

Sexual and reproductive health:
Health access challenges faced by displaced Syrian
women in Lebanon

Organized by:

Koninklijk Instituut voor de Tropen - **KIT** (Royal Tropical Institute) Health Unit

In co-operation with:

Vrije Universiteit Amsterdam - **VU** (Free University of Amsterdam), the Netherlands

MSc in International Health (Erasmus+)

School year: 2016/2017

Student: Anouar Trabelsi

From: Tunisia

Word count: 12441

Sexual and reproductive health:
Health access challenges faced by displaced Syrian women in Lebanon

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

By:

Name Participant: Anouar Trabelsi

Country Participant: Tunisia

Declaration: Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements. The thesis Sexual and reproductive health: Health access challenges faced by displaced Syrian women in Lebanon is my own work.

Signature:.....



Master in International Health 12 September 2016 – 8 September 2017 KIT
(Royal Tropical Institute)/ Vrije Universiteit Amsterdam Amsterdam, The
Netherlands

September 2017

Organised by:

KIT (Royal Tropical Institute) Health Unit Amsterdam, The Netherlands

In co-operation with:

Vrije Universiteit Amsterdam/ Free University of Amsterdam (VU) Amsterdam,
The Netherlands

Table of contents

Table of contents	ii
List of tables and figures	iv
Acknowledgements:	iv
List of acronyms	vi
Glossary	vii
Abstract:.....	ix
Background:.....	ix
Methodology.....	ix
Results	ix
Conclusion.....	ix
Keys words:	x
Introduction	1
Chapter 1 : Background.....	3
Chapter 2 : Problem statement, Justification, Objectives and Methodology.....	6
2.1. Problem statement	6
2.2. Justification:	7
2.3. Objectives:	7
2.3.1. General objective	7
2.3.2. Specific objectives:	8
2.4. Methodology:	8
2.4.1. Search technique and databases	8
2.4.2. Key words.....	8
2.4.3. Conceptual framework	9
2.4.4. Inclusion criteria:	10
2.4.5. Limitations	10
Chapter 3 : SRH needs, coping mechanisms and services use.....	12
3.1. Needs:	12
3.1.1. Predisposing characteristics.....	12
3.1.2. Enabling resources	15
3.2. Coping mechanisms and health services use:	17
3.2.1. Health behaviours:	17
3.2.2. Outcomes:	19
Chapter 4 : Health and social response.....	22

4.1. Health care system	22
4.2. External environment.....	24
Chapter 5 : interventions overview from neighbouring countries	26
5.1. Turkey	26
5.2 Jordan.....	29
5.3 Iraq	33
Chapter 6 : Discussion.....	36
Chapter 7 : Conclusion and recommendations	40
Recommendations:.....	41
7.1. National level: government of Lebanon.....	41
7.2. International level: INGOs and international civil society	41
References:.....	43

List of tables and figures

TABLE 1 : SEARCH KEY WORDS.....	8
TABLE 2: FOOD INSECURITY.....	17
TABLE 3: PERCEPTION OF SYRIAN WOMEN IN LEBANON TO SRH SERVICES, 2014 (RE.	21
TABLE 4:DEMOGRAPHIC CHARACTERISTIC OF SYRIAN WOMEN IN TURKEY, 2014.....	27
TABLE 5: PLACE OF DELIVERY OF SYRIAN WOMEN, TURKEY 2014.....	28
TABLE 6 : HOUSING CONDITIONS OF SYRIAN REFUGEES OUT OF CAMPS.....	30
TABLE 7 : PLACE OF DELIVERIES.	31
TABLE 8 : EDUCATION AMONG MWRA OF SYRIAN WOMEN COMPARED TO JORDANIANS	32
FIGURE 1: LEBANON AND NEIGHBOURING COUNTRIES	3
FIGURE 2 : MOST VULNERABLE LOCALITIES INCLUDING DISPLACED SYRIANS AND HOST COMMUNITY, LEBANON 2017	4
FIGURE 3 : ANDERSEN'S BEHAVIOURAL MODEL AND ACCESS TO MEDICAL CARE 4TH EDITION	9
FIGURE 4 : SYRIAN REFUGEES AGE DISTRIBUTION, LEBANON 2017.....	12
FIGURE 5 : SYRIAN FEMALE MARITAL STATUS IN NORTH LEBANON AND BEKAA, 2014	13
FIGURE 6 : REASON FOR NOT ACCESSING ANC, LEBANON 2016	16
FIGURE 7 : REASONS FOR NOT ACCESSING PNC BY SYRIAN WOMEN, LEBANON 2016	17
FIGURE 8 : PLACE OF DELIVERY AMONG SYRIAN WOMEN IN LEBANON, 2016.....	19
FIGURE 9 : CONTRACTED HEALTH FACILITIES BY UNHCR DISTRIBUTION IN LEBANON, 2017.....	23
FIGURE 10 : SYRIAN REFUGEES DISTRIBUTION ACCORDING AGE IN JORDAN, 2017 ...	29
FIGURE 11 : POPULATION AGE DISTRIBUTION INSIDE CAMPS, JORDAN 2017.	30
FIGURE 12 : POPULATION AGES DISTRIBUTION OUTSIDE CAMPS, JORDAN 2017.	30
FIGURE 13 : SYRIAN POPULATION IN IRAQ, 2017.	33
FIGURE 14 : POPULATION INSIDE THE CAMPS, IRAQ 2017.	33
FIGURE 15 : POPULATION OUTSIDE CAMPS, IRAQ 2017	34

Acknowledgements:

First, I want to say "Thank you" to KIT: tutors and administration for supporting me. I am grateful to my two back-stopper and thesis supervisor for their patience, motivation and for sharing their knowledge with me. Their guidance helped me all the time of research and writing of this thesis.

Also I am grateful to my family and friends who have morally and spiritually supported me through this thesis and life in general, with a special mention to my mother "Lella Baya Wahdi" for believing and pushing me to be a better person.

Finally, thank you to my NTC, MIH and ICHD colleagues. It was great to meet you all, sharing great time and eternal memories.

