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Syrian Refugee Women's Health in Lebanon, Turkey, and Jordan and Recommendations for Improved Practice

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Abstract

Since 2011, an estimated nine million Syrian refugees have fled to neighboring countries, and over four million have fled to neighboring countries of Lebanon, Turkey, and Jordan. Seventy five percent of Syrian refugees are women and children. In times of conflict, women's health disproportionately suffers. Based on an assessment of academic literature and international policy and development reports, this study explores the vulnerabilities of Syrian women and girls in Lebanon, Turkey, and Jordan, and how these countries approach Syrian refugee women's health care. In all settings, sexual and gender-based violence, reduced use of modern contraceptives, menstrual irregularity, unplanned pregnancies, preterm birth, and infant morbidity are ongoing issues. Recommendations for improved practice include taking a multilevel approach to eliminate social and service delivery barriers that prevent access to care, conducting thorough needs assessments, and creating policy and programmatic solutions that establish long term care for Syrian refugee women.

Keywords

Syrian refugee; women's health; conflicts and health

Introduction

The United Nations has declared the Syrian crisis the worst humanitarian crisis of the 21st century (Kimhi & Shamai, 2006). The conflict in Syria is a public health disaster. Since 2011, an estimated 4,812,204 million Syrian refugees have left for neighboring countries, primarily Lebanon, Turkey, and Jordan (UNHCR, 2016). While the number of Syrians arriving in Europe continues to increase, it remains low compared to Syria's neighboring countries, with slightly more than 10% of Syrians seeking safety in Europe. Seventy five percent of Syrian refugees to neighboring countries are women and children, and many are of reproductive age (Baker, 2014).

While Syrians are leaving a violent and unstable Syria, they are also leaving a country where primary care and reproductive health care was most often free (Bashour et al., 2009). In receiving contexts (countries that refugees move to), due to lack of services, gender

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dynamics, and fear of seeking services, Syrian women's reproductive health disproportionately suffers. Small scale needs assessments show high levels of sexual and gender-based violence including rape, assault, harassment, and intimate partner violence, early marriage, early age at pregnancy, frequent urinary tract infections (UTI), complications during pregnancy, and prostitution among refugees (Al-Tuwaijri, 2013; Charles & Denman, 2013; Doedens et al., 2013; Refaat & Mohanna, 2013; Krause et al., 2015; Benage et al., 2015; Masterson et al., 2014). Gender-based violence and sexual exploitation are of primary concern (Parker, 2015). While food aid, water, and sanitation are vital in disaster responses, comprehensive refugee women's health and reproductive health is both a diplomatic and humanitarian effort, integral to long term rebuilding.

The difficulties that refugee women encounter are not a new phenomenon, yet work in this area is limited (Zaatari, 2014). Since the mid-1990s, there has been heightened awareness of the reproductive health issues that affect women during humanitarian crises (Schreck, 2000). Whether these existing programs alleviate Syrian refugee women's reproductive health needs, morbidity, and mortality in Lebanon, Turkey, and Jordan remains to be seen. This review explores how Lebanon, Turkey, and Jordan responded to Syrian refugee women's health, and provides a set of recommendations for improved health provision for Syrian refugee women.

Background

Vulnerabilities of Women and Girls in Times of Conflict

There are several known health risks that women and girls face in conflict and displacement settings. First, armed conflict disrupts access to essential services and distribution of health care, which includes the provision of women's health care (McGinn, 2000). Prolonged emergencies weaken health systems, with long-lasting effect on women's health care (Sami et al., 2014). Second, aspects of women's health that suffer in conflict and displacement include access to family planning, safe motherhood, sexual and gender-based violence, and disproportionate risk for sexually transmitted infections (STIs), including HIV (Hakamies, Geissler, & Borchert, 2008; Petchesky, 2008; McGinn, 2000). Displaced women are at daily risk of safety and security as well as sexual, physical, and mental abuses as they attempt to survive.

Women remain refugees for longer periods of time and are more vulnerable compared to men because it is more difficult for them to obtain legal status, resettlement opportunities, and protection against violence (Akram, 2013). Importantly, violence against women is not a side effect of political conflict – it appears in societies with deep-rooted gender disparities, and Syrian society is a patriarchal society (Charles & Denman, 2013). The proliferation of violence is due to the challenges to the gendered identity of individuals (Parker, 2015). Women face discrimination and violence simply because of their gender. Vulnerability to disasters is a social dynamic rooted in the interaction between gender and class, culture, nationality, age, and other power relations (Enarson, Fothergill, & Peek, 2007). These conceptual intersections shape refugee women's health status and access to health services.

Minimal Initial Service Package

An understanding of the increased vulnerabilities of women and girls in conflict settings fueled the creation of the Minimum Initial Service Package (MISP) designed by the Inter-Agency Working Group on reproductive health in 1996 (Schreck, 2000). MISP is intended to build the foundation for comprehensive reproductive health care and address how to prevent illness among women, newborns, and girls (United Nations Population Fund, 2015). However, evaluations demonstrate MISP's varied success in addressing women's reproductive health care.

