for Syrian refugees when refugees in sub-Saharan Africa succumb to easily preventable diseases? For the national and supranational actors tasked with selecting recipients and allocating resources for health, I have shown how such decisions are more often than not based on a complex web of power dynamics, contrasting priorities, and strategic interests.

A critique of the exclusionary nature of 'vulnerability' should serve as a starting point for a discussion on whose interests are overlooked – or purposefully excluded. This is not to say that those categorized as 'vulnerable' are not indeed vulnerable or in dire need of assistance or that the category of 'vulnerability' itself can never be useful. However, it is of fundamental importance to question how such a category is constructed and how it is employed in ways which further the interests and power dynamics of the humanitarian system while impinging upon the fundamental rights of refugees. In particular, international NGOs should be cognizant of the ways in which they have adapted their discourses to present certain populations as 'worthy' based on their perceived helplessness, or as an economic resource based on their ability to provide human labour (Heisbourg, 2015). Without critical awareness, 'vulnerability' and other such labels and categories conceal an agenda of restricting access to rights while allowing the international

humanitarian system to elude accountability (Sözer, 2020).

8.6 Recommendations for further research

Further research would be welcome on several fronts. The focus of this thesis on the humanitarian and development response in Jordan is largely centred on the roles played by western actors (with the exception of Japan). This is due in part to the fact that a handful of western donors and Japan contributed close to 70% of funding flows to Jordan in 2017 and 2018. As to humanitarian and development actors, the great majority were headquartered in western countries and the overall response largely excluded national actors or Islamic charities. Overall, non-western actors were either excluded or chose not to participate in the coordination mechanisms supporting the refugee response. For this reason, interviews focus mainly on western donors and organization with the exception of two national NGOs: The Jordan Health Aid Society (JHAS), which is a major partner of UNHCR, and Arabian Medical Relief, and organization established in 2013 to provide medical support to Syrian refugees. Interviews with GCC donors, national organizations, and Islamic charities would add great value to an analysis of South-South cooperation within the response to the Syrian refugee 'crisis'.

Beyond the scope of this thesis, more research is needed to investigate whether the framework derived in this thesis can be applied to other geographic and policy contexts. First, a comparative study of health and migration diplomacy would add great value. Within refugee host countries in the Middle East and beyond, how have state and non-state actors negotiated the stakes and power imbalances of the international refugee regime? And how have refugee host states facing more or less severe crises and within more or less geopolitically strategic regions framed their health policies towards their refugee populations? Of particular interest would be a comparative perspective with other host states such as Turkey and Lebanon and, beyond the Syrian refugee crisis, with Colombia, Pakistan and Uganda, each hosting more than 1 million refugees from neighbouring countries. Have the governments of these states attempted to leverage their refugees as forms of 'migration diplomacy'? How have such politics affected refugee health responses?

Second, future research should investigate whether other policy areas have been similarly commodified within attempts at 'migration diplomacy' within Jordan and other host states. Scholars have suggested that both encampment policies and restrictive labour practices towards refugees have served a political function aimed at increasing the visibility of the crisis and maximising support from the international community (Lenner & Turner, 2018; Mansour-Ille, et al., 2018; Turner, 2016). Yet so far little attention has been paid to the role of migration diplomacy in such policy areas. For instance, how do inter-state negotiations and the instrumentalization of the presence of refugees on a given territory affect a host country's labour policies? Are states that are able to leverage the presence of refugees for political gain more or less likely to integrate refugees within their labour markets?

Finally, as Syrian refugees across the Middle East head towards a decade in exile, a longitudinal perspective would provide a more in-depth understanding of how such policies and negotiations evolve over time – particularly when a refugee setting risks becoming 'business as usual'. For instance, can comparisons and lessons be drawn between the case of Syrian refugees in the Middle East and the arrival of larger numbers of Palestinian refugees since 1948?

As we have seen in this thesis, Jordan has historically hosted large numbers of refugees since its independence to the present day. Though a considerable proportion of refugees have remained in Jordan for decades – and even obtained Jordanian citizenship – refugees and host communities have continued to resist integration. As a Palestinian refugee and former medical professional at UNRWA told me, the risk is that Syrian refugees in Jordan will follow the trajectory of Palestinian refugees – some of whom, 50 years since their first displacement, are still waiting to return home. 'If the Syrians stay here, Za'atari [refugee camp] will become a city,' my interviewee explained. 'It starts with tents and then it becomes an urban area. That is the progression.' In sum, a longitudinal perspective of the presence of Syrian refugees in Jordan over the course of a decade would provide valuable insight as to the longer-term prospects of protracted refugee settings.

In what follows, I turn to a brief reflection on the implications of this research in light of the COVID-19 pandemic. More specifically, I examine how my findings on the politics of

health remain particularly relevant in the face of a global health crisis.