List of acronyms

ECHO	European Community Humanitarian Aid Office
GBV	Gender Based Violence
GPD	Gross Domestic Product
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IPV	Intimate Partner Violence
MDGs	Millennium Development Goals
MoPH	Ministry of Public Health
MSF	Médecins sans frontières
MWRA	Married Women of Reproductive Age
NGO	Non-Governmental Organizations
PHC	Primary Health Care
PNC	Post Natal Care
RTIs	Reproductive Tract Infections
SES	socio-economic status
SGBV	Sexual Gender Based Violence
SRH:	Sexual and Reproductive Health and Rights
SRHR	Sexual and Reproductive Health
STDs	Sexual Transmitted Infections
UN	United Nations
UNHCR	United Nations High Commission for Refugees
WHO	World Health Organisation

Glossary

From International Organisation for Migration (IOM) Glossary On Migration, 2nd edition, 2011 (IOM 2011):

Refugees:

.....A person who, "owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country. (Art. 1(A)(2), Convention relating to the Status of Refugees, Art. 1A(2), 1951 as modified by the 1967 Protocol). In addition to the refugee definition in the 1951 Refugee Convention, Art. 1(2), 1969 Organization of African Unity (OAU) Convention defines a refugee as any person compelled to leave his or her country "owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country or origin or nationality." Similarly, the 1984 Cartagena Declaration states that refugees also include persons who flee their country "because their lives, security or freedom have been threatened by generalized violence, foreign aggression, internal conflicts, massive violations of human rights or other circumstances which have seriously disturbed public order. (IOM 2011, p.79,80)

Displaced:

.....A person who flees his or her State or community due to fear or dangers for reasons other than those which would make him or her a refugee. A displaced person is often forced to flee because of internal conflict or natural or man-made disasters. (IOM 2011, p.29)

Asylum-seeker:

.....A person who seeks safety from persecution or serious harm in a country other than his or her own and awaits a decision on the application for refugee status under relevant international and national instruments. In case of a negative decision, the person must leave the country and may be expelled, as may any non-national in an irregular or unlawful situation, unless permission to stay is provided on humanitarian or other related grounds. (IOM 2011, p.12)

Guests:

....It is the given status to the Syrian refugees in Turkey by the government. "...the Syrian refugees may enjoy de facto protection but their status is open to interpretation and to revocation. It lacks the minimum guarantees that the full application of the 1994 Turkish Asylum Regulations would provide"(EMHRN 2011, p.2).

Refugee, displaced, asylum seeker and guest are used in a similar meaning to refugees in this thesis. The definition of refugee according to the International Organisation for Migration is applicable to all Syrians who flee their country despite of the political used term in the receiving countries.

Sexual and Reproductive Health and Rights (SRHR):

.....encompass the right of all individuals to make decisions concerning their sexual activity and reproduction free from discrimination, coercion, and violence. Specifically, access to SRHR ensures individuals are able to choose whether, when, and with whom to engage in sexual activity; to choose whether and when to have children; and to access the information and means to do so. (UN Fondation 2015, p.3)

Abstract:

Background: Lebanon hosts 1.5 million Syrian refugees by 2017 which make it the country with the highest refugee concentration per capita in the world (GoL and UNHCR 2017; ECHO 2017). The continuously increase since 2011 of the population created a shock to the health system. Refugees and especially women and girls as the most vulnerable health are affected. Sexual and reproductive health and rights of women was particularly influenced by the socio-economic determinants. Women and girls were exposed to violence including sexual violence, unmet needs of contraceptives, unfollowed pregnancies, and low use of antenatal care and post-natal care services. In fact, 70% of refugees in Lebanon are living under the poverty line by 2016 (Amnesty 2016). The Lebanese government refused to set any camp to receive refugees and by mid-2015 the Lebanon-Syrian borders were closed to stop refugees' arrival. By consequence, the number of unregistered Syrian refugees increased. As a consequence, women have more difficulties to reach health and social support as well (ECHO 2017).

This study includes a description of the various interventions made in the neighbouring countries (Turkey, Jordan and Iraq) and the good practices that could be adapted in Lebanon to meet displaced Syrian women sexual and reproductive needs.

Methodology: a desk study based on a review of the academic and grey literature. Andersen's Behavioural Model and access to medical care 4th edition was used to analyse the findings.

Results: Syrian refugees are living in sub-standardized houses (UNHCR et al. 2016). They cannot meet the daily needs such food and access to water. Despite the multiple programs to target refugees, there is a lack in the response due to the limitation of funds as by July 2017 only 13% of the needed funds were available (UNHCR 2017d). Refugees cannot afford health care when needed due to the expensive Lebanese health System. Females in need to SRH service are estimated to be 30% of the total refugee influx. The sexual and reproductive health was affected as the contraceptive use declined from 53.9% in 2009 (WorldBank 2017a) to 34.5% in 2014 (Reese Masterson et al. 2014). underage marriage increased 4 times among girls under 18 years (UNFPA 2017b). Socially, female are more exposed to violence including intimate partner violence coupled with low health support (Reese Masterson et al. 2014). Nearly, 50% of Syrian children in Lebanon are out of schools and being exposed to exploitation such as child labour or early marriage (ECHO 2017).

Conclusion: sexual and reproductive health and rights of Syrian women in Lebanon are not met and harmful coping mechanisms are adopted. More data related to maternal and neonatal mortality rates of Syrian nationals in Lebanon and comprehensive studies to assess Syrian women

across Lebanon are needed. An urgent increase of funds to meet targets from the resilience plan is crucial.

Keys words: Syrian women, Refugees, sexual and reproductive health/and rights, Lebanon, services utilisation

Introduction

Nowadays, refugees are the core topic of all news. The world is witnessing the highest refugee movement ever since the Second World War, Syria is the main refugees provider in the world (CDC 2016). The Syrian crisis produced more than 5 million refugees in the middle east (UNHCR 2016c), while an estimated 1.5 million in Lebanon including 1 million registered displaced by 2017 (GoL and UNHCR 2017). Refugees have a high socioeconomic and health vulnerability. The various former studies show that conflict and displacement context have a negative impact especially on women and girls' sexual and reproductive health and rights (SRHR) (Usta & Masterson 2015; Austin et al. 2008; Gagnon et al. 2002). Females are particularly affected in a war and displacement context, they are more exposed to the risk of sexual and gender based violence (SGBV) including intimate partner violence (IPV), early marriage and child bearing, unmet needs for family planning, unsafe abortion and related complications, sexual and transmitted diseases (STDs). These risks lead to higher maternal and neonatal mortality compared to women in stable context (Austin et al. 2008; Sami et al. 2014; El-Masri et al. 2013; Usta & Masterson 2015; Gagnon et al. 2002).

Working in a multidisciplinary clinic with Syrian refugees in Turkey with Médecins sans frontières (MSF) as a project medical referent, gave me the opportunity to hear stories from refugees regarding their experiences with the health system in Turkey in comparison with their relatives' situation in Lebanon. The financial barriers, absence of camps and difficulties to reach health services came out often. Among the health use barriers were the rude behaviour of the Lebanese medical staff toward Syrian refugees, need to pay for health care and medication, and the need to marry young girls as a solution to reduce the household financial burden. The choice to do this literature review about the SRHR needs of Syrian women refugees was triggered by the differences in response of the 2 countries (Turkey and Lebanon) to the same refugee crisis. Also the significant gap observed of studies related to SRHR situation and outcomes of Syrian displaced women in all Lebanon -not only in the most vulnerable areas - despite of the long war duration. The aim of this thesis is to explore the influencing factors on the use of sexual and reproductive health services (SRH) in Lebanon. The term SRHR will be used when the findings are related to women and refugees rights according to the definition made at the International Conference on Population and Development (ICPD).

