Determinants of mental healthcare seeking behavior among Syrian refugee women in Türkiye, Lebanon, and Jordan

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A thesis submitted in partial fulfilment of the requirement for the degree of Master of Science in International Health

By Bethlehem Shiferaw Loulseged

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Master of Science in International Health (MIH)

11 September 2023 – 30 August 2024

KIT (Royal Tropical Institute)/Vrije Universiteit Amsterdam
Amsterdam, The Netherlands

August 2024

Organised by:

KIT (Royal Tropical Institute)
Amsterdam, The Netherlands

In cooperation with:

Vrije Universiteit Amsterdam (VU)
Amsterdam, The Netherlands

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Abstract

Introduction

Following the conflict, displaced Syrian refugees, including many women and girls, sought refuge in Turkey, Jordan, and Lebanon, where they received temporary protection and healthcare services. Syrian refugee women experience high rates of mental disorders due to acute trauma and ongoing stressors such as changing gender roles, financial insecurity, and security risks. Despite high prevalence of mental disorder, their use of mental healthcare services remains low. This study aims to explore Syrian refugee women's perceptions of mental disorders and analyze factors affecting their health-seeking behavior to enhance mental health interventions in host countries.

Methodology

Literature review was done using 32 peer reviewed articles and 57 grey literature and reports. The Andersen behavioural model was used to organize and discuss findings based on four categories: population characteristics, health behaviour, environment and outcomes.

Results

Trusted social networks were found to be primary sources of psychological support for Syrian refugee women. Lack of awareness about mental disorders and mental health services and high prevalence of stigma in the community affect health seeking behaviours of Syrian refugee women. Inadequate availability of affordable, culturally appropriate, accommodating and equitable service provision were barriers to seeking care. New initiatives like the digital mental health interventions has been shown to improve symptoms and increase satisfaction. However, gaps in coordination of services and policy shifts away from psychosocial and community-based services remain.

Discussion

Gender responsive policies and culturally tailored interventions with optimized coordination of activities are needed to effectively address mental health needs of Syrian refugee women.

Key words- Health seeking behaviour, Syrian refugee women, mental health services, utilization

Word count:12,489

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Abbreviations

CA-CBT- Culturally-adapted cognitive behavioural therapy

CMC - Community mental health centres

CMHC - Community mental health centres

DALY - Disability-Adjusted Life Years

GDP - Gross domestic product

IMC - International Medical Corps

MHPSS - Mental health and psychosocial support

mhGAP – Mental health gap

MoH - Ministry of health

MoPH - Ministry of public health

NGO - Non-governmental organizations

PHC – Primary healthcare

PTSD - Post-traumatic stress disorder

TPR - Temporary protection of refugees

UNHCR - United Nations High Commissioner for Refugees

USD - United States dollar

WHO - World Health Organization

Glossary

Health seeking behaviours – It is defined as activities individuals undertake based on their perceptions of ill-health in order to find optimal resolution (1).

Refugee – An individual who has fled their country due to persecution, war, or violence, with a well-founded fear of persecution based on race, religion, nationality, political opinion, or social group (2).

Mental disorder: A disorder characterized by a notable disturbance in a person's thinking, emotional control, or behaviour (3).

WHO's Step-by-Step mental health intervention- It is a digital mental health intervention developed by WHO and National Mental Health Programme at the Ministry of Public Health Lebanon and implemented by trained non-specialists over a period of 5- 8 weeks and adapted to local socio-cultural contexts (4).

Cognitive behavioural therapy - It is a type of psychological therapy proven effective for various mental disorders and enhances functioning and quality of life. Its core principles are based on enhancing problem solving and coping skills, understanding the basis of problems individuals face(5).

Acknowledgements

To rephrase a famous quote by John Donne, no person is an island. From a young age, I have been lucky enough to have incredibly supportive family members around me to encourage and motivate me as I navigated through life. I could not have reached the goals I set for myself without the unwavering support of my extraordinary parents, brother and family members. You have made this year an easier journey and staved off my homesickness. I am grateful for you all.

The past one year has been a remarkable learning experience, made possible by knowledgeable advisors and KIT academic staff. I have had a chance to meet incredible professionals, among academic staff and students, that have enabled me to bring out the best version of myself.

Background

Syria is part of an ancient land with complex geo-political influences (6). The diverse ethnicities include Arab, Kurd, Assyrian, Turkmen among many others while religious groups include a Muslim majority, Shia, Alawite and Sunni Muslims, Christians, Druze and other minority groups (7,8). Prior to the Sykes-Picot treaty, the ottoman empire did not have distinct borders between current middle eastern countries, which allowed intermingling through trade, marriage and migration (9). Under this laissez faire rule, Islamic traditions was dominant, diversity was encouraged, and ethnic minorities were protected (10). After the treaty, Syria became a de-facto French colony under a divide-and-conquer rule which favoured ethnic minorities (6,10). This fostered nationalistic sentiments and distrust of minority groups (6,10).

Since its origin, the Baath party had its foundation in secularism, women's empowerment and unification of Syria under an Arab nation (10). Hafez al Assad, from the Alawite minority group, become the leader of the party in 1971 (6,10). However, his term was complicated by tensions between the Baath Party and the fundamentalist Muslim Brotherhood (10). This led to war and destruction in Hama and birthed Hafez al Assad's authoritarian regime (10). Bashar al Assad succeeded his father after his death in 2000; initially Bashar appeased opposition parties and tried to legitimize his regime through elections but later established the dictatorial regime(10,11).

Arab Springs reached Syria in 2011, with Daraa as its epicentre, following the detention and torture of teenagers for graffiti condemning the Assad regime (12). Tensions between the government and Syrian people escalated into pro-democracy protests; Assad's regime responded with violent military tactics, leading to more protests and riots (10,11). This gave rise to multiple mutually hostile insurgents and foreign based fundamentalists joining the conflict (10,11). These developments not only deviated from the goal of establishing a functioning government but also made achieving peace difficult (10).

Furthermore, deliberate targeting of civilians and public infrastructures including schools and health facilities increased in Syria (13,14). Basic service provision notably declined, including access to food and shelter (15). Recently, natural disasters and the pandemic have caused further deterioration of the social support systems and population's wellbeing (15,16). It is estimated that over 70% of households need humanitarian assistance and less than 60% of health facilities are functioning at full capacity while the population's health needs have increased (14,17). Before the conflict, existing mental health services relied on biomedical approaches and lack legal frameworks (18). According to Syrian mental health professionals, lack of political will had undermined mental healthcare developments (18).

Syrian refugees and host countries

According to the United Nations High Commissioner for Refugees (UNHCR), there are 110 million displaced people globally due to conflict, human rights violations, or persecution, of which 36.4 million are refugees (19). Since 2012, there has been increased external and internal displacement of Syrian population (17,20). It is estimated 1 in 5 refugees globally are Syrian, accounting for 7 million people, about half of whom are women and girls (14,21). Data from 2022 reveals 3.65 million, 844,000 and 670,000 registered Syrian refugees reside in Türkiye, Lebanon and Jordan, respectively

(22,23). While Türkiye hosts the most Syrian refugees, Lebanon and Jordan host the highest number of Syrian refugees per capita (23). All three countries started receiving Syrian refugees soon after the insurgency began; Jordan and Türkiye opened camps while Lebanon adhered to a no camp policy (24). Recent data shows 80% and 98% of Syrian refugees in Jordan and Turkey respectively live outside of refugee camps (23,25). Although the three countries have signed the 1951 refugee convention, only Türkiye has ratified it and uses national framework for protection of refugees (16,24). However, non-European refugees in Türkiye are given temporary protection due to its reservations on geographic limitations (26,27).

Under temporary protection of refugees (TPR), Syrian refugees in Türkiye have access to free public services including mental health and psychosocial support (MHPSS) which fall under the ministry of health (MoH) with health budget allocated by the social security institution (28,29). However, access is largely tied to their province of registration (30). In Lebanon, non-governmental organizations (NGO) take up the lion's share of the responsibility for healthcare and provide MHPSS services with public healthcare facilities under the ministry of public health (MoPH) (31,32). Jordan provides public healthcare including MHPSS services to Syrian refugees following registrations with UNHCR and Ministry of the interior (31,33). In Jordan and Lebanon, UNHCR registered Syrian refugees receive subsidized or free healthcare in public and NGO clinics (34). However, Lebanon has restricted UNHCR registration since 2015 which has affected protection of Syrian refugees (35,36). For MHPSS service provision, organizations follow the 2007 inter-agency standing committee guidelines with core principles of: ensuring human rights, participation of affected community, do no harm, building on available resources, integrated and multi-layered support systems to ensure equitable care (37). The four levels of care start with meeting basic needs at level one and end with specialized care at level four (Annex 1).

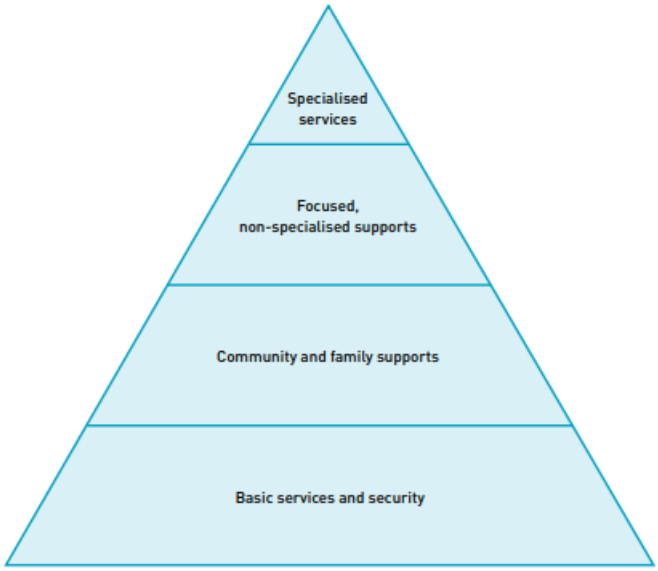

Figure 1: Intervention pyramid for MHPSS in emergencies (37).