Chapter 9 | CONCLUSION AND REFLECTIONS ON THE COVID-19 PANDEMIC

In many ways, the novel coronavirus pandemic has shined a spotlight on some of the central themes of this thesis, including the fundamental importance of health policy in international relations. Already a number of political scientists and, in particular, realist scholars of International Relations have published opinion pieces on the politics of health and health care in a global crisis. To varying degrees, scholars and policymakers such as David Runciman, Stephen Walt, and Henry Kissinger concur that the world order as we know it may be about to change forever. More optimistic viewpoints underscore the role of global interdependence and the importance of collective, multilateral approaches in seeing the world through this crisis (Borrell, 2020). Others, however, point out that an existential threat such as a pandemic justifies emergency responses and, by extension, strengthens nationalistic and authoritarian inclinations (Walt, 2020).

The ongoing global health crisis underscores three themes which lie at the heart of this thesis. First, as in the case of refugee 'crises', the pandemic has exposed the fault lines of an imperfect and deeply unequal world order. We have seen that, though the pandemic is global in nature, its impact is shaped primarily by the decisions of individual governments which emerge as the main actors in global politics (Runciman, 2020). At the same time, we have seen the ambivalent power of supranational organizations and institutions. On the one hand, organizations such as the WHO wield a considerable amount of power in declaring a health emergency or a 'pandemic' and thus defining the reality on the ground. On the other hand, such organizations are highly dependent on the power politics of their major donors. This became particularly evident in the recent announcement that the US would withdraw its funding to the WHO over alleged disagreements over the nature and management of the crisis. Critics of the move, however, have highlighted that the WHO has not only become a scapegoat for weak US policies, but also a pawn in an escalating rivalry between the US and China.

Interestingly, but perhaps not surprisingly, discourses surrounding the crisis have taken on an increasingly militaristic tone. Nations – and patients – are waging a 'war' against COVID-19 which has become a new 'invisible enemy'. As scholars have pointed out, the securitization of a threat rarely enhances international solidarity and collaboration. Rather, the global response to the pandemic appears to have magnified new and re-emerging divisions, while weakening multilateral forums and institutions. This was exemplified by the uncoordinated EU response which left hard-hit countries such as Italy grappling with an overwhelmed health care system with little international assistance. At the same time, Germany accused the US of attempting to bypass international collaboration in a bid to secure exclusive access to a vaccine for its own citizens (The Guardian, 2020). Across the world, unequal power dynamics, ideological divides, and the intrinsic weakness of international regimes are testing the limits of globalization and of a post-war, neoliberal world order.

Second, as in the case of policies affecting Syrian refugees in Jordan, health strategies in response to the pandemic have become tools for furthering national agendas for domestic and foreign policy. In China, the pandemic has largely been seen as an opportunity for the country to extend its soft power and establish its global leadership credentials through international support to other afflicted countries in the West. In the US, emergency measures were followed by a recent announcement that all immigration to the country would be suspended. Critics have seen this policy as an opportunistic strategy to implement a tougher stance on immigration. From increased digital surveillance as a security measure to threatening to shoot citizens for disobeying lockdown orders, authoritarian regimes have similarly used the pandemic as a pretext for consolidating power and legitimizing the use of violence.

Third, as we have seen within the complex politics of distribution in Jordan, fundamental questions on the value of human life in a crisis have come to the fore. Are the lives of younger people more valuable than others? And is saving the world economy more valuable than saving lives? The principle of 'value for money' is not only the domain of international donors operating in countries in the Global South. Around the world, it is the members of

society considered the least productive who are perceived as the least worthy or 'deserving' of investment and access to scarce resources – those with pre-existing conditions, persons with disabilities, and older adults. In the UK, the initial crisis response suggested that a rapid, population-wide exposure to the virus would eventually provide 'herd immunity' (Stewart & Busby, 2020). 'Be prepared to lose loved ones,' Prime Minister Boris Johnson declared from the side-lines (Stewart, et al., 2020). As soon became clear, the intended 'loved ones' were mainly older persons and those with pre-existing medical conditions. In Italy, where an extreme shortage of medical supplies led to rationing, media reports described cases in which patients above the age of 70 were left to die without care. In the US, Texas Lieutenant Governor Dan Patrick suggested that 'lots of grandparents' would be willing to sacrifice their lives to stave off an economic recession (Beckett, 2020).