This thesis intends to identify the use of SRH services and needs of Syrian refugees by exploring the different influencing determinants and the adopted coping mechanisms. In addition, this paper will present various response interventions made in neighbouring countries and what are the good practices, which can be useful for Lebanon to provide women's health needs. Finally, recommendations will be set to optimize the profit

from interventions conducted in Lebanon, to respond to SRHR needs of displaced Syrian women.

Chapter 1 consists on an overview of refugees' situation in Lebanon and description of the socio-economic status (SES) influencing SRHR of Syrian women. Chapter 2 presents the problem statement and the justification of this study. Also, it describes the methodology chosen to elaborate this thesis in addition to the conceptual framework that is used to achieve the objectives described in the same section. Chapter 3 aims to identify different vulnerabilities that Syrian women are exposed to in addition to the different enabling factors put in place by relief actors including the Lebanese government to mitigate them. It seeks to measure the impact of interventions on SRHR needs. Finally, the different adopted coping mechanisms by Syrian women in Lebanon. Chapter 4 presents the role of the Lebanese health system on the interventions, including the predisposing and enabling factors. It describes the external factors influencing the actual response. Chapter 5 outlines the various experiences of the neighbouring countries with Syrian influx. Chapter 6, 7 and 8 include the discussion of the intervention made in Lebanon compared to the other interventions. It contains an analysis of the pros and cons of the main identified interventions. Followed by recommendations concluded from the learnt lessons from neighbouring countries

Chapter 1 : Background

This chapter presents a brief summary of the distribution of Syrian refugees across Lebanon coupled with their SES profile, followed by an overview of interventions and the impact of displaced Syrians in Lebanon. While, demographic details will be discussed in chapter 3 under predisposing characteristics.



Figure 1: Lebanon and neighbouring countries (Taylor Marsh 2014)

Lebanon is located in western Asia and east of the Mediterranean with common borders with Syria and Israel as shown in figure 1. Lebanon is a small country that covers 10,452km² with a mountainous nature and water deficiency resources (CIA 2017a; Cherri 2016). Due to the common borders with Syria, many Syrians chose (willingly or not) Lebanon to seek refuge. Among the 1.5 million displaced whom fled Syria, 52.5% are women including around 30% of the total refugees present in the Lebanese territory are women aged between 12 and 59 years in need of SRH care (UNHCR 2017d). The number of Syrian refugees presents around a quarter of the Lebanese population (GoL and UNHCR 2017), which makes Lebanon as the country with the highest presence of refugees per capita in the world (ECHO 2017). Figure 2 shows that regions close to Syrian borders have the highest refugees' presence. North Lebanon and Bekaa Valley were the most affected by the arrival of refugees due to the already existing poverty among the local community (GoL and UNHCR 2017). In addition to limited financial resources of Lebanese households, only limited health services are available on those areas with an average of 47% of the local population had no access to health services (Reese Masterson et al. 2014). Indeed, social- and health needs increased with the arrival of Syrians fleeing the war.

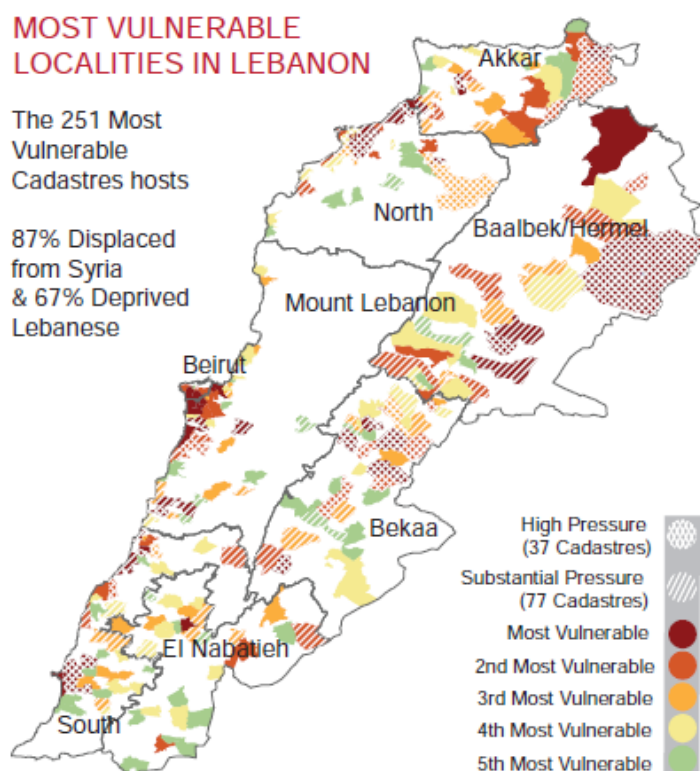


Figure 2 : most vulnerable localities including displaced Syrians and host community, Lebanon 2017 (GoL and UNHCR 2017).

Previous humanitarian emergencies put in evidence the fragility of women and girls in conflicts (Austin et al. 2008; Sami et al. 2014; El-Masri et al. 2013; Usta & Masterson 2015; Gagnon et al. 2002). Syrian women in Lebanon were not an exception as they witness difficulties to access SRH services (Yasmine & Moughalian 2016; ECHO 2017). SRHR needs and outcomes of Syrian women got influenced by contextual factors such as the health system, individual factors such as the bad SES of households or the health behaviour of women and the uptake of the available services.

Efforts from the government of Lebanon and international actors were applied to mitigate barriers to reply to their social and health needs (Dionigi 2016; Cherri 2016). However, only 13% of needed funds were collected by mid-2017 (UNHCR 2017d). As a result, the underfunding of the Syrian crisis response affected many intervention sectors; Shelter, food, cash, core relief items, health and education (Cherri 2016). To cope with the situation, refugees adopted harmful coping mechanisms such as Syrian children work to contribute on house expenditures instead of going to school (GoL and UNHCR 2017). Also, the marriage of teenage girls under 18 years increased 4 times compared to the pre-war period (UNFPA 2017b)- teenage marriage is perceived as a solution to reduce the household financial burden. Early marriage and early child bearing have heavy consequences. In addition to negative health outcomes such as increased maternal and neonatal mortality and increased risk of STDs,

social outcomes can be present such as early school dropout, limited job opportunities and poverty in the future (Mkwananz & Odimegwu 2015).

The Lebanese health system relies on the private health sector with 3.35% (WorldBank 2017b) of Gross Domestic Product (GPD) from a total of 6.4% (Worldbank 2017) of health expenditure in 2014. It is a public-Private partnership; both sectors are working under the umbrella of the Ministry of Public Health (MoPH) (WHO 2006).