Declining economies of host countries, marked by high debt and decreasing gross domestic product (GDP), have increased pressure on Syrian refugees and host populations (16,24). Large proportions of Syrian refugees live in poverty and a majority have accumulated debt to meet essential needs, most notably in Jordan and Lebanon (38,39). Financial insecurity has also restricted access to basic services like healthcare, which disproportionately affected Syrian women and children (16). Similarly, increasing numbers of host populations are affected by countries' economic volatility and high unemployment rates (40,41). Host communities' financial constraints with refuted yet persistent rhetoric of scapegoating refugees for countries' economic downturn have increased hostilities towards Syrian refugees (16,24,42). This has led to rising involuntary returns of Syrian refugees despite their temporary protection status (20,43). Even though host countries are bound by non-refoulement principles, raids, detentions and involuntary deportation continue (16,24,44). Lack of concrete peace plans, limited reconstruction efforts, pervasive insecurity, risk of compulsory military service, and post-return detention in Syria hinders Syrian refugees' return (16,45,46).

Problem statement

Mental health and Syrian refugee women

The World Health Organization (WHO) estimates over half a million Syrians live with severe mental disorders, and about 4 million live with mild to moderate mental disorders (47). Magnitude of mental disorders is more pronounced among Syrian refugees living in low and middle-income countries (13,48,49). In neighbouring host countries, prevalence of mental disorder are high compared to host population (50,51). Several studies done in Lebanon, Jordan and Türkiye highlight increased risk of mental disorder among Syrian refugee women compared to Syrian men (13,50,52–54). Risk of mental disorder was also higher with older age (52,54–56), increased number of children (56–59), but decreased with being married (50,52,54,56,59), higher education (53,55,59,60) and economic status (53,58) for Syrian women. Based on a study in Lebanon, transgender women also faced higher rates of anxiety, depression and post-traumatic stress disorder (PTSD)(61).

In a 2021 study, rates of PTSD, depression and anxiety among Syrian women in Türkiye were 21%, 39% and 40% respectively (51). In 2022, the prevalence of depression, anxiety and PTSD among Syrian women in Jordan were 63%, 57% and 66% respectively (56). In Jordan, Syrian women also report increased somatization, aggression towards children and obsessive compulsive behaviours (53,62). Studies show increased levels of mental distress among Syrian women living in camps near the Syrian-Türkiye border and in urban residences in Jordan (63,64). From studies in North Lebanon, PTSD prevalence was 47% (54) while in greater Beirut, nearly a third of Syrian women were living with PTSD and depression (65). Similar increase in PTSD symptoms was found among Syrian women in Beqa'a's informal camps (13).

Predisposing factors

Gender and conflict

Environmental stressors predispose displaced Syrian women to mental health disorders (66). Although they follow different pathways, both acute, traumatic experiences and longstanding hardships in host countries cause psychological harm (66,67). Forced displacement disrupts girls' and women's education; this impacts their social, physical, and psychological well-being and hinders adaptation to new environments (60). In addition, Syrian women in several studies have reported exposure to at least one life-threatening event including exposure to shelling, detention, violence, and torture which increases the risk of mental disorders (13,51,60,68–70).

Gender and post-displacement

Post-displacement circumstances can be enduring sources of pressure that erode resilience and negatively affect mental health(66). Major contributors are compromised safety and security, difficulties securing legal status, limited access to health care, and tension with host populations in host countries, which are issues the refugee population has limited control over (51,66,71).

Socio-cultural factors

While societal norms encourage seeking support from reliable social networks, Syrian community structures are gendered with distinct public and private spheres for women (60,72,73). After the insurrection, Syrians were forced to leave safe spaces and established support systems to live in refugees camps and settlements with safety hazards and security liabilities (13,60). Studies show Syrian women in Türkiye and Jordan live in overcrowded residences, which deny privacy and elevate their risks of harassment, physical and sexual violence (14,26,69,74). Many Syrian women living outside of camps in Türkiye and informal settlements in Lebanon face exploitation and violence from landlords, including coercion into transactional sex (26,75). Language barriers, particularly in Türkiye, is found to play a role in causing isolation, difficulties integrating, and increasing risk for mental disorders for Syrian women (26,76,77).

Economic pressure and gender role reversals

Due to forced displacement Syrian women's role changed drastically (78). Over a third of Syrian refugee households in Jordan and a fifth in Lebanon and Türkiye are headed by women (79–81). In both male headed and female headed households, there has been a shift in functions and decision making authority (82). Although this shift has empowered some, adapting to new roles has generally added stress and anxiety particularly in households where decisions are solely made by Syrian women (75,82). In Jordan, a report found some Syrian women felt shame for pursuing employment as they consider it culturally inappropriate (82). In the three host countries, studies show working conditions are precarious (26,30), expose women to exploitation (26,30) and wage discrimination (57), all of which adversely affect mental health (30,83). Socio-economic challenges intensify women's vulnerabilities and profoundly jeopardize mental health increasing female Syrian refugees' needs for psychological support (50,51,75,84). A study in Jordan also found low levels of marital and life satisfaction reported by Syrian women(53).

Security

A large proportion of Syrian women in host countries have experienced physical or psychological abuse from spouses and host communities members (82,85,86). Studies show opportunities for Syrian refugee men to provide for their families are scarce, as they are seen as threats (78,82). Sudden gender role reversals and loss of social identity increases Syrian men's frustrations and aggression towards women; studies show domestic disputes and intimate partner violence increased Syrian women's risk for developing mental disorders (26,56,57,60,62,63). Despite the high risk for ill-treatment, UN women revealed a majority of Syrian refugee women lack awareness about their rights to protection and available legal support in host countries (84). Syrian women are also reluctant to report abuse due to stigma and fear of consequences like loss of children or legal status (14,74,75,82,84). Regarding Syrian refugees in LGBTI communities, a study in Jordan showed they face unique protection risks, extreme stigma, and discrimination (87).

Health seeking and practices

In 2018, utilization of MHPSS was 7% among Syrian refugee women in Lebanon (75). Based on a qualitative study in 5 cities in Jordan, only 8% of Syrian women used mental health services (70). Low utilization was also found in a 2020 study in Türkiye(88). Socio-cultural factors such as stigma

associated with mental disorders in Syrian communities affect health seeking of Syrian women (30,57,89). Challenges renewing residency permits, cost of transportation and fear of safety restricts Syrian women's free movement which creates a barrier to access services (75,82). Furthermore, overarching discriminatory behaviours in host communities contribute significantly to limiting access to essential services like healthcare(14). While some Syrian refugees are integrating with host communities and developing new coping mechanisms, many are still struggle to do so; such efforts are thwarted under threats of forced repatriation (50,60). Despite substantial investment in social protection systems in the three host countries, coverage and responsiveness for mental health care and psycho-social support, are inadequate and inconsistent for Syrian refugee needs (13,16,51,90). If gaps in mental healthcare remain unaddressed, untreated mental disorders not only adversely affect Syrian women's mental health but also contribute to generational trauma and poor psychosocial outcomes for children, decreased utilization of other healthcare services and limited participation in social, economic, and political life (30,91–94).

Justification

According to the World Health Organization (WHO), 10% of the total global burden of disease, measured by Disability-Adjusted Life Years (DALYs) was due to mental disorders (95). A 2019 study estimated the economic value of the burden was USD 5 trillion with estimated increase to USD 6 trillion in the next 6 years (95,96). In 2019, the burden of disease in the Middle East and North Africa region was 23.4% with 31.3 million DALYs. Beyond cost of treatment, mental health conditions incur indirect costs by affecting economic productivity and employment opportunities (95). However, cost-of-illness studies often overlook societal costs of mental health disorders by excluding unpaid work, social factors like relationships, and intangible consequences like psychological pain (95).

For displaced Syrian populations, appropriate mental health interventions are integral; needs increase due to conflict, displacement and post-displacement stressors, which have disproportionate adverse effects on women's mental health and vulnerabilities (16,49,97–100). Consequently, Syrian refugee women face disproportionately higher risk of negative mental health outcomes (50–53,67). The magnitude of the exodus from Syria following the conflict has made assessments for mental health needs difficult (101). The three countries are the top three with the highest numbers of Syrian refugees. Although there is some research on Syrian refugees' mental health, gender-specific research is crucial to understand the unique barriers and facilitators they face in accessing mental health care.

As mental health needs remain unmet for Syrian women in the three host countries(102), it becomes imperative to understand nuances of explanatory models and health seeking behaviour for mental health among Syrian women as it can affect their general wellbeing in the long-term and influence their rights to be essential stakeholders for post conflict reconstruction and the recovery. While the study's focus on Syrian women may limit its generalizability, it provides the opportunity for meaningful exploration into the unique needs of this subset of the Syrian refugee population. The findings from this research will be used to inform the three host countries' mental health strategies.

Objectives

General objectives

To explore Syrian refugee women's understanding of mental disorders and analyze factors influencing their health-seeking behavior for mental healthcare to inform mental health interventions in Lebanon, Jordan, Türkiye.

Specific objectives

1. To assess personal and communities' perceptions and understanding of mental disorders.
2. To identify personal, socio-cultural, systems' barriers for mental health seeking behaviour of Syrian refugee women.
3. To explore factors that facilitate health seeking behaviour of Syrian refugee women for mental health care.
4. To identify gaps in existing systems and generate insights and recommendations that highlight gender considerations for future mental health interventions.

Methodology

Study search strategy

This thesis is based on literature review on mental health, disorders, and factors influencing health-seeking behavior among Syrian refugee women in Türkiye, Jordan and Lebanon. Peer-reviewed, grey literatures and reports were retrieved from PubMed, Google Scholar, PubMed Central and reports from reputable organizations' websites. Grey literature was incorporated because relying solely on peer-reviewed literature would not fulfil the research objectives. Literature included for the review were published in English language to avoid misinterpretation of findings and literature published from 2011 to 2024. This time span represents the beginning of the conflict to the current year, for an overview of factors affecting health seeking behaviour. Literature without full gender-disaggregated data was included with certain conditions. Studies with Syrian women as more than half participants were included to meet the objectives of the study. These were supplemented with gender-specific qualitative data and other gender-disaggregated literature to corroborate findings and ensure a focused and comprehensive analysis of female refugee experiences. The combination of words used to search for literature were "Syrian refugee", "Syrian women", Syrian transgender women, health seeking, mental healthcare utilization, Türkiye, Lebanon, Jordan and Middle east (Annex 2).

Google scholar was used to generate initial search using combination of key words (Annex 2). Google scholar was used to include a broad base of literature including peer reviewed articles. This step generated a total of 690 literature, based on titles 150 literature were eligible, based on abstract and executive summary 55 were eligible. Based on the content and applying conditions, 20 were included. Other literature were collected through snowballing technique from reference list of included studies using PubMed, and based on searches on websites of reputable organizations working with Syrian refugees and mental health. Literature that met the inclusion criteria were analysed and categorized under appropriate section of the modified framework.