Overall, scholars have emphasized that, in the face of a crisis, we find ourselves at the mercy of our governments who have been entrusted with making life and death decisions on our behalf (Runciman, 2020). Whether opting to sacrifice lives or the economy, providing or withholding benefits, and opening or sealing borders, policymakers and virologists are the experts whose authority and 'professional discretion' we defer to. At the same time, the 'life chances' of citizens around the world are determined not only by their governments, but by the health care systems of their respective countries. In the United States, one of the wealthiest countries in the world, migrants, the poor, and the victims of the 'gig economy' suffer the consequences of a privatized health system which favours those who can afford to pay for care. In many countries in the Middle East, already struggling with an overburdened health system and high levels of poverty and unemployment, the pandemic may very well exacerbate existing inequalities in accessing care.

In Jordan, the response to the crisis has been swift and decisive. Amid military curfews and a total lockdown, the country has managed so far to avoid the rapid spread of the virus. Months of economic standstill, however, is a scenario that Jordan can ill afford. In the meantime, in response to the coronavirus pandemic, the EU has increased its support for Syrian refugees in host countries in Lebanon, Jordan, and Iraq. At the end of March 2020, member states had committed to delivering a € 240 million assistance package, of which

more than € 60 million is dedicated to providing education and health services for Syrian refugees in Jordan (European Commission, 2020). To what extent assistance packages will help to support Syrian refugees and to boost a stagnant economy in Jordan, remains to be seen.

In a rapidly evolving international context, future research will be needed to determine the impact of a global health crisis on the national and foreign policies of a refugee host state such as Jordan. Similarly, research will be needed to examine the ways in which powerful state and non-state actors grappling with a disease that transcends national boundaries will inevitably alter the political geography of the world as we know it. What will be the lessons learned from a health crisis which is rapidly subverting the power structures and economic principles of a globalized world? Lastly, and perhaps most importantly, when a crisis hits close to home, we will all have to come to terms with the conscious and unconscious biases which influence our perceptions of 'vulnerability'. As I conclude in this thesis, health care policies in times of crisis provide a harsh spotlight under which our collective understandings of ethics, morality and the value of life will be judged by the global court of public opinion.

Appendix A | Interview list

No.	AFFILIATION	LOCATION	DATE
1	UK Department for International Development (DFID)	London	7-Aug-17
2	UK Department for International Development (DFID)	London	7-Aug-17
3	Consultant (DFID and NGOs)	Phone interview	11-Aug-17
4	Academic, American University of Beirut	Skype call	18-Aug-17
5	UNFPA	Amman	22-Aug-17
6	Catholic Relief Services (CRS)	Skype call	23-Aug-17
7	HelpAge International	Amman	24-Aug-17
8	HelpAge International	Amman	24-Aug-17
9	International Rescue Committee (IRC)	Skype call	24-Aug-17
10	Médecins du Monde (MdM)	Amman	28-Aug-17
11	UK Department for International Development (DFID)	Amman	28-Aug-17
12	UNFPA	Amman	31-Aug-17
13	UNDP	Amman	1-Sep-17
14	Médecins du Monde (MdM)	Amman	7-Sep-17
15	WHO	Amman	12-Sep-17
16	Academic, American University of Beirut	Beirut	21-Sep-17
17	WHO	Skype call	24-Sep-17
18	UNHCR	Amman	25-Sep-17

No.	AFFILIATION	LOCATION	DATE
19	International Rescue Committee (IRC)	Amman	26-Sep-17
20	US Department of State, Bureau of Population, Refugees, and Migration (PRM)	Amman	26-Sep-17
21	HelpAge International	Amman	27-Sep-17
22	UNHCR	Amman	11-Oct-17
23	UNHCR	Amman	11-Oct-17
24	UNHCR Geneva	Skype call	13-Oct-17
25	HelpAge International	Skype call (London)	17-Oct-17
26	HelpAge International	Skype call (London)	18-Oct-17
27	Caritas Jordan	Amman	24-Oct-17
28	UNHCR	Amman	26-Oct-17
29	European Commission, European Civil Protection and Humanitarian Aid Operations (ECHO) Regional Office	Amman	30-Oct-17
30	Red Crescent Society Jordan (RCS)	Amman	31-Oct-17
31	International Federation of Red Cross and Red Crescent Societies (IFRC)	Amman	31-Oct-17
32	United States Agency for International Development (USAID)	Amman	1-Nov-17
33	Handicap International (HI)	Amman	1-Nov-17
34	Ministry of Social Development (MoSD)	Amman	2-Nov-17
35	German Embassy in Amman	Phone interview	8-Nov-17
36	Terre des Hommes Italy (TDH)	Amman	9-Nov-17
37	European Commission (ECHO) Regional Office	Amman	9-Nov-17
38	Medair	Amman	13-Nov-17