Despite the health system coverage: the half of the Lebanese population is covered either with public or private health insurance when the non-covered ones receive support from MoPH (Ammar et al. 2016), in addition to free access to primary health care (PHC) for Lebanese citizens (and Syrian refugees) (GoL and UNHCR 2017). The health system is an expensive one with 70% of the private expenditure are out-of-pocket 2014 , it decreased compared to 75% in 2011 (WorldBank 2017d). As a result the most vulnerable Lebanese community can't afford it (Salti et al. 2010). The limited access to health services will impact the health seeking behaviour: promote traditional practices, use of informal health providers or delay in consultations will impact the general health outcomes and creates burden on the individual and social level (push the person in deeper need and poverty), and on the health system As a result, refugees' health was impacted and more specifically SRHR needs of Syrian female in Lebanon (ECHO 2017).

In 2016, 70% of Syrian refugees in Lebanon were estimated to live under the poverty line (Amnesty 2016). The low financial capacities of refugees has led to poor use of health services in general and SRH services in particular (ECHO 2017). Since the start of the armed conflict, Syrian refugees used their savings in order to survive, coupled with the expensive health system care in Lebanon, makes those health services inaccessible for refugees due to need to pay out of pocket if they are not registered (ECHO 2017)

Lebanon avoided any political commitment towards Syrians fleeing from the war and attributed to them a so called "Displaced" status instead of "Refugees"-in Addition, Lebanon as a host country strictly refused to establish camps for the Syrian refugees(ECHO 2017). Due to it limited capacity to manage the refugees crisis, the government of Lebanon collaborated with international humanitarian actors by facilitating their presence and work in the country in order to respond together to Displaced needs (Dionigi 2016). BY mid-2015, all neighbouring countries including Lebanon closed their borders with Syria (Amnesty 2016). The closure of borders, coupled with the request from the government to United Nations High Commissioner for Refugees(UNHCR) to stop all new registration, was a direct factor to increase the number of unregistered refugees in the Lebanese territory, consequently the difficulty to access to health and social care amplified (ECHO 2017).

Chapter 2 : Problem statement, Justification, Objectives and Methodology

First, this chapter will include a brief description on how SES including living conditions impact on the SRHR outcomes of displaced Syrian women in Lebanon. Secondly, a justification section addresses the reason of this study. Thirdly, the objectives of this thesis will be presented followed by the methodology including the conceptual framework.

2.1. Problem statement

Currently, nearly 800.000 female Syrian refugees are in Lebanon (UNHCR 2017d). The official report released by the government of Lebanon in collaboration with UNHCR states the underuse of SRH services by displaced Syrian women (GoL and UNHCR 2017). This fact comes to confirm findings from other studies (Reese Masterson et al. 2014; Yasmine & Moughalian 2016), for example: the use of contraceptives decreased from 53.9% in 2009 in pre-war time (WorldBank 2017a), to 38% in 2016 (GoL and UNHCR 2017) and the antenatal care (ANC) passed from 87.7% in 2009 (WorldBank 2017e) to 70% in 2016 (GoL and UNHCR 2017). The low uptake of SRH services can be explained by various factors, such as beliefs of unavailability of services or fear of mistreatment, far distance and inability to cover transportation fees (Reese Masterson et al. 2014; GoL and UNHCR 2017).

A survey made by UNHCR in 2016 identified the high cost of services as the main barrier to use ANC and postnatal care (PNC) care as shown in (UNHCR 2016a). MSF reported that due to the expensive birth costs in Lebanon, many Syrian women take the risk to go to deliver inside Syria for free (Aljazeera 2013).

Refugees are not in camps, as decided by the government of Lebanon, but they are scattered in urban areas living in rental houses-the ones who could afford it- or with relatives. According to European Community Humanitarian Aid Office (ECHO), refugees are scattered in more than 1700 localities around Lebanon. In fact 42% of refugees are living in inadequate houses by 2016: overcrowding, dangerous building in need to rehabilitation and lack of toilets (UNHCR et al. 2016).

Women are highly exposed to SGBV including IPV due to the displacement context, studies showed the high prevalence among Syrian women in Lebanon (done only in the most vulnerable areas) (Cherri 2016; Reese Masterson et al. 2014). An assessment among Syrian women showed that 30.8% of the total participants survived to a form of violence while 64.6% of survivors did not seek any medical help (Reese Masterson et al. 2014). The increase of non-registered refugees with UNHCR made the access to health and social services very limited (MSF 2013a). Despite the

financial support that refugees receive from the government and the non-governmental organizations (NGOs), low SES and instability of refugees led to an increase in harmful coping mechanisms to reduce the financial burden of households (GoL and UNHCR 2017) . For instance, children go to work instead of attending schools: by the end of 2016 only 42% of children were enrolled in schools (GoL and UNHCR 2017), and young girls are getting married: in 2011 the teenage marriage was 12% (JCAPA 2016) and it is estimated to be increased by four times by the beginning of 2017 (UNFPA 2017b).

The actual health system stills suffer from sequels of its instable past such as the privatisation of the health sector or unbalanced work forces distribution in addition to the shelling of health structures (Kronfol & Bashshur 1989). This fact makes the health response limited especially that the demand on Lebanese health service increased by 50% since the start of the Syrian crisis (GoL and UNHCR 2017).

UNHCR as a coordinator of interventions targeting Syrian refugees in Lebanon released reports such as vulnerability assessment (UNHCR et al. 2016) or services access and health utilization by the displaced (UNHCR 2016a). However, those surveys are conducted among the registered households which exclude the unregistered ones, presumed more vulnerable as they have less access to health and social support. As consequence and in spite of the long term war in Syria, there is no data regarding maternal mortality, neonatal mortality or SGBV cases. Overall there is limited data regarding health services utilisation by all Syrian women in Lebanon. There is no comprehensive statistics to give real figures on SRHR status of female Syrian refugees in Lebanon.

2.2. Justification:

Despite the learnt lessons from previous humanitarian crisis putting in evidence the impact of war and displacement context on women and girls' health and reproductive needs (Austin et al. 2008; Usta & Masterson 2015; Gagnon et al. 2002), there is a scarcity on the data related to SRHR needs and outcomes of displaced Syrian women in Lebanon. The unknown knowledge of females refugees' needs, make humanitarian interventions less efficient to target urgent SRHR problems and to reach the most vulnerable groups. The problem is emphasized by the fact that refugees are scattered across the country in addition to the limited funds. A study on them seems justified. Indeed, it is a must to understand the reasons behind the limited use of SRH services by Syrian women in Lebanon and their health behaviour.

2.3. Objectives:

2.3.1. General objective

To describe the SRH needs and health behaviour of Syrian women in Lebanon and the related response, in order to inform policymakers and stakeholder to be more responsive to their needs.

2.3.2. Specific objectives:

1. To describe the SRHR needs and coping strategies of Syrian women refugees in Lebanon
2. To describe the use of SRH services by Syrian women refugees in Lebanon.
3. To analyse the Lebanese health system policies and approaches influencing needs of Syrian women refugee.
4. To explore various interventions and learnt lessons from bordering countries that can be adapted in Lebanon
5. Make recommendations to stakeholders and policy makers to optimize the SRH interventions outcomes for Syrian refugee women in Lebanon.