Framework

To describe determinants of health seeking behaviour of Syrian refugee women, Andersen's behavioural model was used. The original intent behind this model was to assess 'how's' and 'why's' of healthcare utilization to formulate policies for equitable access to care (103). This aligns with the overall objective of this research. Since its development in 1968, the model has had 4 revisions (103). The model was initially designed to explain individual's healthcare utilization using predisposing characteristics, enabling resources and perceived need for use (103). After criticism due to minimization of impact of health beliefs, the framework was integrated with behavioural and health belief model; health belief was included with demographic factors and social structure in predisposing characteristics (103). Under enabling resources, organizational factors and social relationships that facilitate or impede health service use are included under population characteristics, which centre social structure and health belief as a determinant for healthcare use (103). Outside population characteristics, health behaviour, outcomes of service utilization and the health system and external environment's contribution to health seeking behaviour relay the dynamic nature of health service represented by feedback loops (103).

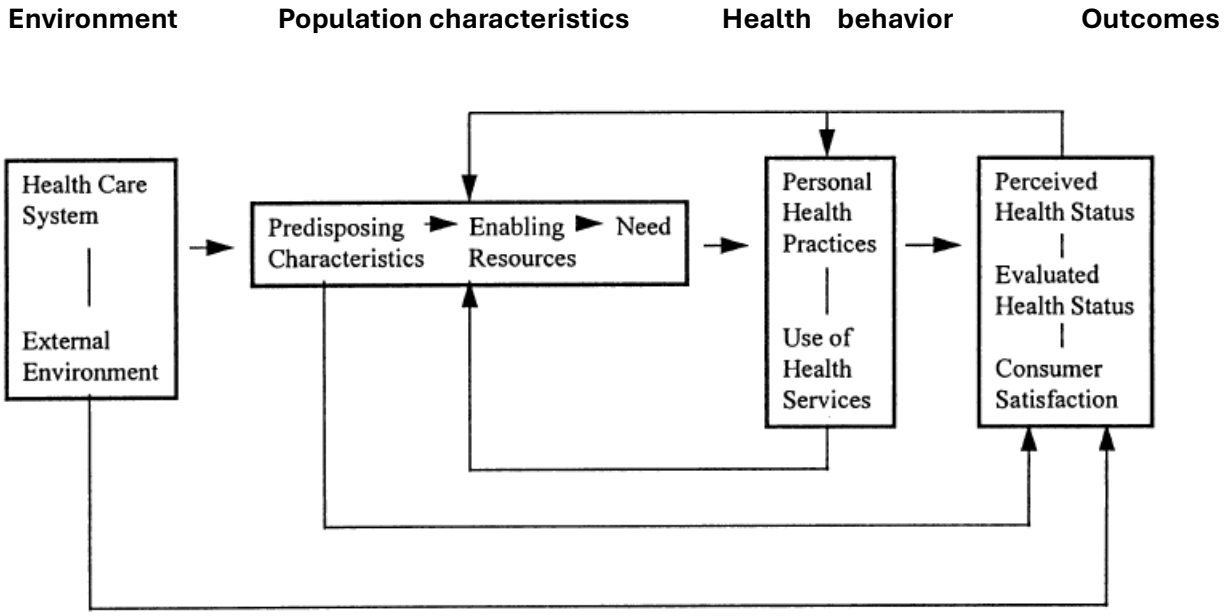

Figure 1. Andersen behavioural model- phase four (103).

Findings will be discussed under the four categories

Andersen's model was chosen for its versatility and ability to showcase different intersecting factors that affect health seeking behaviours of individuals. Health behaviour describes the practices of Syrian women and gives a broad overview of health seeking behaviour for mental healthcare. Health beliefs under population characteristics was used to gain insights about perceptions on mental disorder and seeking mental healthcare to meet the first objective. Other components of population characteristics and environmental factors provided information about facilitators and barriers that affect health seeking practices of Syrian refugee women. This framework was also used to analyse the intersectionality of factors and their compounded effect on Syrian women's practices. Since this model was not created for refugee populations has been modified to address relevant factors to meet the objectives of the thesis. Modification was based on Andersen's three factor model of health service utilization (Annex 3) (104). Major adaptations made were under predisposing factors, gender was categorized under social structure instead of demographic data. And under external environment, socio-cultural and legal factors were included for a comprehensive overview.

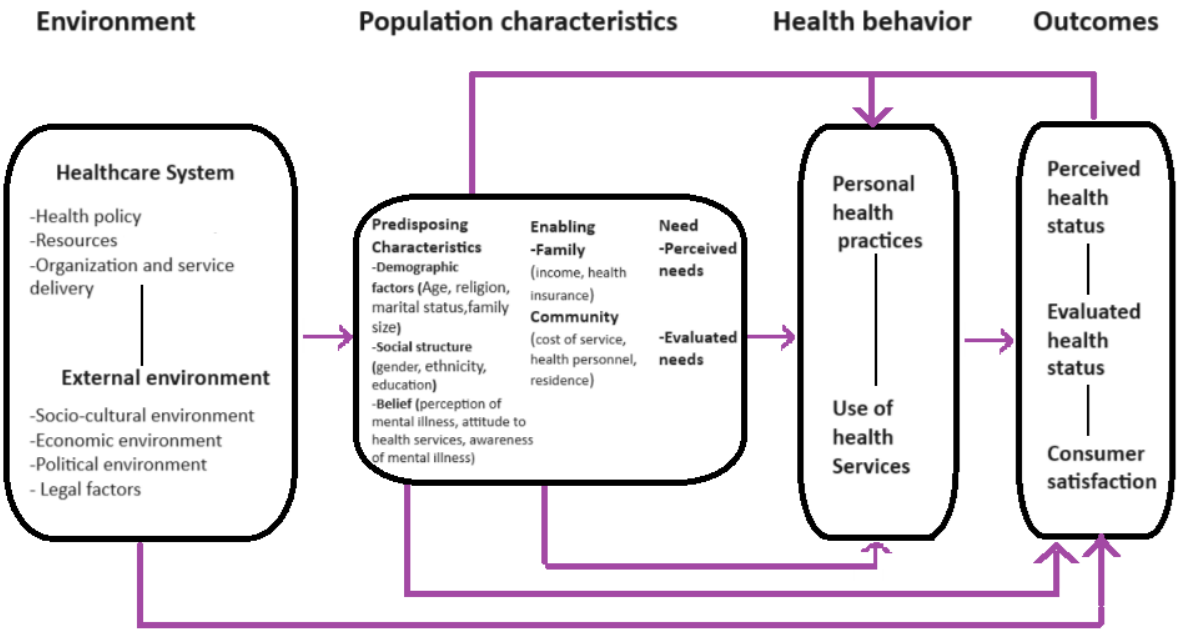

Figure 2. Adapted from phase-4 Andersen's behavioural model.

Limitation- The study could have been better served through primary methods from Syrian refugees residing in the three countries but due to language barriers and feasibility issues due to resource constrains, literature review was conducted. Similarly, adequate numbers of key informants were not available to contribute to the thesis. Use of reports could introduce bias based on funding sources or author's views; in addition, grey literature without peer-review could have issues with quality. Literature without gender-disaggregation also affects the generalizability to Syrian refugee women, but conditions were used to mitigate its impact.

CHAPTER 3

RESULTS

In this chapter, findings are presented according to categories and factors in the conceptual framework based on the objectives for the study. Health behaviour is presented and analysed first, followed by population characteristics, environmental factors and outcomes. Outcomes based on patient's perception regarding their health condition, their satisfaction from mental health services and their health condition after the use of health services are analysed to generate feedback about services.

Literature meeting inclusion criteria from those retrieved from search results using key words and snowballing from relevant articles were 32 peer reviewed literature. Using websites of international organizations, NGOs and ministry of health of each country 57 grey literature, reports and policies and strategies were used. Although most of the literature reviewed served multiple categories, most of the grey literature, reports and government documents were categorized under environmental factors.

Health behaviours

Personal health behaviours

As trust is a basis for confidentiality, studies show Syrian refugee women in Jordan share adversities with trusted social networks or women's groups (60,87). Qualitative studies in Lebanon revealed Syrian refugee women considered close family and friends as first-line support systems for psychological needs (57,105). Similarly in Türkiye and Jordan, several studies show over 50% of Syrian participants sought help from family and friends for mental distress (64,88). However, a 2019 report in Jordan showed urban residing Syrian participants were less likely to seek help from friends and family compared to those in camp settings, particularly women participants (64). Even though many Syrian women share psychological distress with family members some prefer to self-manage to avoid burdening relatives or because they considered it inappropriate (57,70,77,88).

Studies in all three countries revealed other methods used by Syrian women to cope like actively distracting themselves with chores, avoiding reminders of traumatic events and participating in religious activities like reading the Qur'an (60,70,87,89,105,106). Studies show passive coping techniques like crying and isolating oneself are commonly used to resolve stress and frustrations By Syrian refugee women (87,106). Qualitative studies in Lebanon found in the absence of support from relatives, some Syrian women resorted to crying to find relief; others described it as a form of catharses(60,105). According to a qualitative study in Lebanon, many Syrian women refugees considered seeking mental healthcare when social networks or self-management does not produce change in symptoms(57) while a study in Jordan, showed they sought MHPSS services when symptoms of mental disorder are severe(70).

Use of Services

Studies in host countries found significant stigma is attached with seeking mental health services among Syrian refugees and host communities (30,77,89,105,107). However, 2020 evaluation of mental health services utilizations in Türkiye revealed, 70% of Syrian women attending refugee health centres (RHC) engaged with MHPSS services (108). In this study, 91.3% of participants received services from psychologists and social workers (108). However a 2020 study in Türkiye, showed a majority of Syrian refugees used mental healthcare at government hospitals (54%), RHCs (48.3%), and religious leaders (43%), while only 31% utilized NGO or community organizations (88).

According to a 2019 report in Jordan, seeking care from mental health professionals less frequent among urban based refugees than those in refugee camps (64). In Lebanon, limited data exists on patterns of use for mental healthcare among Syrian women, however, a qualitative study in rural Lebanon revealed religious leaders are preferred by some women compared to using facility based services (107). Although many expressed negative experiences with 'Sheiks', social networks encourage these practice (107). In Türkiye, Syrian refugees using facility based mental health services, many reported discriminatory practices from mental healthcare providers like shorter therapy sessions, longer waiting times and prioritization of Turkish citizens, negatively affect use of services (106).

Population characteristics

Predisposing factors: Demographic factors

Even though there is a strong relationship between demographic factors and mental disorders, there was limited literature found on their association with Syrian refugee women's health seeking behaviour for mental healthcare in the three host countries.