No.	AFFILIATION	LOCATION	DATE
39	Japan International Cooperation Agency (JICA)	Amman	14-Nov-17
40	Médecins Sans Frontières (MSF)	Amman	16-Nov-17
41	International Medical Corps (IMC)	Amman	16-Nov-17
42	IOM	Amman	20-Nov-17
43	UNRWA	Amman	20-Nov-17
44	UNRWA	Amman	20-Nov-17
45	Un Ponte Per (UPP)	Amman	21-Nov-17
46	Qatar Red Crescent Society (QRCS)	Amman	21-Nov-17
47	International Orthodox Christian Charities (IOCC)	Amman	28-Nov-17
48	Ministry of Health (MoH)	Amman	28-Nov-17
49	International Relief and Development (IRD)	Amman	29-Nov-17
50	Ministry of Health (MoH)	Amman	5-Dec-17
51	UNRWA	Amman	6-Dec-17
52	The Center for Victims of Torture (CVT)	Amman	7-Dec-17
53	The Center for Victims of Torture (CVT)	Amman	7-Dec-17
54	Jordan Health Aid Society (JHAS)	Amman	12-Dec-17
55	International NGO Forum	Amman	30-Apr-18
56	Inter-Agency Coordination officer	Amman	1-Apr-18
57	National Council for Family Affairs (NCFA)	Amman	3-May-18
58	National NGO - White Beds Society	Amman	5-May-18
59	Arabian Medical Relief	Amman	6-May-18

No.	AFFILIATION	LOCATION	DATE
60	Ministry of Social Development (MoSD)	Amman	7-May-18
61	Higher Population Council (HPC)	Amman	10-May-18

Appendix B | Member organizations of the Health Sector Working Group in Amman[168]

1. Caritas Jordan
2. International Organization for Migration (IOM)
3. UNICEF
4. Qatar Red Crescent Society (QRCS)
5. The Center for Victims of Torture (CVT)
6. Medair
7. Jordan Health Aid Society (JHAS)
8. Médecins du Monde (MdM)
9. International Medical Corps (IMC)
10. International Rescue Committee (IRC)
11. Handicap International (HI)[169]
12. UNHCR
13. UNFPA
14. International Relief and Development (IRD)
15. Première Urgence Internationale (PU-AMI)
16. International Orthodox Christian Charities (IOCC)

[168] Based on the list of members provided by the one of the two chairs of the Health Sector Working Group on October 25, 2017. As discussed in Chapter 3, 19 out of 22 of the listed organizations agreed to participate in an interview.

[169] In January 2018 Handicap International officially changed its name to Humanity & Inclusion (HI)

17 Jordan Paramedic Society (JPS)

18 Terre des Hommes Italy (TDH-Italy)

19 Un Ponte Per (UPP)

20 International Federation of Red Cross and Red Crescent Societies (IFRC)

21 WHO

22 Save the Children (SCJ)

Appendix C | Interview Guide

Personal information

1. Affiliation
2. Length of time working for the organization
3. Key role and responsibilities
4. Background and professional experience

Organizational profile

1. Mission and priorities of the organization
2. Main activities related to health and refugees
3. Any changes in priorities/activities over time

Syrian refugees and health

1. How has the arrival of Syrian refugees affected the delivery of health care?
2. Does the arrival of Syrian refugees represent a (health) crisis? Follow up: Why/why not?
3. In your opinion, what are the strengths and weaknesses of the Syrian refugee health response?

Funding and priorities

1. For donors:
    a. What are your funding priorities and why?
    b. What criteria do you use to evaluate and select project proposals?
    c. How do you monitor results?
    d. Have your priorities changed over time? Follow up: if so, how and why?
2. For government officials:
    a. How well are your priorities reflected in the JRP?
    b. How would you evaluate your collaboration with international actors?
    c. How would you evaluate the overall refugee response?
3. For international NGOs:
    a. What are your main sources of funding?
    b. How do you structure your project/funding proposals?
    c. What do you think makes funding proposals successful?

Partnerships and collaboration

1. Most important partners (if any)
2. What partnerships and forums does your organizations participate in? How often do you attend?
3. How successful has collaboration been among the various actors of the Syrian refugee health response? Follow up: what have been the challenges and opportunities?
4. To what extent do you think your organization's priorities are represented in these forums?
5. Any changes in funding, partnerships, and priorities since the beginning of the crisis

Vulnerability criteria

1. Who are your target beneficiaries and why?
2. How would you define a vulnerable person?
3. What are examples of vulnerable people within the health care system? Follow up: What makes them particularly vulnerable?
4. What criteria does your organization employ to identify vulnerable people?
5. In your experience, would you consider older people/young men a vulnerable group? Follow up: Why or why not?
6. Do any of your progammes specifically target the needs of young men/individuals above age 60? Follow up:
    a. If yes, how many and what do they provide?
    b. Why do they target older people/young men specifically?

Interview conclusion: Is there anything you would like to add?

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