As intended, MISP includes priorities to conduct coordination, prevent and respond to sexual violence, reduce HIV transmission, prevent excess maternal and newborn morbidity and mortality, and plan for comprehensive reproductive health. In 2010, additional priorities were added to MISP including ensuring that contraceptives meet the demand, sexually transmitted infection (STI) treatment is available, antiretroviral are available to prevent mother to child transmission of HIV, and culturally appropriate menstrual protection materials are distributed to women and girls (Onyango, Hixson, & McNally, 2013).

Minimal evaluations of MISP show mixed success. Assessments of MISP have indicated gaps in implementation, poor overall coordination, lack of donor support, poor quality and availability of referral services, and inadequate monitoring of service delivery (Krause et al., 2015). Assessments also show that there is a lack of trained staff to prevent maternal morbidity and mortality, sexual violence, and HIV (Krause et al., 2015; Onyango, Hixson, & McNally, 2013; Doedens et al., 2013). Despite limitations, MISP is implemented in numerous crisis settings, including for Syrian refugees in Lebanon and Jordan.

MISP implementation in Lebanon and Jordan provides a starting point for understanding reproductive health provision. However, each country, Lebanon, Turkey, and Jordan, has policies on distribution of refugee health care and responds to the needs of Syrian women within these constraints. As such, the review is driven by the following questions: What is the magnitude of displacement in the setting? What is the approach to reproductive health services – whether MISP or otherwise? What problems have been encountered in disseminating reproductive health care or for Syrian women receiving care?

Methods

The literature search for this study was conducted in English and included published peer reviewed articles and reports from national and intergovernmental organizations on Syrian refugee women's health in Lebanon, Turkey, and Jordan published from July 2011 to March 2016. Literature databases and electronic collections included Medline, PsycInfo, CINAHL, Academic Search Complete, and Web of Science. The search also included the Syrian Regional Refugee Response: Inter-agency Information Sharing Portal, which includes reports from the United Nations High Commissioner for Refugees (UNHCR) and the United Nations Population Fund (UNFPA) (UNHCR, 2016). The search terms included "Syrian"; "Refugee"; "Women"; "Girls"; "Health"; "Reproductive Health"; "Lebanon"; "Turkey"; and "Jordan".

Articles and reports were considered for inclusion if they explicitly discussed Syrian women's health in Lebanon, Turkey, and Jordan. Topics included reproductive health, violence against women, reproductive health services, child marriage, maternal and child health, and family violence. Forty-five peer-reviewed articles were screened, and 11 peer-reviewed articles on Syrian refugee women's health in Lebanon, Turkey, and Jordan were included. Sixty-seven national and intergovernmental reports were screened, and 18 reports were included (see Table 2). The synthesized results of these articles and reports for each country are discussed below.

Results

Lebanon

Refugee Response—There are 1,067,785 Syrian refugees in Lebanon (UNHCR, 2016). In 2013, it was estimated that at least 2000 to 3000 people were entering Lebanon every day (Coutts, Fouad, & Batniji, 2013). Currently, twenty-five percent of the Lebanese population are Syrian refugees (Herbert, 2013; Refaat & Mohanna, 2013; Naufal, 2012; Charles & Denman, 2013). Of these refugees, 52.3% are women (UNHCR, 2016; Saadallah & Baker, 2016). Syrian refugees live within host communities, in settlements, and are scattered across 1800 locations (Benage et al., 2015; Saadallah & Baker, 2016).

Although there is a solidarity between populations, Syrian refugees put pressure on the Lebanese health-care system and economy (Refaat & Mohanna, 2013). All refugee medical needs are placed on the existing Lebanese health care infrastructure. The health care system is highly privatized and based on user fees. Lebanon has three mobile clinics and 24 medical centers providing health care for refugees (Refaat & Mohanna, 2013). However, the influx of refugees has strained the public hospital system and directly effects the provision of medical resources and operation of medical staff (Hampton, 2013; Sen, Al-Faisal & AlSaleh, 2013).

Women's Health and Access to Care—In Lebanon, Syrian refugees report gynecologic problems such as menstrual irregularity, reproductive tract infection, severe pelvic pain or dysmenorrhea, and some combination of the above conditions (Table 2) (Masterson et al., 2014; Usta & Masterson, 2015). The majority of Syrian women do not visit a gynecologist except when they are pregnant because of stigma, fear, and lack of knowledge on reproductive health. In a rapid needs assessment, only a quarter of women reported visiting a gynecologist in the past six months, and only a third thought reproductive health services were easily accessible (Masterson et al., 2014). While close to 60% of the general population of Syrian women reported using contraceptives prior to the conflict, only 34.5% report using family planning during displacement (Masterson et al., 2014; Benage et al., 2015). This contributes to high fecundity.