Age

Regarding age's association with health seeking behaviour for mental health, a 2019 report in Türkiye showed ages 18-29 had the highest use of psychologists (109). However, a 2020 study in Türkiye, with predominantly Syrian women participants, found age over 40 years have twice the likelihood of using MHPSS services (108). While studies showing a direct link between age and use of mental health services is limited In Jordan and Lebanon, a 2020 qualitative study in Jordan found older Syrian refugees had low likelihood of accessing mental health services (69). Similarly in Lebanon, a 2018 report found awareness about healthcare services decreased with increasing age but specific data on mental healthcare use is not available (75).

Marital status

In Türkiye, a 2020 study found that married Syrian women had significantly lower odds of using mental health services (108). However, single and widowed individuals had the highest satisfaction rates with MHPSS services which may suggest either needs are more prevalent among single and widowed participants or marriage addresses issues leading to MHPSS needs (108).However, a qualitative study in Türkiye found that married Syrian women living in difficult conditions preferred

not to discuss their psychological needs with their spouses in order to maintain family harmony; this research also found psychological issues of Syrian women is unlikely to be acknowledged by their spouses (77). In Jordan and Lebanon, studies relating marital status of Syrian women refugees and use of mental health services were not found.

Family size

From the literature available, studies that show associations between number of children or size of the family and health seeking behavior for mental healthcare were not found. Since increasing family size could increase financial and psychological burden, the potential association with health seeking behavior for mental healthcare requires research.

Predisposing factors: Social structure

Gender

In a 2020 study among Syrian refugees attending RHCs, a higher proportion of men (74.1%) compared to women (69.9%) used MHPSS services in Türkiye (108). While there is a relatively small difference in the 2020 study, a 2019 report in Türkiye revealed 24% of Syrian men used services from psychologists compared to Syrian women (9.0%) (109). In Jordan, a 2019 report showed that women had increased barriers to accessing mental health services (64). In Lebanon, a 2018 report found that utilization of psychosocial support services by Syrian refugee women ranged from 3-18% (75). For LGBTQI+ Syrian refugee women, no literature was found exploring health seeking behaviour for mental disorders.

Ethnicity

In Türkiye, a higher proportion of Arabs (72.8%) compared to other ethnicities (59.6%) engaged with MHPSS services was found in a 2020 study. However, Arabs made up 85.4% of the participants (108). Regarding ethnicity, there were no studies found that evaluated the relationship between ethnicity and mental healthcare seeking among Syrian refugee women in Lebanon and Jordan. Due to the diversity of Syrians, it is important to analyse its effects on displaced Syrian ethnic minorities.

Religion

In Türkiye, a study found higher proportions of Muslims (72.2%) used MHPSS services compared to Christians; however, the study consisted of 99% Muslim majority(108). Like ethnicity, no studies were found that analyse variations in mental health service use among Syrian women based on religion in Jordan and Lebanon. Emphasis should be placed on studying the relationship between mental health-seeking behavior and religion, as religion has a role as a coping mechanism for mental disorder.

Education

Studies that explored the relationship between health seeking behaviour for mental healthcare and education level were limited. However, a 2020 study in Türkiye found no association between education levels and health seeking behaviour for mental health (108).. In Lebanon, while not a direct association with service utilization in Lebanon, a 2018 report showed awareness about mental health care services increased with level of education level of Syrian women (75)

Predisposing factors: Beliefs

Perception of mental disorder

Among displaced Syrians in the three host countries, studies show mental disorder is perceived as a personal shortcoming or weakness, which is heavily stigmatized and associated with shame for individuals and their family members (77,89,107). Syrian women reported use of disparaging terms like 'crazy', 'weird' or 'stupid' to describe individuals with mental disorder who are considered dangerous and avoided (77,89,107). In a 2022 qualitative study, Syrian refugee women in Türkiye described how managing mental disorder independently is seen as a measure of mental fortitude (77)..According to a 2022 qualitative study in Jordan, there is lack of awareness and willingness to acknowledge symptoms of mental disorder; many Syrian women that acknowledge symptoms, avoid disclosing issues to their relatives (89). Based on a 2019 report, over 50% of Syrian participants perceived the desire to self-manage mental disorders as a barrier to seeking care (64).

In addition to stigma, a 2018 study in Jordan also highlighted that Syrian women living with mental disorders are considered liabilities to the family due to their increased vulnerability (62). Studies in Lebanon and Jordan also show reliance on explanatory models based on spirituality for mental disorders is common (64,107). Use of religious healers and Ruqya, a ritual to exorcise 'possessed individuals' by reading Quran and striking body parts is common, most notably in rural Lebanon(107). In both Lebanon and Jordan, studies show Syrian women perceive symptoms as normal responses to their environment and healthcare providers attribute it to mental disorder (105,110). This has created discordance between the providers and Syrian women particularly in Lebanon (110).

Attitude towards mental healthcare

Several studies in the three countries show seeking mental health care is associated with stigma, negative labels and marginalization (30,62,77,89,105,107). Studies in Jordan and Lebanon also show mental disorders are generally not accepted as health conditions that require treatment (57,89). In rural Lebanon, many Syrian women report use of derogatory terms against individuals with mental disorder, including by those enrolled in mental healthcare (107).

> **'They will call us crazy and people won't come to us anymore. They say we might hurt them. This is why we come to MSF clinic without telling anyone.'**
>
> **A Syrian woman in Lebanon** (107 p.880)

Studies in Lebanon show seeking care from religious healers is preferred and considered more acceptable than formal health care (105,107). In Jordan, a study showed Syrian women are discouraged from seeking care as it may affect marriage prospects for themselves and other unmarried female relatives (62). To preserve honour and pride of the family, many Syrian women reported avoiding disclosure of psychologically harmful but stigmatizing experiences, particularly to male professionals (87). A contrary finding was present in a 2020 qualitative study in Lebanon where psychological symptoms are attributed to contextual stressors, seeking care is normalized as it is not consider an personal failure (110). Therefore, among Syrian women able to access healthcare in Lebanon, many did not believe their symptoms would resolve without resettlement in countries where their rights including their children are respected (110).

Knowledge about mental disorder

Studies in host countries show many Syrian women attributed mental disorder to conflict and forced migration (57,64,106,110). In several studies many Syrian women in Lebanon acknowledged effects of isolation particularly related to resident permit issues, social and occupational role reversals on their mental health (107,110).

> **'Our life is very hard. We are not happy with this lifestyle…our mental state is not well. We left our country, we left our jobs, our homes, our people and it is very hard'.**
>
> **60 year old Syrian woman (107 p.879)**

In 2020, a study in Türkiye found that 78% of participants said NGOs did not provide mental health information (88). However from a 2024 study in Türkiye, many participants acknowledged mental health professionals as their primary information source (106). Despite the stigma of mental disorder, studies in Lebanon show many Syrian women believe in the importance of social networks for mental health (107). However, multiple studies show low awareness about mental disorders and their manifestations among Syrian refugee women, particularly in Jordan and Lebanon which has affected health seeking behaviour (57,70,88,89,105,107).

Predisposing factors : Enabling factors

Family

Employment and income

In all three countries, studies show Syrian women face financial challenges and difficulty meeting basic needs disproportionately more than Syrian men (13,53,75,106). Studies show financial insecurity and work permit challenges push many Syrian women to rely on unregulated informal sectors in host countries (20,24,45,57). According to a 2023 study, 97.8% of Syrian women in Jordan earn below 550 Jordanian Dollars per month (59). Similarly in Lebanon, 68% of Syrian women earn below the minimum wage and 39% reported relying on informal credits as primary sources of income (75).

Studies have found Syrian women, particularly female head of households(111), living in rural Lebanon and outside refugee camps in Jordan are financially vulnerable; many are reportedly dependent on aid for basic needs (69,75,111). While initiatives like mobile wallets by the UNHCR and the Jordanian government were implemented for ease of access to cash assistance, low donor funds have resulted in significant aid reductions for Syrian refugees living out of camps since 2023 (112,113). Based on studies from all three countries, unfulfilled basic needs, lack of employment and inadequate income have led to deprioritizing seeking care for mental health needs (30,69,106,110).

Health insurance

In Türkiye, MHPSS services are free for registered Syrian women due to provision of health insurance following registration into the Turkish health system and social security institution (106). Initially UNHCR-registered Syrian refugees in Jordan, received free primary healthcare (PHC) services in

public facilities, including mental healthcare; more recently Syrian refugees are required to pay for services at 80% of the non-Jordanian rates (23,114). In 2020, a study found 68% of Syrian women living in urban areas of Jordan did not have health insurance (58). More recently in 2023, another study in Jordan found 93.5% of Syrian women did not have health insurance (59). Studies show lack of insurance adds to the barriers to utilize mental health services (58,115). In Lebanon, the Ministry of Public Health, Ministry of Social Affairs and non-governmental organizations (NGOs) have been providing free primary mental healthcare services for UNHCR-registered Syrian refugees. Yet, due to financial constraints, these efforts are unable to meet rising needs (52,57).

Community

Residence

In Türkiye and Jordan, the majority of Syrian refugee women live out of refugee camps(23). However, studies in Türkiye and Jordan show that Syrian women in refugee camps have better access to mental healthcare and social services due to their proximity and access to services and information (62,69,106). This was corroborated a 2020 qualitative study among urban-based Syrian women in Jordan who reported distance from services and inability to pay for transportation was a barrier to use mental health services (70). Despite ease of access and recent improvements in camps, qualitative studies in Jordan reveal that Syrian women struggle to adapt to overcrowded, sub-standard, and unsafe camp conditions (60,69). Although no formal camps are present in Lebanon, a 2018 report shows disparities in mental health services utilization among Syrian women in different governorates; the highest rates were found in South Lebanon and Nabatiyeh (18%) and lowest in Beirut and Mount Lebanon (3%) (75). Geographical inaccessibility of MHPSS services, is also frequently cited as a barrier for Syrian women in studies from Türkiye and Lebanon (57,75,107) (106).

Cost of services

In the three host countries, direct cost of mental healthcare services and indirect costs like transportation are reported barriers to seeking mental healthcare for Syrian refugee women (64,70,89,106,107). In Türkiye and Lebanon, studies highlighted cost of transportation to facilities was a barrier to seeking mental health care, particularly for single and newly arrived Syrian women in Lebanon (75,106). Since 2018, Syrian refugees are required to pay 80% of non-Jordanian rates for public healthcare services which tripled of out-of-pocket spending (116). Based on a 2019 report, cost of treatment was a major barrier for accessing care, for over half of urban based Syrian women in Jordan (64). Studies in Jordan and Lebanon show inability to pay for services including medications which are largely out-of-pocket (57,70,75,89). These factors have been shown to affect utilization of mental healthcare (115), especially affects Syrian households headed by women (38,62,70,117,118).