2.4. Methodology:

2.4.1. Search technique and databases

This research is a desk study based on a review of the academic and grey literature. The research will be conducted with accessing in the following websites: UNHCR, UNFPA, WHO, reliefweb, Amnesty and databases such as PubMed, Cochrane Library, and Google Scholar as search engine. Statistics, data and response plans were obtained from the websites of international actors engaged in the emergency response related to the Syrian crisis.

2.4.2. Key words

Table 1 : search key words

	Introduction/ Background/ Problem statement/	objective1&2	Objective 3	Objective 4
step 1: Broad key words	Syrian, Refugees, Lebanon , women, SRH	Women, sexual reproductive health, teenage marriage	Health system, health policy, influencing factors, politics, economics	Turkey, Jordan, Iraq, Refugees, policies, camps

Step2: combination of key words	refugees AND camps, refugees AND socioeconomics, refugees AND living conditions	refugees AND health access, Women AND health services use, Women and sexual and reproductive health, Women And health behaviour,	Refugees And impact, refugees and health policy, health system AND health workers, Lebanon AND economic AND refugees, Lebanon AND politic	Turkey AND Syrian refugees, Syrian women AND Turkey, Turkey And resilience plan, Iraq AND Syrian refugees, Syrian women AND Iraq, Iraq And resilience plan, Jordan AND Syrian refugees, Jordan women AND Iraq, Jordan And resilience plan
step 3:specific statistics	refugees numbers, Registration, funds	contraceptive use, education rates, teenage marriage, antenatal care; post-natal care, maternal mortality, infant mortality, violence, stress	health expenditure, utilization rates, contracted hospitals,	education, population inside camps, population outside camps, work permit,

2.4.3. Conceptual framework

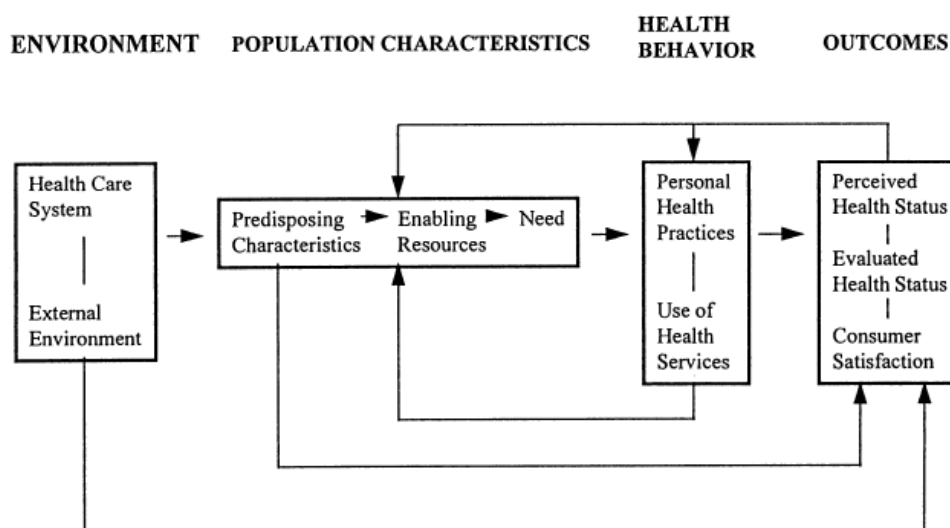


Figure 3 : Andersen's Behavioural Model and access to medical care 4th edition (Andersen 1995)

The Andersen's Behavioural Model and access to medical care 4th edition will be used and adapted to analyse findings and to respond to questions

addressed in this thesis. This framework allows defining challenges that may impede or increase the need for health care and use of services by assessing the individual characteristics. The individual characteristics are factors related to Syrian women and their community. The individual characteristics include predisposing and enabling factors that will allow the identification of female refugees' needs from their perspectives. In addition, the framework helps to assess the impact of the environment characteristics: health system care and external environment- on the health behaviour and health outcomes. The choice made about the use of this model rather than other editions, is due to the flexibility of its different components. The published literature regarding Syrian women refugees in Lebanon are mainly focused on SES of households coupled with a scarcity on data targeting SRHR. The purpose is to build an approximate image of Syrian female by using previous studies together with the available data.

As the model does not detail what should be included under each characteristic category. The factors will be introduced before each section of this thesis. The model explication cited by Andersen & Davidson (2007) and Andersen (1995) will be adapted to define the factors according to the available findings and the pertinence to the topic (Andersen 1995; Andersen & Davidson 2007).

However, this model neglects mental health and psychological factors (Andersen 1995). As it has been proven that psychological factors influence the SRH outcomes (Zahan 2014). This factor will be addressed later on under the predisposing factors

2.4.4. Inclusion criteria:

The articles, data and response plans since the start of the Syrian crisis and the movement of Syrian refugees to Lebanon in 2011 until today will be included in the analysis. Former statistics and indicators related to SRHR in pre-war will be included to analyse the outcomes according to the conceptual framework.

Only practices from countries having common borders with Lebanon will be included in this thesis. It includes: Turkey, Jordan and Iraq.

Only reviews and reports published in English will be included.

2.4.5. Limitations

Data related to refugees may be accurate only for a period of time due to the fast context change. Only data from official reports and official websites regarding refugees' numbers and distribution across the countries were included in this study.

There is a scarcity of the available data and statistics regarding the SRHR status of Syrian women in Lebanon. Data from other receiving countries of Syrian refugees has been used. The results were aligned with previous displacement crisis in addition to the similarity of other findings such SES of the Syrian refugees. They confirm the assumptions made regarding female Syrian refugees in Lebanon.

The Majority of data and statistics related to Syrian refugees in Lebanon were extract from reports released by UNHCR and used as it is either the exclusive coordinator of all interventions such as in Lebanon or in collaboration with the host government as in Jordan. It is important to mention that surveys were conduct among refugees registered with UNHCR.

Chapter 3 : SRH needs, coping mechanisms and services use

The structure from Andersen’s model will be used along this study to analyse the findings. However a modification on the structure of this chapter will be made in order to identify SRHR needs of Syrian women in Lebanon as suggested in the specific objectives.

3.1.Needs:

3.1.1. Predisposing characteristics

In order to identify the needs of female refugees related to SRHR we will study the so called predisposing factors. The predisposing factors in this chapter are: demographic factors (gender distribution, age and marital status), the social factors such as ethnicity/religion, spoken languages, education, living conditions, family size and beliefs (values concerning health and illness, attitude toward health services, knowledge about disease). In addition to the identification of influencing factors, this chapter shows how they are correlated with SRHR outcomes and needs.

52.5% of refugees in Lebanon are females divided as shown in figure 4 including around 30% within reproductive age brackets, in need of SRH service (UNHCR 2017d).