Many Syrian women are pregnant and need proper care throughout pregnancy and delivery. Approximately 40% of all referrals to secondary and tertiary care centers are obstetric and gynecological in nature, indicating that pregnant women represent a significant burden of incomplete care (Benage et al., 2015). Close to 100 babies are delivered each month (Coutts, Fouad, & Batniji, 2013). Many Syrian women experience complications during labor and delivery including abortion and hemorrhage (Masterson et al., 2014). Only 16% of Syrian

refugee women report adequate antenatal coverage, putting them at greater risk for preterm birth (Usta & Masterson, 2015; Benage et al., 2015). The highest percentages of women with inadequate antenatal coverage are those who are not registered with UNHCR and who live closest to the Syrian border because these women move around frequently (Benage et al., 2015).

In a small scale survey of refugees, over a quarter of women in Lebanon also report exposure to violence, abuse, and sexual and gender based violence (Usta & Masterson, 2015). While there are anecdotal reports of violence against women, assessments on the prevalence of violence against women are scarce (UNHCR, 2015). Underreporting is common due to shame or fear of stigmatization. Fifty-three percent of women report never once feeling safe in Lebanon, and 41% of young women have thought of ending their lives (Baker, 2014). In Lebanon, all victims of torture or survivors of sexual and gender-based violence will be covered for up to 100% after the incident; however, Syrian refugee women typically do not report incidents.

Primary barriers for accessing reproductive health care include the cost, distance, and fear of mistreatment and discrimination (Table 3) (Usta & Masterson, 2015). UNHCR covers 75% of the cost of obstetric and emergency hospital care for refugees. But increasingly refugees cannot gather their 25% (Gornall, 2015). Without legal status and means of gaining employment, women and girls resort to an underground economy where they are vulnerable to exploitation. Some Syrian women in Lebanon are involved in sex work to obtain financial resources (Charles & Denman, 2013). Women also cannot travel the distances required to access reproductive services (Masterson et al., 2014). Very few specialized staff have training in reproductive health care (Saadallah & Baker, 2016). In a focus group, Syrian women noted that the lack of coverage for basic needs like water and sanitation combined with discrimination in aid distribution were contributing factors to deprioritizing their reproductive health (Usta & Masterson, 2015).

Turkey

Refugee Response—Turkey is home to the largest population of Syrian refugees (close to 3 million) because of ease of transportation to Turkey. However, compared to Lebanon and Jordan, Syrian refugees make up a much smaller proportion of the total Turkish population of 75 million people. Syrians in Turkey are recognized as “guests” and not as “refugees” because Turkey only grants asylum to persons who are refugees as a result of events occurring in Europe (Ozden, 2013; Dinçer et al., 2013). Due to this policy, the refuge model consists of hosting refugee camps. The government of Turkey takes the lead role for implementing assistance for the 2,715,789 Syrian refugees, through the Prime Ministry of Disaster and Emergency Management Authority (AFAD) (UNHCR, 2016). Turkey is hosting refugees in 22 government-run refugee camps across 10 provinces. Of all Syrian refugees in Turkey, 49.2% are female (UNHCR, 2016). Importantly, Turkey signed a Readmission Agreement with the EU that will be instated by 2017, specifying that Turkey will readmit all third country persons or stateless nationals (Ekmekci, 2016). In March of 2016, the EU-Turkey refugee agreement was also signed, declaring to end irregular

migration of refugees to Europe. These agreements will inevitably increase Turkey's population of Syrian refugees, including women and girls.

As of 2013, Turkey had successfully introduced health system changes and brought universal health coverage to its citizens (Atun et al., 2013). On January 18, 2013, the government declared that all Syrians would be entitled to the same health services as Turkish citizens, but this is not uniformly applied (Dinçer et al., 2013; Ekmekci, 2016). Health-care services are provided through primary health-care centers, medical emergency stations, and tent hospitals. Over 90% of refugees in camps report access to services at field hospitals in camps (Oktay, 2013; Sahlool, Sankri-Tarbichi, & Kherallah, 2012). State hospitals are dedicated to providing health care to refugees (Demirtas & Ozden, 2015). However, 1.2 million patient consultations for Syrian refugees were registered in outpatient settings. Health-care workers who provide services to Syrians are also affected as doctors also often face a language barrier and a shortage of resources.

Women's Health and Access to Care—There is very limited data on reproductive health issues among Syrian refugees in Turkey. In contrast to Lebanon and Jordan, very few NGOs are working to deliver refugee health care in Turkey. MISP was not initially implemented in Turkey. During the first two years of Syrian displacement, Turkish authorities were very strict about not allowing any independent observers, journalists, NGOs, national or international humanitarian relief organizations to enter the camps (Ozden, 2013). After three years of refugee flows, on July 24, 2014, the Ministry of Health in Turkey signed a memorandum of understanding with UNFPA to coordinate delivery of women's health services.