Healthcare personnel

Based on WHO evaluations, the Turkish mental health workforce is predominantly mental health nurses and the number of psychiatrists, psychologists and social workers are 2.21, 3.24 and 2.36 per 100,000 Turkish population respectively (119). In 2022, Jordan reportedly had less than 1 psychiatrist and 13 psychiatric nurses per 100,000 Jordanian population (120). In Lebanon, the number of psychiatrists are less than 1 per 100,000 Lebanese population and mental health nurses,

psychologists, social workers and other mental health workers like occupational therapist make the grand majority of the mental healthcare workforce (32). In Türkiye, under Social Inclusion of Persons with Mental Disabilities and WHO's mental health gap (mhGAP), over 3000 Syrian and Turkish general practitioners, community health workers and mental health professionals were trained to address refugees' psychosocial needs (121). In Jordan, as of 2022, 200 primary care professionals were trained under the special initiative for mental health for comprehensive mental health system improvements (120).

Need factors

Perceived needs

From studies in host countries, there is a reportedly high lack of awareness about mental health services by Syrian refugee women (70,106,107). In Türkiye, studies show many Syrian women reporting not knowing about available services for MHPSS services which hindered seeking care (30,106).

> **'They said she is touched or something, they took her to Sheikh as they didn't know about the psychiatrist and up till now the majority do the same.'**
>
> **36 year old Syrian woman in Lebanon(107 p.880)**

Studies in host countries reveal that despite recognizing the psychological impact of trauma and awareness of mental healthcare services, many Syrian women avoid seeking help due to the stigma surrounding mental disorder (57,64,77,106,107). From a 2020 study in Lebanon, many Syrian women disagreed with negative attitudes toward mental disorder and supported therapy, but only a minority believed mental disorder was accepted in their communities(57).

From a 2019 report in Jordan, over half of Syrian women, particularly urban-based refugees raised concerns about maintaining privacy and confidentiality, since they were exposing their vulnerabilities (64,70). Similarly in Türkiye, studies show there is pervasive mistrust towards mental healthcare providers, particularly their capacity to maintain confidentiality and deliver quality and effectiveness of care which influences use (57,77). In addition, language barriers affected use of mental health services, as many are unable to express their issues clearly or access services in public facilities (106). Other perceived needs according to a 2019 report were affordable services, medications and transportation, particularly for urban based Syrian refugees (64). In addition, Syrian women in a 2023qualitative study reported preference of gender separate sessions to freely engage in sessions (122).

Evaluated needs

In the three countries, multiple studies reported high rates of lack of awareness about available MHPSS services which contribute to low service utilization (69,88,106,123). In Türkiye and Lebanon, studies show inadequate information about MHPSS services has hampered service utilization and increased reliance on word of mouth to find services, particularly in Lebanon where awareness about psychosocial services was 23% (30,75). Key informants from a 2020 study revealed that mental health service provision for Syrian women in urban areas of Jordan is limited, and services that target older Syrian refugees are lacking (69). Societal beliefs about mental health and gap in services may increase engagement with 'Sheiks' to fill the gap (18,107). However, a 2019 report indicates that some professionals in Jordan believe stigma is not a significant barrier to mental healthcare for Syrian refugees, who face pressures from displacement and are seen as strangers in the country (64).

From a qualitative study in Lebanon, professionals stated Syrians need persuasion to engage with MHPSS services and over 90% of providers blame the 'traditional' Syrian culture, which they associate with high illiteracy, fertility and perceived 'uneducated' coping mechanisms; this created misalignments between Syrian women's explanatory models for mental disorder and providers' biomedical approach (110). Similarly in Türkiye, studies found similar discordance resulted in dissatisfaction with diagnosis, lack of trust with providers and psycho-social support being considered culturally inappropriate, especially in mixed-gender groups(30,124) Similarly in Jordan, services separated by gender have better acceptance by Syrian women (60). In Lebanon and Türkiye, insufficient numbers of female mental healthcare providers, especially of Syrian origin has also become a barrier to use services in all three host countries (30,102) Shortage of female providers is a barrier due to discomfort of Syrian women or family members unwillingness for women to interact with male service providers (87).

Based on a 2020 qualitative study, financial insecurity also affects service utilization as most Lebanese mental health professionals reported increasing requests for assistance acquiring material aid or resettlement through services; this was perceived to increase mistrust and disrupting patient-health provider relationship (110). However, a minority of mental health professionals believe referrals for treatment are premature, often prior to basic needs being met (110).

> **'Many Syrian women ask me to write reports stating they need diapers…So, I write: "This is to certify that Mrs. X is in urgent need of diapers for her children as this will tremendously affect her mental health.'**
>
> **Mental healthcare provider in Lebanon** (110 p.22)

Healthcare system

Health policies and strategies

All three host countries have national mental health policies (32,119,125). Although considered inadequate adhering to human rights principles like equitable access to quality care and protection from stigma and violence, legislation dedicated to mental health is only found in Lebanon (32,126). Based on WHO's evaluation, equity in mental healthcare based on gender, vulnerable groups and socio-economic status lack targeted strategies in Jordan (127). In host countries, policies and strategies guide collaborations with international organizations and NGOs to enhance mental healthcare services to Syrian refugees; this has primarily been conducted through PHC expansion and its integration with mental healthcare (127–130). Community-based services and psychosocial support has been given focus particularly in Türkiye and Jordan (120,121). However, in Lebanon, psychosocial support is met with some resistance, in favor of short term, clinical and evidence-based practice (110).

Türkiye's refugee health programme supports migrant health centres and training of Syrian health professionals to integrate into the national health system (25,109,131). In addition, adopting MHPSS and WHO mhGAP has directed strategies towards patient-centred care in Türkiye by: supporting transitions to psychosocial support and community mental health centres (CMHC), guideline development to improve community-based care, and training Syrian and Turkish physicians to manage mental disorders, and address language and cultural barriers (121,132). Jordan's 2018 mental health action plans, supported integration of mhGAP training into curricula for medical and nursing students(127,133). Since 2019, there has been increased capacity building, expanded implementation of mhGAP program and support for CMHC (120). Jordan's latest strategy (2022-2026) promotes de-institutionalization of mental health care, strengthening community-based services and affordable services for refugees (120).

In Lebanon, following the adoption of a national mental health plan in 2015, despite some gaps in service provision for Syrian refugees, there has been expansion of mhGAP training and mental health services in PHC (32,134,135). Incorporating Syrian refugees as informal healthcare workers and using digital platforms through WHO step-by-step mental health intervention have had varying degrees of success(136,137). Challenges fully realizing expansion of community-based services in Türkiye and Jordan and integration of mental health care into PHC in all three countries, due to financial and human resource allocation and inadequate coordination persist (30,32,120,128).

Resources

While national expenditures in Türkiye and Jordan are not specified, Lebanon dedicates 5% of its GDP to mental healthcare (32,120,128). However, in Jordan and Lebanon, the majority of the budget is allocated to tertiary mental healthcare (32,120). As of 2020, Türkiye has the highest numbers of in-patient and out-patient facilities, however, comparatively higher proportions of mental health facilities in Lebanon are community-based (32,119,125). It should also be noted that based on a 2017 study, Lebanon's mental health sector was found to be dominated by expensive private sector and underfunded public sector (126). In addition, studies show most mental healthcare providers, particularly psychiatrists in Jordan and Lebanon work in the private sector which is not covered by insurance and incurs high out-of-pocket expenditure (114,120,126). Limited number of mental

health professionals hinders progress towards decentralization and expansion of services outside hospital-based care in Jordan (114,120). Despite shortages in mental health professionals, regulations on employment and state budget constraints have resulted in many unemployed Jordanian psychology graduates; legal restrictions also exclude Syrian refugees from participating as providers in mental healthcare (118).

In Türkiye, the WHO with MoH provides MHPSS services through 180 RHC by general practitioners psychologists and social workers (138). Regarding health professionals' skills, a 2019 report in Türkiye revealed deficiency in mental healthcare for gender-based trauma (30). Outside the public sector, a 2021 survey identified 33 MHPSS services in Jordan and a 2015 report showed 12 in Lebanon provided by NGOs; these were primarily focused on community-based MHPSS and women's centres particularly in Lebanon (139,140). However, in both reports, most organizations did not provide information about financing for MHPSS activities or number and specializations of staff, but in Jordan majority were volunteers (139,140). However, In Jordan, nearly 80% of financed activities were implemented (139). In Lebanon, a 2015 mapping revealed that about 50% of community-focused activities were funded but not implemented (140). Diminishing external funding and mental health services by non-governmental agencies for mental healthcare, particularly in Jordan and Türkiye has affected MHPSS service provision, capacity building efforts and scalability of mental health programmes (118,141). In 2020, key informants from Lebanon also noted policies encouraging short-term interventions perpetuated funding gaps and affect MHPSS services (110).

Organization and service delivery

In host countries, government authorities collaborate with NGOs and international organizations to deliver MHPSS services to Syrian refugees (127,138,142). While the Disaster and Emergency Management Presidency is responsible for services in Turkish refugee camps(, UNHCR leads service provision in refugee camps in Jordan (124,143). International organizations and NGOs in Jordan provide free psychosocial support services, including participatory psycho-social activities (62,142). In both Türkiye and Jordan, reports show poor coordination of activities that create barriers for service utilization and sustainable scaling up MHPSS projects to support the public health system (30,110,116,118). Despite resource limitations, studies in Lebanon show efforts to increase outreach to informal settlements, community-based mental health services, inpatient services and remote mental health services (144). Despite the MoH's efforts, psychosocial support services are evolving slowly, particularly for Syrian women in Türkiye and Jordan (30,118). In Lebanon, while WHO evaluations have shown increasing integration of mental health services into primary healthcare (PHC), it still remains inadequate (32,144).