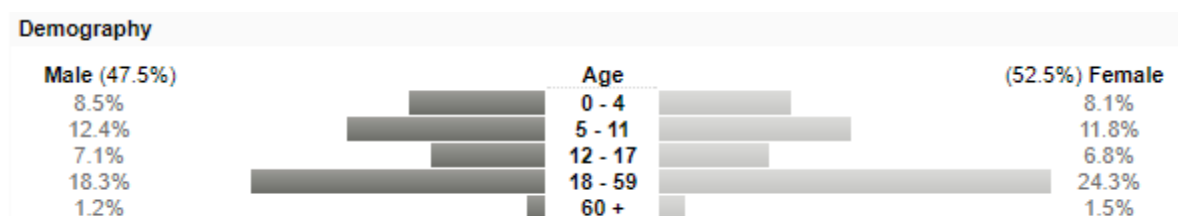


Figure 4 : Syrian refugees age distribution, Lebanon 2017 (UNHCR 2017e).

Syrian women living by their own such widow, female-headed households and divorced and young girl are more exposed to harassment and sexual exploitation (El-Masri et al. 2013; Yasmine & Moughalian 2016). In Lebanon, the majority of adult Female refugees are married as detailed is figure 5. However, the majority of married women are responsible of households as the husbands are absent, they count for 85% in 2016 (UNHCR et al. 2016).

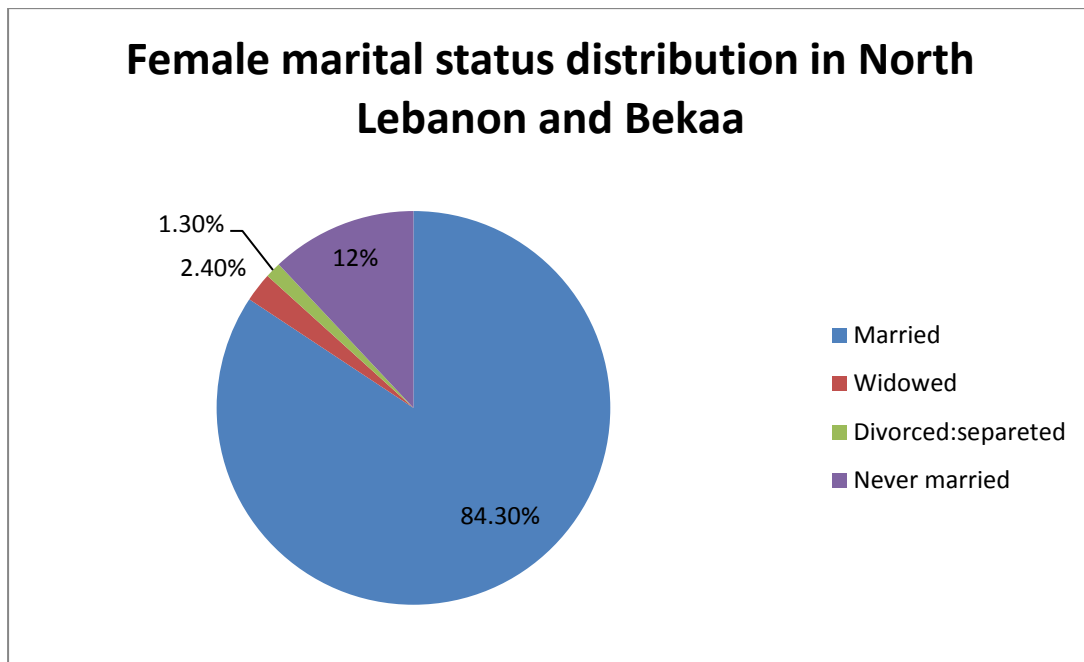


Figure 5 : Syrian female Marital Status in North Lebanon and Bekaa, 2014 (Reese Masterson et al. 2014)

Socially, Islam is the predominant religion among Syrians (87% versus 13% other religion minorities) (CIA 2017b; CDC 2016). Arabic is the main spoken language in Syria. In addition to other minor languages, English and French are spoken and understood mainly among the educated people (CDC 2016). In Syria, there is no big discrepancy between male and female education ratio. The literacy rate among female Syrians above 15 years old was above 80% by 2015 (WorldBank 2015). Nowadays, the educational attainment among Syrian displaced children aged between 3 years and 14 years old is low, as half of them have no access to any form of education (ECHO 2017). In fact, children not attending schools have less access to sexual education, less job opportunities more poverty threat in the future and are more susceptible to be abused in early marriage and early child bearing (Chaaban & Cunningham 2011; Mkwanzanz & Odimegwu 2015).

The war pushed refugees into poverty; the majority of the displaced Syrians are living in hard economic conditions. Since their arrival to the host country, refugees depend on their savings to cover rent and daily living costs (Cherri 2016). After more than 6 years, most likely displaced spent all savings and they are pushed to poverty and bad coping mechanism, which will be discussed in the next section. 70% of the displaced Syrians in Lebanon are living under the poverty line (Amnesty 2016). Refugees are dispersed all over the country due to the absence of camps in more than 1700 localities (ECHO 2017). The Syrians poverty can be reflected on the bad housing conditions such as living in unfinished buildings or construction sites in addition to the lack of running water and

appropriate latrines and sanitation (UNHCR et al. 2016; Cherri 2016; GoL and UNHCR 2017). In fact, findings from a former study in displacement sitting among female refugees established the link between the lack of hygiene and reproductive tract infections (RTIs) among this group (Balsara et al. 2010). Indeed, RTIs are often reported by medical NGOs (MSF 2013b). Beside the living conditions, refugees adopted bad habits secondary to the limited financial capacity. Usta & Masterson (2015) in their study showed in this respect that 49.7% of Syrian female did not seek SRH care due to the inability to cover the health fees care, also the food intake (quality and quantity) got negatively influenced (Usta & Masterson 2015).

Syrian families are characterized to be large with an average of 5.1 members (UNHCR et al. 2016). Actually, some women reported to be sharing houses with more than 5 children and 5 adults (Reese Masterson et al. 2014; Usta & Masterson 2015). The family size can be interpreted in two ways how it interferes with SRHR. First, the expenditures on basic needs (e.g: food) of households are high, coupled with the poverty affects SRHR outcomes as explained above. Secondly, it can be a risk factor of psychological concerns. Stress was associated to menstrual irregularities, severe pelvic pain and RTIs symptoms (Reese Masterson et al. 2014; Usta & Masterson 2015).

Before the war, Syrians were used to high quality health service in their country. They were used to seek health care when needed and there was trust towards the health provider (CDC 2016). The rate of births attended by skilled health professional reached 96% in 2007 (last available data) which is very high compared to 58% regionally (WHO 2015).