Between 2014 and 2015 UNFPA worked to establish reproductive health counseling centers for Syrian refugees, which includes three reproductive health clinics or mobile teams (Saadallah & Baker, 2016). According to the Turkish government, 96% of pregnant women deliver in a health care setting (Oktay, 2013). Without an independent assessment, the accuracy of this figure is unknown. A third of pregnant Syrian women were registered with complications and in need of reproductive health services (Oktay, 2013; Oktay et al., 2014). Additionally, morbidity among Syrian refugee infants appears to be higher compared to Turkish infants (Buyuktiryaki et al., 2015). The underlying reason for this disparity is not reported. Turkish women do not claim to have a preference on the gender of their gynecologist; however, Syrian women in Turkey prefer female physicians (Demirgöz Bal, 2014).

In 2015, UNFPA's priorities centered on addressing sexual and gender based violence in the camps in Turkey. With the escalating conflict spanning the Syrian and Turkish border and tensions rising in communities housing refugees, sexual and gender based violence is an escalating issue (Saadallah & Baker, 2016; Ouyang, 2013). Due to rising economic disparities, some Syrian women in Turkey have also turned to sex work (Demirtas & Ozden, 2015). Beyond economic and physical burdens, there is an emotional burden too. Fifty-five percent of refugees are in need of psychological services, and close to half of the Syrian refugees think they or their family members need psychological support (Oktay, 2013; Oktay et al., 2014).

Primary barriers for accessing reproductive health care in Turkey include the ongoing conflict and instability, delayed deployment of comprehensive reproductive health services, escalating sexual and gender based violence, and lack of programming for urban refugees (Table 3). For women in camp settings, factors that contribute to poor reproductive health are women's lack of access to amenities for basic hygiene including, lack of drinking water, access to feminine hygiene products, washing water, soap, and bathing facilities (Masterson et al., 2014). Contributing factors for urban refugees include economic disparities, lack of services, and lack of access to reproductive health care (Ay, Arcos González, & Castro Delgado, 2016; Ekmekci, 2016). Importantly, because of the delayed involvement of international organizations in Turkey, the magnitude of women reproductive health issues has not been assessed.

Jordan

Refugee Response—In Jordan, there are an estimated 613,252 Syrian refugees (UNHCR, 2016). Syrian refugees are about 10% of the total Jordanian population of 6.5 million. Over 70% of Syrian refugees are residing among host Jordanian communities, and only 30% of refugees are in camps (Murshidi et al., 2013). The Za'atri camp, with an estimated population of 120,000, is considered the fifth largest city in Jordan. The government of Jordan also estimates that the number of refugees is much higher than what is reported. Women, ages 18 to 35 years, represent the majority of new arrivals. An estimated 152,711 women and girls currently registered are of reproductive age (Saadallah & Baker, 2016).

The Jordanian Ministry of Health works with multilateral organizations to meet Syrian refugee health care needs. In Jordan, there are 12 health centers per 100,000 persons, with an average travel time of 30 minutes to the nearest center. The Ministry of Health provides free primary health care, including maternal and child health (Doedens et al., 2013). Similar to Lebanon, in the camps, UNHCR helps provide health and humanitarian support. The hundreds of thousands of urban refugees in cities face the same costs as Jordanians. Similar to Lebanon and Turkey, the added burden from the Syrian refugees strains the public hospital system (Murshidi et al., 2013). Only a quarter of the total and 17% of the healthcare funding for refugees has been received for 2016 (Gornall, 2015).

Women's Health and Access to Care—The Jordanian Ministry of Health appointed a reproductive health lead early in the emergency, indicating a strong commitment to women's health (Krause et al., 2015). As such, Jordan has the most humanitarian aid dedicated to reproductive health, and there are 17 reproductive health clinics or mobile teams (Saadallah & Baker, 2016). Rapid assessments in camps indicate that 23% of women were unaware about reproductive health services, 28% had experienced unplanned pregnancies, and 17% did not access antenatal care for pregnancy (Kohler, 2014). There is also a lack of access to contraceptives (West et al., 2016). Jordan recently started an initiative – the Jordanian Communication, Advocacy, and Policy (JCAP) project to increase demand for and use of modern family planning methods for Jordanians and Syrian refugees. The baseline results show that Syrians have more concerns about method effectiveness and side effects compared to Jordanians (USAID, 2015). An evaluation of MISP implementation in camps also

indicates that there is inadequate availability of services and supplies related to STIs, HIV, and menstrual hygiene (Krause et al., 2015). Refugees who are HIV positive can be deported. This reduces HIV testing and availability of treatment among refugee populations in Jordan (Doedens et al., 2013). Women report a lack of menstrual hygiene. They also have fears about sexual abuse and exploitation as they seek ways to obtain materials (Krause et al., 2015).