Based on a 2018 report access to mental health services was better and more equitable in Türkiye compared to Lebanon (13). However, recent studies in Türkiye report limited availability of MHPSS services and language barriers challenge Syrian women's use of mental health support (30,77,106). Similarly in Jordan and Lebanon, studies show inconsistent availability of services affect utilization, particularly from NGOs in Jordan (57,89). From a 2021 report in Jordan, community-focused activities have decreased since 2017 by 10% (139). In 2020, the provision of free mental health services in primary healthcare (PHC) in Jordan was reportedly limited, often offering only psychoeducation (127). Insufficient number and distribution of mental health professionals and medication shortages in PHCs are reported in Lebanon and Jordan, while low service provisions of digital mental health

services due to poor infrastructure supporting virtual communications is particular to Lebanon (114,127,144). Another barrier for such interventions is that only one in three Syrian women having access to mobile phones based on a 2018 report in Lebanon (75).

External environment

Sociocultural environment

Studies show society's patriarchal nature persists and affects Syrian women's roles in host countries (57,60,62,124). Gender inequality and male dominance within and outside the home adds pressure to daily responsibilities of Syrian women (57). In Lebanon, Syrians women's influence in household and community matters is increasing but decision-making power often lies with Syrian men (75). In addition, prioritization of Syrian men's transport needs and legal permits restricts Syrian women's movement and access to services (45,75). Similarly in Jordan, Syrian women's access to mental health services is dependent on spouse's or other male family member's approval (89,118). This includes leaving their residence which is predicated on men escorting them which creates a barrier to mental health services if male relatives are the source of mental distress (60,62).

Discrimination including harassment, evictions and violence, disproportionately affects Syrian women, especially those without male relatives (57,62,70,75). Safety and security risks has led to restricted social engagement and mobility; this is often imposed by relatives to protect Syrian women while preserving family honour and adhering to cultural norms (26,60,75,77). This has increased mistrust towards host communities and lack of integration and adaption (26,57,62,70). This has been shown to not only affect Syrian women's mental wellbeing but also their desire to leave the house and seek MHPSS services (30,56,57,62,70,77).

With respect to gender roles, studies in Jordan and Türkiye found Syrian women are expected to take care of and facilitate healthcare for family members in addition to child care leaving little time for their needs(30,62). In addition, several studies report that Syrian refugee women prioritize their children's mental health needs over their own psychological needs (70,77,122). Other sited reasons for to family disapproval, fear of divorce (89) influence of religious leaders(107) and prioritization of other caretaker duties(70).

Economic environment

Among the three host countries, Türkiye has a stronger economy but since 2016, progress has stalled and further impacted by the pandemic and the earthquakes (145). Jordan's economy while growing, has rising inflation rates since 2019 (23,146) and Lebanon's inflation rates have reached triple digits since 2021, with expected shocks from the Gaza conflict (147). In addition, the decline in international funding for Syrians in host countries has shifted healthcare services to underfunded national systems (16,147,148). Furthermore exclusionary policies, underdeveloped plans for socioeconomic participation of Syrian refugees have resulted in diminishing formal employment with marked gender disparities and weakened social protection (16,24). Despite commitments to integrate Syrian women into the work force only 5% in Jordan, 9% in Lebanon and 5%% in Türkiye have work permits (75,149,150). Even though employment for Syrian women is possible in Türkiye, opportunities are limited due to legal and social barriers (26). In Jordan, a 2023 study showed Syrian women have lower SE compared to Syrian men, particularly in camps (53). Declining cash assistance

for refugees living out of camps in Jordan, has also affected economic status of urban-dwelling Syrian refugees (69). A 2018 report in Lebanon showed 45% of Syrian women could not fulfil basic needs (75). Studies show inability to meet essential needs often leads to forgoing mental health needs (30,69,106,110).

Political environment

Until recently, open door policy was instituted and maintained for Syrian refugees in Türkiye while restriction were placed for UNHCR registration by the governments of Jordan and Lebanon since 2015 (151,152). In recent years, political will towards Syrian refugees has decreased in three host countries (152–154). Blaming refugees for host countries' economic decline, rising unemployment, security issues and low quality of public services has increased discrimination and violence towards Syrian refugees (45,152,154,155). Since 2019, there have been increased reports of cancellations of refugee registrations, expulsion of unregistered refugees and setting quotas for registrations which has closed 16 provinces to new Syrian refugees in Türkiye_(153). Following the attacks on the Jordanian and Lebanese army by militant and extremist groups, involuntary returns have intensified from both countries (154). In Lebanon, there is pressure from Hezbollah to align with the Assad regime along with intensified raids and forced deportation without means of ensuring security of Syrians (56,154). While Increasing repatriation have aggravated psychological burden of Syrian refugees in all three countries, it has also increased fear and decreasing health service utilization, particularly among refugees in Lebanon that have to cross checkpoints to reach clinics (56,77,156).

Legal factors

Legal protection is a challenge for Syrian women due to structural barriers and discriminatory practices based on gender and nationality (30,82). Under TPR, Syrian refugees with legal registration have better to access PHC services than unregistered refugees, but clarity about receiving psychosocial services is lacking (30). In addition, access is tied to the province of registration, otherwise conditional on providers' willingness(30). Issues regarding identity cards and bureaucratic difficulties like road permit requirements are deterrents for seeking care for Syrian refugees in Türkiye particularly when sites of registrations do not offer MHPSS services (106). Their temporary guest status also creates structural uncertainty, impacting their economic and resource access which affects access to MHPSS services (30).

Legal status and access to care of Syrian women in Jordan is linked to UNHCR registration (70,82). According to a 2018 report, many Syrian women faced difficulties accessing services due to a lack of registration (82). This issue often arose when women left camps without authorization—either due to poor camp conditions or to reunite with relatives—which led to the loss of their registration status (60,82). Access to basic rights, healthcare services and freedom of movement in Lebanon is predicated on registration with the Lebanese General Security Office (GSO); this includes annual renewal, which is a challenge especially to Syrian women due to high cost, conditional waiver for fees, lack of guarantors or denial of services (16,75). This was reflected in a 202 report, where Syrian women had lower rates of legal residency and experience higher rejection rates (157).

Outcome

Perceived health status

A 2022 study evaluating interventions on integrating psychosocial services and sexual and reproductive health interventions in Ankara found engaging with trusted providers contributed to alleviating symptoms (77). In Jordan, studies on counselling interventions consisting of sharing experiences and psychoeducation have resulted in improved general well-being, autonomy, adaptability, interpersonal relationships and self-acceptance among Syrian women (92,122). Syrian women also reported better awareness of mental disorders, acknowledgement of their own psychological needs and utilization of healthy coping strategies (122). However studies in Türkiye and Jordan revealed Syrian refugee women receiving specialized care perceived no significant improvement despite medication adherence including some women in Jordan reporting experiencing side effects (70,106). A 2020 study in Lebanon found many Syrian women valued MHPSS services not only for supporting their mental well-being but also as an advocacy mechanism for UNHCR aid and resettlement (110). An RCT evaluating digital mental health interventions in Lebanon has also reported improvements in subjective wellbeing of Syrian refugees (136).

Evaluated health status

A 2020 survey in Türkiye evaluating mhGAP training showed MHPSS services improved mental health among refugees (132). More recently, a 2023 randomized controlled trial (RCT) on use of culturally-adapted cognitive behavioural therapy (CA-CBT) for Syrian women in Türkiye revealed improvements in anxiety, depressive and PTSD symptoms (158). An RCT in a Jordanian refugee camp showed group behavioral therapy significantly reduced depression and related disability while improving parents' harsh disciplinary practices. This was attributed to improved mental health and better problem-solving skills by Syrian refugees (159). However, no reductions were seen in anxiety, grief, or PTSD symptoms, likely due to ongoing camp challenges and the intervention's insufficient focus on trauma (159). In Lebanon, a 2022 RCT revealed support from WHO's step-by-step intervention had sustained improvements in functional status and symptoms than those who received existing enhanced care comprising of basic psychoeducation and referrals (136).

Consumer satisfaction

Studies in Türkiye show Syrian women's satisfaction with MHPSS services in primary care, particularly with service quality, confidentiality, staff attitude, and stated their needs were met; they expressed desire to continue using services or recommend the service (108,132). In a 2024 study in Türkiye, non-specialized services in CHCs not focused on biomedical-based treatment was perceived as supportive with good service quality and no discriminatory behaviour (106). However, high satisfaction rates, studies show lack of professionals with mental health training is a source of complaint (106,108). Among Syrian refugees in Türkiye, particularly those attending specialized care, many noted language barriers led to miscommunications (106). In addition, difficulty booking appointments, long waiting time, , and lack of privacy cause discontent with services(106,108). though dissatisfaction persisted due to long waiting times and a shortage of trained professionals(70). From a 2023 study, Syrian women reported psycho-education encouraged them to speak about mental disorder, reduced fear of stigma and enhanced communication with relatives (122). A 2018 report showed psychosocial support completely or partially addressed the needs of

80% Syrian refugee women (75). In a 2020 study, Syrian women in Lebanon described MHPSS services as supportive and safe spaces and acknowledged the value of social workers and home visits to their mental health (110). However, some Syrian women expressed doubt on whether services without resettlement can help (110).

CHAPTER 4

Discussion

This chapter is dedicated to interpretation of findings from literature review and key informant interviews about health seeking behaviour of Syrian refugee women in Lebanon, Jordan and Türkiye. This study is conducted with the intention to assess perceptions around mental health and illnesses, predisposing factors to mental disorder, barriers and facilitators to seeking mental and psychological support among Syrian refugee women and identify gaps in services in the three countries. Population characteristics, health behaviour and the environment in host and Syrian communities are found to exert prominent influence and create intersections among each other to ultimately affect health seeking behaviour in this population.

Relevance of the framework

The Andersen behavioral model was used for this literature review, providing a framework for organizing and exploring factors that shape health-seeking behavior among Syrian refugee women, from individual characteristics to the broader socio-economic and political environment in the three contexts. It facilitated the analysis of the interaction between multiple factors influencing health-seeking and allowed for comparisons of findings across the three countries. However, the review did not address factors such as years spent in host countries, the origin of Syrian refugees within Syria, or experiences with violence and safety issues.

Strengths and limitation of the study

The literature review incorporated peer-reviewed articles, grey literature, and information from credible websites. Non-gender disaggregated data were included if Syrian refugee women comprised more than half of the participants. Findings from these sources were corroborated by other qualitative studies whenever possible, with an emphasis on recent literature. However, the review was limited by the available literature, which may introduce bias due to the setting and the population.

Some studies focused solely on Syrian women attending healthcare facilities, potentially leading to sampling bias as unregistered refugees and those without access to facilities were excluded. Qualitative studies in this review provide insights that cannot be generalized to the broader population. Publication bias is also a concern, as unsuccessful interventions are less likely to be published. Additionally, limiting the review to literature in English may exclude relevant studies.