The health seeking behavior is influenced by cultural norms and religious belief, such as the belief that women should be consulted by female doctors (CDC 2016; Kridli 2002; Roudi-Fahimi 2003). Beside the financial barriers, the scarcity of female medical staff presents an additional hurdle to use SRH service especially (Reese Masterson et al. 2014). Also, extramarital sexual relationships are not allowed (Roudi-Fahimi 2003). As a consequence, non-married women may not seek SRH care when needed. They may lack access to contraceptives, be more exposed to STDs, unwanted pregnancies and by consequence unsafe abortion.

Culturally, large families are common and appreciated but contraceptives were largely used among Syrian women before the war with a percentage of 53.9 in 2009 (most available recent data) (WorldBank 2017a). The study conducted by Reese Masterson et al (2014) showed that only 34.5% in 2014 of displaced female are using contraceptives (Reese Masterson et al. 2014). This result is aligned with the findings from the study conducted by Benage et al (2015) and the official report released by the lebanese government in collaboration with UNHCR (GoL and UNHCR 2017; Benage et al. 2015). As identified obstacles, low financial

capacity, distance from the health facilities, unavailability of contraceptives of choice and fear were pointed out by Syrian women (GoL and UNHCR 2017; Benage et al. 2015; Reese Masterson et al. 2014). Also, frustrated husbands who are unable to fulfil their duties as the head of family are interfering in women's decisions regarding contraceptive use or choice of method (Yasmine & Moughalian 2016). Finally, caesarean section rates reached 30% in 2016 (GoL and UNHCR 2017) compared to 26.4% in 2009 (UNICEF 2013) which makes Syrian women are exposed to factors such the encouraging environment -as caesarean section is popular among Lebanese women with 44% from the total deliveries (GoL and UNHCR 2017)- or/and forced caesarean sections as it was proven (Yasmine & Moughalian 2016).

3.1.2. Enabling resources

This section presents the enabling factors that were collected from the various sources in favour to increase or improve SRHR indicators of displaced Syrian women in Lebanon. It includes financial and social determinants in addition to the organisational resources such as transportation, access to SRH services or the availability of providers.

In addition to cash support and seasonal assistance during winter which are being distributed to the vulnerable Syrian refugees' families, women are receiving UNHCR financial support with 75% of obstetric and lifesaving fees (Yasmine & Moughalian 2016). In some circumstances, the percentage reaches 90% if the household is proved to be severely vulnerable and while SGBV cases are fully covered (GoL and UNHCR 2017). In fact the government of Lebanon made PHC and reproductive health free of charge for displaced Syrians (GoL and UNHCR 2017). In addition to UNHCR financial support to deliveries cost, in some cases refugees can solicit the remaining fees from other NGOs (Yasmine & Moughalian 2016; GoL and UNHCR 2017).

The financial support helps refugees to preserve their dignity, to reply to the basic needs such as food, health or shelters. Also, one of the aims of monetary aid is to reduce and limitation of bad coping mechanisms, a study showed that receiving the cash support reduce the exposure to violence- 33% of the beneficiaries are women headed households (GoL and UNHCR 2017; Cherri 2016). In fact women headed households are more exposed to sexual advances against money (Yasmine & Moughalian 2016).

Women need to have UNHCR registration documents to be able to benefit from the above mentioned services (MSF 2013a). In addition to health care support, NGOs took the responsibility to cover other needs of refugees such as: Shelter, Wash (Water, Sanitation and Hygiene), food, education, protection, energy, basic assistance, livelihood and social stability (GoL and UNHCR 2017; Cherri 2016; Benage et al. 2015).

However, many refugees are not registered with UNHCR for various reasons: lack of information regarding procedures or the appropriate places to register or far distance, Other refugees did not had the necessary papers for registration and they were afraid to be send back to Syria (MSF 2013a). among the displaced who had UNHCR registration around 25% claim not receiving any assistance while 65% claim receiving insufficient assistance to cover their needs (MSF 2013a).

Outreach programs will be focused in areas with high presence of Syrian refugees to target the vulnerable population and to promote the school enrol to be included in the support programs, also to provide protection for Syrian females from exploitation and violence (GoL and UNHCR 2017). In addition, leaflets, to increase the knowledge and awareness of the available services among the refugees are distributed. However information related to health services may not reach the new comer upon their arrival to Lebanon (Benage et al. 2015).

In summary displaced Syrian women in Lebanon are facing many barriers to access SRH services despite efforts put in place by the NGOs. From this section the main identified needs are related to financial support. Women could not afford health care when needed due to high fees of services in addition to the transportation fees and long distance. Also, the assessment done by UNHCR pointed lack awareness regarding services as shown in figure 6 and 7 as a main barrier (UNHCR 2016a). Among women who were aware of the services did not accept the health support due to the lack of female doctors and the contrast with their religion/ethics believes. In the other side, the lack of financial resources was reflected on the living style. Syrian women have difficulties to access to water and to meet hygiene standards while lack of hygiene was associated to RTIs. To response to the identified needs, next section will present the adopted coping mechanisms.

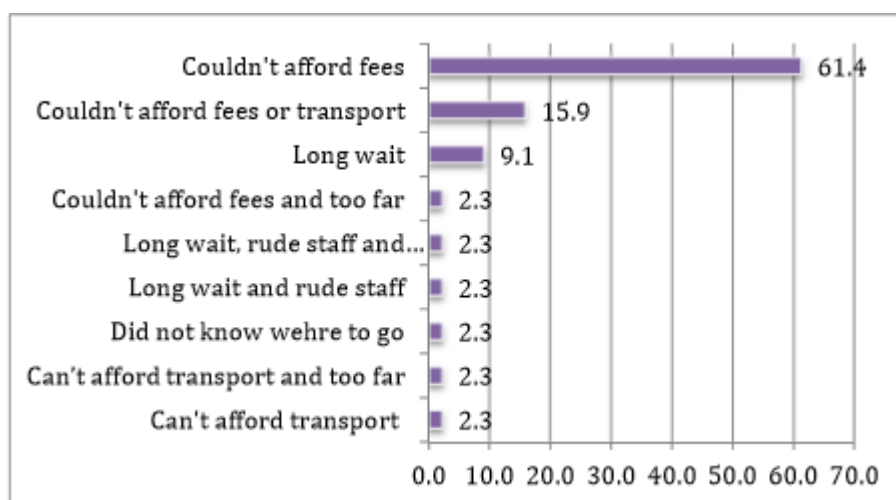


Figure 6 : reason for not accessing ANC, Lebanon 2016 (UNHCR 2016a) .