Similar to Lebanon, while Jordanian law requires antenatal coverage, most refugee women do not have complete coverage (Kohler, 2014). In the Za'atari camp, UNFPA supports a reproductive health clinic run by the Jordan Health Aid Society with a female gynecologist. Syrian women feel comfortable seeking services provided by a female gynecologist. The clinic sees 200 women a week, and services need to be expanded to reach more women (Malkwai, 2014; Gavlak, 2013). Services are available for delivery – skilled birth attendants, emergency obstetric care, and newborn resuscitation (Kohler, 2014). However, refugee women are displeased with the quality of care because of the demands on service providers, limited number of primary health clinics, and lack of female doctors in the public sector (Doocy et al., 2016).

In Jordan, early age at marriage and child marriage is a significant issue with health implications for young refugee girls. In 2013, 25% of girls were married under the age of 18. One in every four marriages is of a refugee girl under the age of 18 (Save the Children, 2014). Islam forbids sexual relations outside of marriage, yet in the camp setting, rape, prostitution, and underage forced marriages are rampant. As economic resources are depleted, survival sex becomes the only way for girls to support themselves and their families (Akram, 2013). Preservation of family honor serves as a justification for marrying off young girls to their perpetrators. In other cases, families marry off their daughters to provide protection, alleviate poverty, or help girls escape the environment (Baker, 2014; Save the Children, 2014). Some clerics have issued fatwas against these child marriages. Despite this effort, in 2014, the proportion of deliveries in girls under the age of 18 was 11%. These girls are four times less likely to use family planning and are at greater risk for inadequate antenatal care and for neonatal complications like low birth weight and preterm labor (Jolly et al., 2000; Clark et al., 2016).

Sexual and gender based violence is also of primary concern in Jordan. The lack of security and lighting in refugee camps lends itself to increased violence (Woldetsadik, 2014). Some women fear that if they report abuse or violence, their husbands will send them back to Syria. No sites are equipped to provide clinical care for rape survivors, and efforts to prevent sexual violence are insufficient (Krause et al., 2015). No policy in Jordan handles gender-based violence or care for survivors of sexual violence. A few programs are established to help survivors of domestic violence (Doedens et al., 2013). The Ministry of Health and UNFPA have worked to improve the clinical care for sexual assault survivors through development of guidelines, trainings, and distribution of post-rape kits; however, messaging on gender-based violence is limited and provider knowledge continues to be limited (Kohler, 2014).

Primary barriers for Syrian refugee reproductive health care in Jordan include cost, fear of reporting abuse or violence, child marriage, inadequate STI and HIV coverage, lack of attention to menstrual hygiene, and lack of programming to address the needs of urban refugees. Cost is a barrier for Syrian refugees seeking care outside of camps (Doocy et al., 2015; Doocy et al., 2016). An evaluation of MISP in Jordan finds the primary limitation is the lack of attention to urban refugees (Krause et al., 2015). Similar to Lebanon and Turkey, there is no available representative data on women's health over time and very little on urban refugees.

Discussion

Lebanon, Turkey, and Jordan have all approached the refugee challenge in different ways resulting in a variety of challenges, yet in all three contexts, women and girls are particularly vulnerable. In all settings, sexual and gender-based violence, reduced use of modern contraceptives, menstrual irregularity, unplanned pregnancies, preterm birth, and infant morbidity are ongoing issues and should be prioritized (Table 3).

Limited data from Lebanon, Turkey, and Jordan shows a lack of general reproductive health care services, antenatal coverage, obstetric and gynecological care, psychological and mental health services, urban refugee health care, access to modern contraceptives, STI and HIV prevention efforts, and care for survivors of sexual violence. This demonstrates that future work should address MISP objectives 2 through 5, namely, to prevent and manage the consequences of sexual violence, to reduce the transmission of HIV, to prevent maternal and infant mortality, and to integrate reproductive health care into primary health care. International organizations should take a multilevel approach to eliminate barriers to service delivery and social barriers that prevent access to care, conduct thorough needs assessments, and create policy and programmatic solutions that establish long term care for Syrian refugee women.

Recommendations for Improved Practice

Eliminating Barriers to Access Reproductive Health Care—Addressing barriers that prevent Syrian women from accessing health services can extend the reach of current efforts. There are some consistent social and services provision barriers for Syrian women's reproductive health in Lebanon, Turkey, and Jordan. Social barriers include stigma, fear of mistreatment or discrimination, lack of awareness, fear of reporting violence, and difficulties obtaining legal status (Table 3). Service provision issues that appear in all contexts include cost, overloaded public or private hospital systems, strained medical workforces, a lack of medical professionals and female physicians, and no care coordination. Addressing some or all of these barriers will enable women to access health care.