Health behaviours

Conflict and displacement cause loss of identity, family ties, social networks, and sense of security. During these times of increased vulnerabilities, community can serve as protection. In Syrian communities, social cohesion and community perceptions guides individual behaviour. This collectivist attitude around mental disorder has created diverging coping mechanisms. It has provided some Syrian women with safe spaces among trusted relatives and friends. Studies in all three countries show that Syrian women rely on social networks for their mental health needs. However, some Syrian women who wish to seek MHPSS services could also become isolated due to pervasive stigma around mental disorders which is perpetuated by lack of awareness about mental health and services in Syrian communities. In addition, mental disorder has other social implications for Syrian women. Mental disorder could affect individual's or other female family members' prospects for marriage, which studies show can be associated with economic standing of the family (60,76,79). This may lead to Syrian women forgoing individual health choices and following culturally acceptable practices like seeking help from religious leaders, isolating oneself and self-management or delaying seeking care. This is seen among some Syrian women in Türkiye and Lebanon who expressed confiding in relatives and friends would clash with their cultural perspectives and instead would prefer to self-manage their psychological distress.

Studies in Türkiye show MHPSS service utilization at RHCs was comparatively higher by Syrian women, this is likely due to integration of services with mental healthcare. However, it is important to note that the gains made in Türkiye is particular to RHCs, while those attending facilities with predominantly specialized care report discriminatory practices due to their nationalities and dissatisfaction with services. Studies in Jordan and Lebanon show Syrian women's reluctance to seek MHPSS services and preference towards culturally accepted, informal services from religious leaders, even as they acknowledge their potential harmfulness. In addition to lack of awareness about services and stigma, this may also indicate inequitable distribution of services, particularly for urban residing Syrian women, unavailability of culturally appropriate or affordable services in host countries. In addition to cost of transport, difficulties renewing residency permits restricts freedom of movement which creates barriers for Syrian women to seek care.

Population characteristics

Demographic characteristics have been shown to affect the prevalence of mental health among Syrian women in the three host countries. However, there are gaps in research focused on demographic characteristics of Syrian women and their effect on utilization of MHPSS services. From available research, older age has been associated with increased risk to mental disorder for Syrian women. However, studies in Jordan and Lebanon show MHPSS interventions have not given enough focus for this high-risk group as there is low likelihood of service utilization among older Syrian women. While the effect of gender is evident in all three countries, studies in Türkiye have shown married Syrian women have a lower likelihood of service utilization. This finding could be due to protective effects of marriage from mental disorder or due to gender related barriers like limited decision-making powers among married Syrian women, increased caretaker responsibilities or prioritization of spouse's needs in terms of transportation, residency permits that allow for free mobility. Even though there is evidence of gender role reversals among Syrian refugees in host countries, studies have also highlighted the persistence of traditional gender norms in host

countries. This was evident particularly in Jordan where Syrian women's movement out of their residence required men's presence (60,62). However, overall increased safety and security risks towards Syrian refugees in host countries, likely increase Syrian women's dependence on male relatives and adds a barrier for MHPSS utilization. Studies on the effect of ethnicity and religion on MHPSS service use were not found. Although most of the Syrian population is Arab and Muslim, studies evaluating potential persistence of ethnic tensions that were present in Syria and their potential effect on interventions were lacking. Even though risks of mental disorders are high for Syrian refugee women who are a part of the LGBTQI+ community, research on their health seeking behaviour was not available in the three countries.

Regarding socio-economic positions of Syrian women, studies have shown their disproportionate vulnerabilities in host countries. Based on studies, this has multiple layers. Affordability of services, including direct and indirect cost, was prevalent in the three host countries. Studies show, Syrian women have low socio-economic positions compared to male counterparts, particularly in Jordan and Lebanon (59,75). Their inclusion into the formal workforce is negligible, and those employed are involved in the informal sectors with low pay and high risk of exploitation (75,82,111) which denies them the financial means to seek MHPSS services. This decreases service utilization in host countries, due to high direct and indirect cost of MHPSS services, particularly for the majority of Syrian women unable to meet basic needs. In Jordan, this may have implication on the differences found in utilization of MHPSS services between urban and camp settings. In Jordan, while camp settings offer proximity to services, Syrian women in urban areas not only lack information about available services but also contend with the additional cost of transportation. Furthermore, studies show most Syrian women in Jordan don't have health insurance and are unlikely to afford services, especially due to recent increases in service cost. Even in Türkiye, where public MHPSS services are provided for free for registered Syrian refugees, studies show transportation cost is perceived as a barrier among Syrian women. These factors likely decrease the likelihood of service utilization.

Acceptability of available services and perceptions towards mental health care providers also affects Syrian women's pattern of seeking MHPSS services. Studies show that concerns about confidentiality and quality of care is a concern with MHPSS services among Syrian women, most notably in Lebanon and Türkiye. This lack of trust in providers may discourage Syrian women to approach MHPSS services, especially since it comes at a high social and financial cost. However, in Lebanon, using MHPSS services was perceived as less stigmatizing when the cause of mental disorder was not focused on the individual but is considered a byproduct of the contextual difficulties shared by the Syrian community. The dissonance between this explanatory model on mental disorder and providers' predominantly biomedical approach, evident in Türkiye and Lebanon, increases hesitancy to services. Providers accommodating for Syrian women's perspectives that alleviate the focus of mental disorder from the individual to the collective, may result in more acceptance towards services and less stigma when Syrian women seek care.

Environmental factors

Host countries, particularly Türkiye and Lebanon, do not give full recognition to Syrians as refugees, but as temporary guests, which curtails certain rights and freedoms. This may limit Syrian refugees' entitlements under these host countries' mental health policy and legislation. All three countries have collaborated with international agencies and NGOs to revise strategies and action plans for MHPSS service provision in PHC to Syrian refugees. However, budget allocation for mental health is concentrated with tertiary care in Jordan and Lebanon which affects MHPSS service provision in more accessible PHC. This is especially relevant in Jordan as recent mapping of MHPSS activities have shown a decrease in community-focused MHPSS towards case-focused services, which limits further limit access to Syrian women. The literature also shows low commitment to psychosocial activities in favour of clinical approach Lebanon. However, research has shown that majority of Syrian women have had higher satisfaction and better mental health outcomes with psychosocial approaches. This policy direction may decrease service utilization by Syrian women.

In Jordan and Türkiye, despite various trainings, including mhGAP for mental health providers, studies show services for gender related trauma are still inadequate. Insufficient female service providers also limit Syrian women's engagement with MHPSS due to cultural and familial influences. However, efforts to integrate Syrian refugees as formal healthcare provider is present in Türkiye while in Lebanon, Syrian professionals work informally. Syrian MHPSS providers could encourage Syrian women to seek MHPSS services as cultural and language barriers are alleviated. In addition, this strategy can alleviate human resource constraints in host countries to expand accessible PHC care to Syrian women. Despite challenges with human resources, studies in Jordan also show restrictions of towards Syrian professionals and Jordanian psychologists who can potentially provide relief to human resource shortages. Furthermore, lack of coordination of services between MHPSS services delivering organizations, particularly in Jordan and Türkiye, affects equitable MHPSS service provision. However, most of these strategies apply to Syrian refugees who have legal registration with appropriate government authorities, services towards unregistered Syrian refugees remain limited.

These issues are further exacerbated by economic and political discourse surrounding Syrian refugees. Blaming Syrian refugees for the economic conditions has increased tensions between host communities and Syrian refugees which in turn increases discrimination and violence. This disproportionately increases Syrian women's security risks, ability to meet basic needs and freedom of movement, which affects MHPSS service utilization. As studies have reiterated, unmet basic needs lead to low prioritization of mental health needs but also shifts the focus of service utilization to a means to fulfil their basic needs. Findings in Lebanon have shown this negatively affects the relationship between Syrian women and their MHPSS service providers (110).

Political environment also affects registration and legal residency of Syrian refugees. Findings show that women are doubly affected based on their nationalities and gender. Lower proportions Syrian women have legal documentations compared to Syrian men due to social and financial barriers. This affects access to free or subsidized mental health services, ability to meet basic needs through employment and free mobility due to fear of detention or repatriation to Syria. The negative rhetoric towards Syrian refugees could also permeate into MHPSS service delivery, particularly in Lebanon and Türkiye. Studies in facilities with Turkish and Lebanese service providers have been reported to be less accommodating or discriminatory towards Syrians refugees which likely has bred mistrust.

The general perceptions of Syrian refugees in host countries, including mistrust from host communities, poor living conditions, and restriction of rights, has influenced Syrian women's belief that their mental health status will improve using MHPSS. This may hinder the use of MHPSS services if they are seen as ineffective without the possibility of resettlement.

Outcomes

In the three host countries, studies show Syrian women report better health outcomes with psychosocial services, particularly counselling and psychoeducation. In addition, incorporating digital platforms and CA-CBT have had positive outcomes for Syrian women's mental health. These interventions can reduce barriers for Syrian women for whom transportation costs, childcare responsibilities or cultural differences and language are barriers to use MHPSS activities. Studies on group behavioural therapy have also shown success in Jordan, which potentially increases Syrian women's social support systems and decreases isolation but also can capitalize on Syrian women's preference to confide in social networks. However, there was lower degrees of satisfaction among Syrian women receiving care at specialized care levels, particularly in Lebanon and Türkiye, but higher satisfaction rates with services provided by non-specialists. This is likely due to low numbers of specialized mental health care professionals for the population needs and even less professionals trained on culturally appropriate mental healthcare.

CHAPTER 4

Conclusion

This literature review explored and described understanding of mental disorders and factors affecting health seeking behavior for mental healthcare services among Syrian women living in Türkiye, Jordan and Lebanon. The phase-4 Andersen behavioral model was used to categorize and present findings.

The factors influencing Syrian women's pursuit of mental healthcare are complex and multifaceted. Starting with personal characteristics and community norms, to systemic and structural influences which have strong intersections. This comprehensive analysis reveals insights into these dynamics and highlights areas for intervention and improvement.

Syrian refugee women's health-seeking behaviour is influenced by their community's understanding and attitudes toward mental disorders. Prevalent lack of awareness about mental disorders and associated stigma adversely affects health seeking behaviour for mental healthcare. Limited awareness about MHPSS and stigma towards services hinders utilization. Community focused MHPSS services including activities to increase awareness will result in better engagement of Syrian women and awareness of free or subsidized services.