Social Barriers—To overcome some social barriers, at the individual level, Syrian refugee young women should be equipped with knowledge, skills, and approaches to deal with their current situation including areas related to gender-based violence. Many women do not feel comfortable coming forward with their reproductive health issues. There is an irrefutable cultural patriarchy among Syrian refugees, which creates difficulties for all women and a lack of agency (Charles and Denman, 2013). The first step of providing refugee women and

girls with more agency is to make known a number of underreported difficulties that they face every day (Baker, Miquel, & Hikmat, 2015; Lehmann, Bain, & Pandit, 2014). To improve reproductive agency, laws that prohibit child marriage should be strengthened, and the health sector should be actively involved in screening for violence (Clark et al., 2016; UNHCR, 2015).

Importantly, individual efforts cannot just target women. Programmatic solutions must include men and households (Lehmann, Bain, & Pandit, 2014). For example, the lack of use of contraceptive methods is possibly linked to lack of awareness. However, there may also be a gap between knowledge of reproductive services and desire to use them. Among Syrian refugees, contraceptive decisions are made by a couple and not by an individual woman. As such, reproductive health education must target both women and men. Syrian refugee men need to be involved in reproductive health decision-making so that they do not serve as a barrier to access.

Health System—In health care delivery, resource limitations, personnel shortages, and care coordination are the biggest gaps. Limited stock of reproductive health supplies have also been reported (Saadallah & Baker, 2016). Organizations have had difficulty finding reproductive health trained staff to deliver services (Saadallah & Baker, 2016; Crisp et al., 2013). Female service providers are of particular importance in Lebanon, Turkey, and Jordan. Efforts to ensure increased availability of female physicians will provide women's health services in a culturally appropriate manner.

Poor coordination remains a large gap in health care delivery. Communication lapses in the health cluster lead to both gaps and overlaps in services (Onyango, Hixson, & McNally, 2013). When reproductive health coordinators are appointed, as seen in Jordan, this alleviates some coordination issues as individuals move more easily through the health care system (e.g. moving from a primary care physician to a reproductive health specialist). The relationship between violence, mental, and reproductive health in all three countries also points to the need to integrate mental and reproductive health services (Baker 2014; Saadallah & Baker, 2016). Mental health care is an aspect of primary health care, and integration of reproductive health and primary care is a MISP objective. Many Syrian refugees are in need of psychosocial assessments (El Chammay & Ammar, 2014). If adequate psychosocial services are not in place, women face long-term mental health consequences and will not seek care for other health issues.

For service delivery, refugee entitlements to health care need to be clearly communicated to both refugees and service providers. Clear standard operating procedures for medical services should be distributed to refugees, and to avoid confusion among refugees and health providers, these operating procedures must not change frequently (Maglietti, 2015). In some cases, Syrian refugees are familiar with services (e.g. Jordan), yet they are not using them or are afraid to use them. Syrian women refugees also need greater awareness of the importance of reproductive and antenatal care. Qualitative work shows that digital technologies like cell phones can be used to create awareness of reproductive health services and antenatal care (Talhouk et al., 2016).

Data to Drive Solutions—It is difficult and problematic to fully assess the health of Syrian women in Lebanon, Turkey, and Jordan without adequate data and statistics. It is imperative that the international community adopt a more scientific approach to monitoring and evaluating the MISP (Onyango, Hixson, & McNally, 2013). These measurements, done over time, can become a core part of assessing need, operationalizing accountability, and informing solutions (Batniji et al., 2014). Whether programs are implemented to address individual knowledge or system-wide service delivery barriers, all interventions need to be tailored for the specific country context and undergo process and impact evaluation. A monitoring and evaluation system will better assess the impact of programs and contribute to data shortages in the region (Hakamies, Geissler, & Borchert, 2008).

Needs assessments can clarify what additional risks Syrian refugee populations' face. An understanding of how refugee women's reproductive health problems are both similar to, and different from, women in settled populations can help policymakers address refugees' health needs (McGinn, 2000). While small scale needs assessments have been conducted (Krause et al., 2015; Usta & Masterson, 2015), there is room for greater understanding of the risks that Syrian refugees face, particularly, gender-specific and reproductive health risks. Evidence on effective gender-based violence prevention strategies in refugee settings is limited (Tappis et al., 2016). For sexual and gender based violence assessments, interviewers must have existing relationships with refugees to maximize quality of information shared (Syria Needs Analysis Project, 2013).

International health and development organizations, including WHO and the World Bank, have been constrained by their reliance on governments to collect information about health and development in the region. Population health statistics from the Arab world tell us little about the least advantaged residents, including displaced populations and women and children. Few countries in the region report any information about their non-citizen populations, including refugees. In order to have better health measures, it is necessary for international stakeholders to liaise with civil society, activists, and, in some cases, political parties and revolutionary governments to measure the health of all people living in the Arab world, not just citizens.

Funding and Multilateral Coordination—Programmatic and evaluation efforts require funding. One strategic priority must be to substantially increase the level of support available to host states, thereby mitigating the socioeconomic and political pressures generated by the refugee influx. While donor preferences are to channel aid through non-governmental mechanisms, aid to local governments can protect national sovereignty, supplement programmatic efforts, help service delivery, and link governments with key international actors (Dupuy, Ron, & Prakash, 2016). Foreign aid is far lower than what is needed to respond effectively (UNHCR, 2016). This hampers any effective humanitarian and health response. Lebanon, Turkey, and Jordan all have a funding deficit, and since food, shelter, and emergency care are the priorities, women's health care suffers.

Agencies ought to carry out awareness-raising activities internally and among partner organizations, strengthen internal organization and interagency collaboration, and share expertise in order to save resources at the local level. The academic community must further

collaborate with humanitarian organizations. Incorporating thoughtfully designed interventions based on evidence into routine humanitarian protocols may help conserve resources (Jefee-Bahloul & Khoshnood, 2014). Furthermore, multilateral organizations ought to continue to collaborate with local partners and governments. For example, UNFPA's work with the Jordan Health Aid Society can increase capacity and resources to meet demands. The health sector must also work in conjunction with child protective services to strengthen interventions to reduce early marriage. Health care provision is not specific to one agency and requires coordination across sectors. Proper synergistic integration of reproductive health and sexual and gender-based violence programs with all the sectors of response and recovery will reduce duplicity and save money.

Conclusion

Traditionally, health responses always focus on emergency and humanitarian needs (El-Khatib et al., 2013). However, Lebanon, Turkey, and Jordan demonstrate a need for attention on Syrian refugee women's health refugee. Women's reproductive health should be seen as fundamental to the long term response to the crisis in Syria. Continued efforts towards the MISP objectives, reducing barriers to accessing care, better data collection and evaluation, and improvements in funding and coordination across sectors can improve women's health. If women's reproductive health needs are not met, women are limited in their ability to contribute to social, economic, and political life. Syrian women's reproductive health needs should be met so they can emerge from this crisis as essential stakeholders in post conflict reconstruction and the recovery process.

Limitations

This review has several important limitations. Since the review was limited to studies of women's health, it may have excluded broader health studies of potential value in informing the design of future research and intervention work with Syrian refugee women. This review is not a systematic meta-analysis and does not involve data or rigorous evaluation of the methodologies used in various studies. This review also does not consider the health of Syrian women in Syria prior to forced migration, which may be important for the health of Syrian women in destination countries. Importantly, the review is limited to the contexts of Lebanon, Turkey, and Jordan. As Syrian refugee migration expands to new countries, future research and intervention development must simultaneously be aware of the trends in Syrian women's health issues across settings and be context-specific.

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Table 1

Minimum Initial Service Package (MISP) Objectives and Activities

1	**Identify an agency to lead the implementation of MISP**
	Appoint a reproductive health officer
	Coordination of reproductive health services
	Reproductive health officer reports back to health cluster
	Reproductive health kits and supplies are made available
2	**Prevent and manage the consequences of sexual violence**
	Protection system in place for women and girls
	Medical services and psychological support for survivors
	Community awareness of services
3	**Reduce transmission of HIV**
	Safe blood transfusion available
	Standard precautions practiced
	Free condoms available
4	**Prevent maternal and infant mortality**
	Emergency obstetric and newborn care services available
	24/7 referral system established
	Clean delivery kits provided to skilled birth attendants and visibly pregnant women
	Community awareness of services
5	**Plan for comprehensive reproductive health services integrated into primary health care**
	Background data collected
	Sites identified for future delivery of comprehensive reproductive health.
	Staff capacity assessed and trainings planned
	Reproductive health equipment and supplies ordered.