Limited availability of trained mental health professionals with cultural competence and the presence of language barriers, particularly in Türkiye, has affected effective communication and resulted in mistrust of providers. The proportions of professionals with gender-based trauma management are also inadequate for Syrian women's needs. Incorporating regular training of professionals on management of gender-based trauma and cultural appropriate interventions will result in higher utilization of services by Syrian women. Training should extend to translators working in MHPSS interventions. In addition, increasing the number of Syrian professionals and women mental health providers will contribute to alleviate human resource shortages while increasing access of services to Syrian women.

Socio-cultural and systemic barriers such as caretaker responsibilities, and restrictive legal status have affected Syrian women's access to MHPSS services. Increasing community-based services and better integration of MHPSS with PHC will promote patient-centred, equitable care. These include innovative interventions through digital platforms based on appropriate assessment of the context. Development of policies and planning of interventions for Syrian refugees should be evidence informed and gender responsive. Development of frameworks to facilitate better coordination among service providers will enhance equitable service provision.

Finally, research of gendered aspects of MHPSS service utilization in the three host countries is limited and not inclusive. To amplify the voices of Syrian refugee women and advocate for their mental healthcare needs and sustainable solutions, there needs to be increased research and publication that identifies the most at risk Syrian refugee women.

Chapter 5

Recommendations

Authorities, service providers and researchers responsible for providing and evaluating MHPSS services should play an active role in the provision of services to Syrian women. With that in-mind the following interventions are recommended

Policymakers:

1. Develop culturally appropriate policies:
    - Mandate cultural competence training for all mental healthcare providers to enhance understanding of the Syrian refugees' cultural backgrounds.
    - Facilitate the recruitment of Syrian and women mental healthcare providers to improve communication and cultural responsiveness.
    - Support community-based services and psychosocial support activities.
    - Examine refugee health policies' and strategies' ability to address Syrian refugees women's needs.
2. Enhance service integration and accessibility:
    - Advocate for policies that ensure mental health services are at an affordable subsidized rate or free for Syrian refugees.
    - Develop coordination frameworks of MHPSS activities for equitable service provision.
    - Increase integration of mental health services within primary healthcare and other health services for Syrian women including reproductive health care and paediatric care.
    - Develop and support mobile health units to provide services in remote or underserved areas to reduce transportation barriers.

Service Providers:

1. Cultural sensitivity and competence:
    - Undergo regular training on cultural competence and the specific mental health needs of Syrian refugee women considering the patient's characteristics such as gender, language and their socio-economic background.
    - Train and employ Syrians for MHPSS as translators or service providers to bridge language and cultural gaps and incorporate explanatory models of mental disorder in treatment provision.

- Provide translators that are not of Syrian origin with culturally sensitive training programs

2. Integrated and equitable service delivery:
    - Offer integrated mental health services within existing healthcare facilities for Syrian women to ensure comprehensive care.
    - Collaborate with community organizations to provide support that addresses both mental health and socio-economic needs.
    - Assess feasibility and implement digital health solutions and telemedicine to reach Syrian women who face mobility and transportation challenges.
3. Community-based approaches:
    - Integrate community-based mental health services with community awareness programmes
    - Develop and promote community-based mental health programs, such as group therapy separated by gender, leveraging the strong social networks within Syrian communities.
    - Increase safe spaces within the community where Syrian women can discuss mental health issues openly and receive support.
    - Provide psychoeducation to both individuals and groups to improve understanding and management of mental health conditions.
    - Provide community-based childcare services for Syrian women inability to access care due to caretaker responsibilities.

Researchers:

1. Conduct in-depth studies:
    - Investigate specific mental health needs and challenges faced by Syrian refugee women in each host country.
    - Examine the effectiveness of various mental health interventions through a gender perspective and identify best practices.
    - Study the impact of socio-economic, cultural, and legal factors on mental health service utilization among Syrian refugee women.
2. Disaggregate demographic and socio-economic factors affecting mental health by gender:
    - Ensure research includes disaggregated data to understand the unique experiences and needs of different subgroups to identify more vulnerable populations.
    - Use this data to inform and advocate for targeted interventions and policies.

- Research outputs particularly about Syrian women in LGBTQI+ communities need to increase.

3. Evaluate and improve Services:
    - Conduct regular evaluations of mental health services provided to Syrian refugee women to identify gaps and areas for improvement.
    - Collaborate with service providers and policymakers to implement evidence-based improvements.
    - Share findings with a broad audience, including international organizations, to foster global best practices.

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ANNEX

Annex 1: IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings

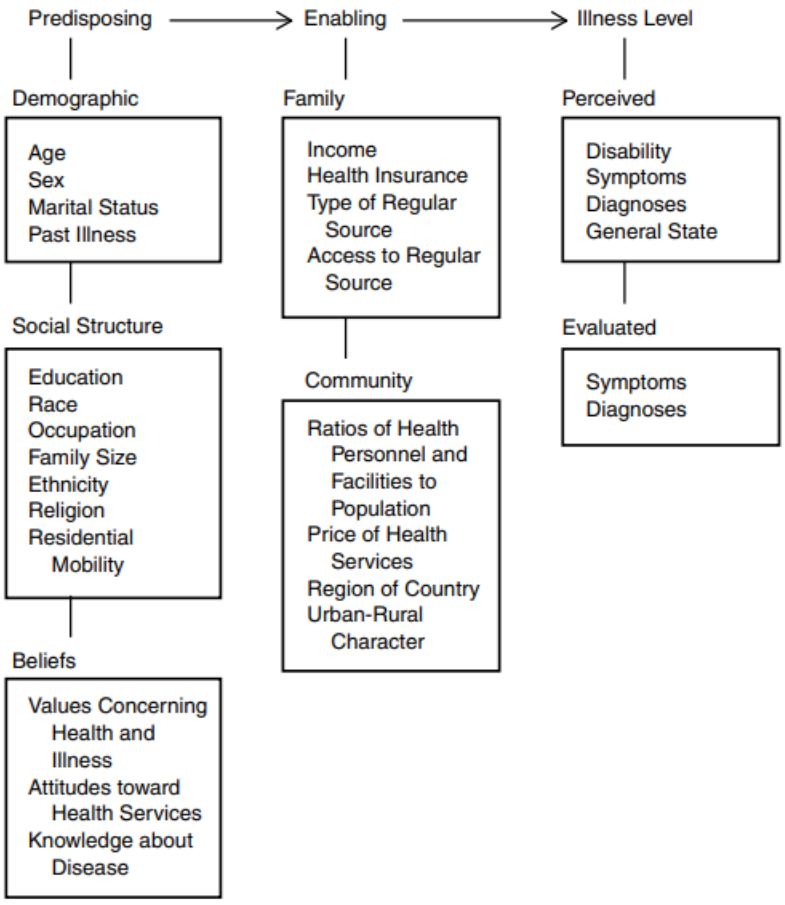
Multi-layered supports

In emergencies people are affected in different ways and require different kinds of supports. A key to organizing mental health and psychosocial support is to develop a layered system of complementary supports that meets the needs of different groups. This may be illustrated by a pyramid (see Figure 1). All layers of the pyramid are important and should ideally be implemented concurrently.

1. Basic services and security: The well-being of all people should be protected through the (re)establishment of security, adequate governance and services that address basic physical needs (food, shelter, water, basic health care, control of communicable diseases). In most emergencies, specialists in sectors such as food, health and shelter provide basic services. An MHPSS response to the need for basic services and security may include advocating that these services are put in place with responsible actors; documenting their impact on mental health and psychosocial well-being; and influencing humanitarian actors to deliver them in a way that promotes mental health and psychosocial well-being. These basic services should be established in participatory, safe and socially appropriate ways that protect local people's dignity, strengthen local social supports and mobilize community networks
2. Community and family supports: The second layer represents the emergency response for a smaller number of people who can maintain their mental health and psychosocial well-being if they receive help in accessing key community and family supports. In most emergencies, there are significant disruptions of family and community networks due to loss, displacement, family separation, community fears and distrust. Moreover, even when family and community networks remain intact, people in emergencies will benefit from help in accessing greater community and family supports. Useful responses in this layer include family tracing and reunification, assisted mourning and communal healing ceremonies, mass communication on constructive coping methods, supportive parenting programs, formal and non-formal educational activities, livelihood activities and the activation of social networks, such as through women's groups and youth clubs.
3. Focused, non-specialized supports: The third layer represents the supports necessary for the still smaller number of people who additionally require more focused individual, family or group interventions by trained and supervised workers (but who may not have had years of training in specialized care. This layer also includes psychological first aid (PFA) and basic mental health care by primary health care workers.
4. Specialized services: The top layer of the pyramid represents the additional support required for the small percentage of the population whose suffering, despite the supports already mentioned, is intolerable and who may have significant difficulties in basic daily functioning. This assistance should include psychological or psychiatric supports for people with severe mental disorders whenever their needs exceed the capacities of existing primary/general health services. Such problems require either a referral to specialized

services if they exist, or initiation of longer-term training and supervision of health care providers. Although specialized services are needed only for a small percentage of the population, in most large emergencies this group amounts to thousands of individuals.

Annex 2 : Andersen's 3 factor model of health service use



Annex 3 : research table

"Syrian refugee" OR "Syrian women" OR Syrian refugee women OR Syrian transgender women OR lgbtiq Syrian women AND mental health care utilization OR MHPSS utilization OR health seeking OR mental health service use OR mental healthcare utilization OR psychosocial support utilization AND Türkiye OR Türkiye OR Lebanon OR Jordan OR middle east OR age OR religion OR marital status OR family size OR number of children OR income OR health insurance OR cost of mental health service OR healthcare personnel OR residence OR perceived needs OR evaluated needs OR personal health practices OR coping OR perceived health status OR satisfaction OR health policy OR financing OR organization OR cultur* OR econom* OR politic* OR legal

		AND			
OR	Domain 1	Age	"Syrian refugee" "Syrian women" Syrian refugee women Syrian transgender women lgbtiq Syrian women	mental health care utilization MHPSS utilization health seeking mental health service use mental healthcare utilization psychosocial support utilization	Türkiye
		Religion			Türkiye
		Marital status			Lebanon
		Family size			Jordan
		Number of children			Middle east
		Income			
		Health insurance			
		Cost of health service			
		Healthcare personnel			
		Residence			
		Perceived needs			
		Evaluated needs			
	Domain 2	Personal health practices			
		Coping			
	Domain 3	Perceived health status			
		Evaluated health status			
		Consumer satisfaction			
	Domain 4	Health policy			
		Financing			
		Organization			
		cultur*			
		econom*			
		politic*			
		legal			