Table 2

Key Peer-reviewed Articles and Reports from Literature Review

Author(s)	Title	Year	Journal or Agency	Type of Publication
Al-Tuwaijri, S.	Gender-based violence and child protection among Syrian refugees in Jordan with a focus on early marriage	2013	UN Women	Report
Amnesty International	Agonizing Choices: Syrian Refugees in Need of Health Care in Lebanon	2014	Amnesty International	Report
Baker, D.	Regional Situation Report for Syria Crisis	2014	UNFPA	Report
Baker et al.	Breaking the Silence: Hope for a New Life	2015	UNFPA	Report
Benage et al.	An assessment of antenatal care among Syrian refugees in Lebanon	2015	Conflict and Health	Peer-reviewed Article
Buyuktiryaki et al.	Neonatal outcomes of Syrian refugees delivered in a tertiary hospital in Ankara, Turkey	2015	Conflict and Health	Peer-reviewed Article
Charles and Denman	Syrian and Palestinian Syrian refugees in Lebanon: the plight of women and children	2013	Journal of International Women's Studies	Peer-reviewed Article
Clark et al.	The influence of family violence and child marriage on unmet need for family planning in Jordan	2016	Journal of Family Planning and Reproductive Health Care	Peer-reviewed Article
Crisp et al.	From slow boil to breaking point: A real-time evaluation of UNHCR's response to the Syrian refugee emergency	2013	UNHCR	Report
Doedens et al.	Reproductive Health Services for Syrian Refugees in Zaatri Refugee Camp and Irbid City, Jordan	2013	US Department of State Bureau of Population, Refugees and Migration	Report
Gavlak, D.	Syrians flee violence and disrupted health services to Jordan	2013	Bulletin of the World Health Organization	Report
Krause et al.	Reproductive health services for Syrian refugees in Zaatri Camp and Irbid City, Hashemite Kingdom of Jordan: an evaluation of the Minimum Initial Services Package	2015	Conflict and Health	Peer-reviewed Article
Lehmann et al.	Are we listening? Acting on our commitments to women and girls affected by the Syrian conflict	2014	International Rescue Committee	Report
Maglietti, M.	Women & Girls Safe Spaces: A guidance note based on lessons learned from the Syrian crisis	2015	UNFPA	Report
Malkwai, K.	Delivering Sensitive Reproductive Health Care to Syrian Refugees in Jordan	2014	UNFPA	Report
Masterson et al.	Assessment of reproductive health and violence against women among displaced Syrians in Lebanon	2014	BMC Women's Health	Peer-reviewed Article
Oktay, F.	Syrian Refugees in Turkey: Field Survey Results	2013	Turkey Prime Ministry of Disaster and Emergency Management Authority	Report
Oktay et al.	Syrian Women in Turkey	2014	Turkey Prime Ministry of Disaster and Emergency Management Authority	Report
Ouyang, H.	Syrian refugees and sexual violence.	2013	The Lancet	Peer-reviewed Article
Parker, S.	Hidden crisis: violence against Syrian female refugees	2015	The Lancet	Peer-reviewed Article
Saadallah and Baker	Women and Girls in the Syria crisis: UNFPA response	2016	UNFPA	Report
Sami et al.	Responding to the Syrian crisis: the needs of women and girls	2014	The Lancet	Peer-reviewed Article

Author(s)	Title	Year	Journal or Agency	Type of Publication
Save the Children	Too young to wed: the growing problem of child marriage among Syrian girls in Jordan	2014	Save the Children	Report
Syria Needs Analysis Project	Needs assessment lessons learned: Lessons identified from assessing the humanitarian situation in Syria and countries hosting refugees	2013	Syria Needs Analysis Project	Report
UNHCR	Sexual and Gender-based Violence Prevention and Response in Refugee Situations in the Middle East and North Africa	2015	UNHCR	Report
Usta and Masterson	Women and health in refugee settings: The case of displaced Syrian women in Lebanon	2015	Gender-Based Violence	Book Chapter
West et al.	Factors in use of family planning services by Syrian women in a refugee camp in Jordan	2016	Journal of Family Planning and Reproductive Health Care	Peer-reviewed Article
Woldetsadik, M.	The Health Needs of Syrian Women in and Around the Za'atari Refugee Camp	2014	RAND	Report
Zaatari, Z.	Unpacking Gender: The Humanitarian Response to the Syrian Refugee Crisis in Jordan	2014	Women's Refugee Commission	Report

Table 3

Syrian refugee women's health issues by country context

All Countries	Lebanon	Turkey	Jordan
Sexual and gender-based violence	Pelvic Pain	Complications during pregnancy	Menstrual hygiene
Reduced use of modern contraceptives	Labor and delivery complications		Low birth weight babies
Menstrual irregularity and dysmenorrhea			
Unplanned pregnancies			
Preterm birth			
Infant morbidity			

Table 4

Services Needed and Barriers for Syrian Refugee Women's Access to Reproductive Health Care

Country	Services Needed	Service Delivery Issues	Social Barriers
All Three Countries	General reproductive health services	Cost	Stigma
	Antenatal coverage	Overloaded public or private hospital system	Fear of mistreatment and discrimination
	Obstetric and gynecological care	Strained medical workforce	Lack of awareness of existing services
	Psychological and mental health Services	Lack of female physicians	Fear of reporting violence
	Urban refugee health care	Limited Obstetric and Gynecological medical professionals	Obtaining legal status
	Access to modern contraceptives	No care coordination	Limited personal agency
	STI and HIV services		Limited social cohesion and capital
	Care for survivors of sexual violence		Sex Work
Lebanon	Basic needs - water and sanitation	Distance Medical staff lacks reproductive health training	
Turkey		Language barriers Shortage of reproductive health care resources Delayed deployment of MISP	Ongoing violence in border region Hostility towards communities with refugee
Jordan		High turnover of service providers	Child Marriage Sexual Exploitation

Note: Issues that occur in all three country settings are listed in all countries; issues that are limited to one or two countries are listed in each country section