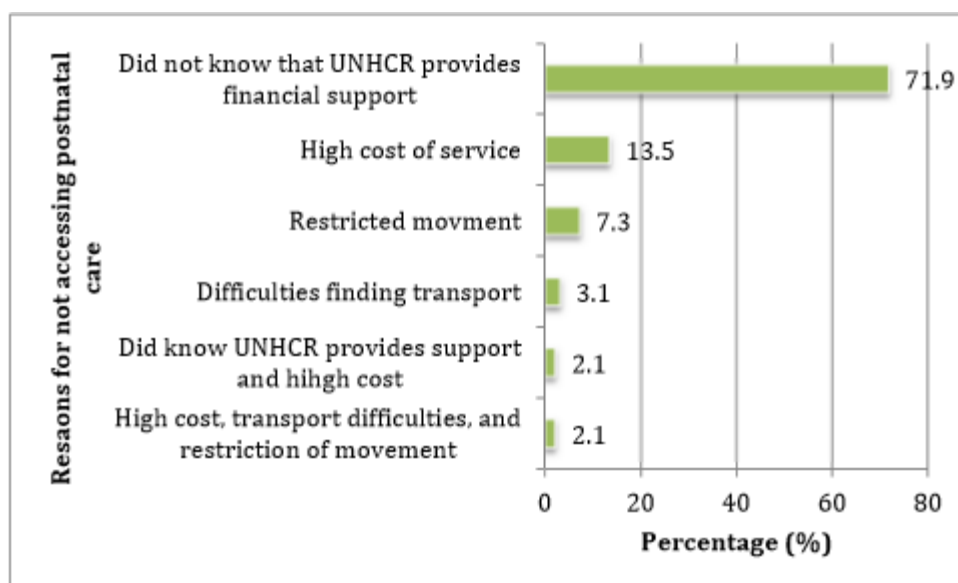


Figure 7 : Reasons for not accessing PNC by Syrian women, Lebanon 2016 (UNHCR 206a)

3.2. Coping mechanisms and health services use:

3.2.1. Health behaviours:

This section presents the health behaviour of displaced Syrian women. Health behaviour can be defined as the personal health practices: such as food/diet, smoking habits, coping with stress that may influence SRHR outcomes and use of formal health services. Also the health behaviour allows assessing the coping mechanisms of Syrian refugees in general and especially female ones to mitigate the barriers related to their SRHR needs or the influencing factors.

Due to low SES conditions cited in the previous section, the lack of financial means pushed women to cope with the situation in a harmful way. Many assessments conducted among the refugees in general (GoL and UNHCR 2017) or targeting the women using SRH clinics (Reese Masterson et al. 2014; Usta & Masterson 2015) reported that women are aware of food insecurity risk and they pushed to change food habits as shown in table 2.

Table 2: Food insecurity (Reese Masterson et al. 2014)

	Percentage (%)
Worry about having enough food (sometimes/often)	62.8
Eat non-preferred food (sometimes/often)	58.4
Skip meals (sometimes/often)	55.1

Total*	176.3
--------	-------

*the total is higher than 100% because women could choose more than 1 answer

Anaemia was largely reported among the women visiting SRH clinics in addition to an imbalanced vitamins diet. Research put in evidence that the undernutrition is related to higher maternal and neonatal mortality rates, low birth weight, preterm birth, abnormal menstrual function and infertility (Hally 1998).

In fact, bad SES conditions pushed refugees to adopt negative alternatives to improve their situation. The teenage marriage increased 4 times since the start of the war, the percentage increased from 12% (JCAPA 2016) in 2011 to more than 40% in 2016/2017 (UNFPA 2017b). Married young girls are usually forced to leave schools, limited access to reproductive health information and contraceptives, maternal and neonatal mortality is higher compared to adult women (UNFPA 2017a). Complications related to early pregnancy and child birth are the main killer of teenage girls 15-19 years worldwide (WHO 2017a).

There are no available accurate statistics regarding safe abortion in Lebanon. While Syrian refugee women in Jordan-similar to Lebanon-have low knowledge about the available services, how to access to family planning and financial barriers; for those reason women wishing to end unwanted pregnancy they will try to carry heavy objects (Krause et al. 2015). Every year unsafe abortion is responsible for 4.7% to 13.2% of maternal death globally, it is one of the main maternal death reasons (WHO 2017b): The related complications can manifest on heavy bleeding, incomplete abortion, uterine perforation (in case sharp material is used), infections or damage to the genital tract and internal organs. According to World Health Organisation (WHO) women lacking access to health and facing financial barriers are highly exposed to unsafe abortion (WHO 2017b). Syrian women in Lebanon meet both conditions.

Figure 8 shows that a high percentage of displaced Syrian women in Lebanon delivered in formal health facilities. According the assessment done by UNHCR the majority of women delivered at home are not receiving any assistance from a skilled birth attendant- again, expensive costs and the low awareness of available services including financial assistance are main causes to opt for home deliveries (UNHCR 2016a).

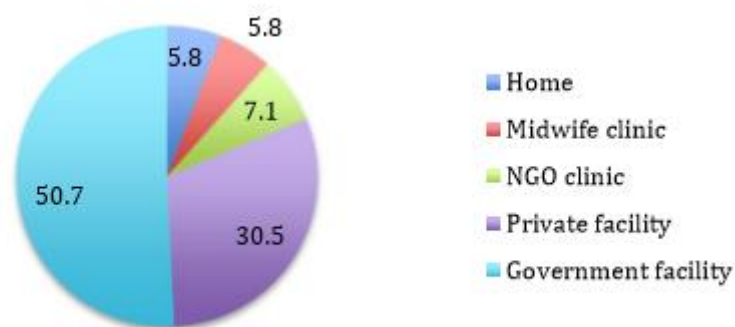


Figure 8 : Place of delivery among Syrian women in Lebanon, 2016 (UNHCR 2016a)

During pre-war time, 17% and 5% of Syrian women were using tobacco and water pipe respectively. More than 15% of young girls aged between 13 and 15 years were using tobacco products as well. Tobacco risk is greater among young adolescent starting early smoking: it increases the chance to get addict in adult age. Maternal smoking is responsible for SRH complications such as low birth weight and miscarriage (Samet et al. 2001). It is needed to put extra attention to harmful practices such smoking, especially among young Syrian girls as they are already exposed to early marriage and related complications. Maternal smoking is varying between areas and according to the selection criteria of each study- the rates are varying between 9.5% (Benage et al. 2015) and 19.9% (Reese Masterson et al. 2014). Women attending ANC have better rates of supplement Iron, vitamin intake and lower smoking rates (Benage et al. 2015). This can be interpreted as women are more exposed to education messages during ANC. It should be expanded to include all Syrian pregnant women in addition to non-pregnant women receiving SRH consultation.

91% of the reported violence case among Syrian refugees are reported after arrival to Lebanon: female (young aged, old women, female heads of household, female living with disability) are the most exposed; among the total 18% survived from SGBV including 7% with rape (GoL and UNHCR 2017). Survivors are exposed to the risk of STDs in addition to the psychological damage. Despite UNHCR is fully covering the SGBV cases, a high number of women witnessing violence did not seek any medical help either for financial reasons or for shame (due to cultural issues) (Reese Masterson et al. 2014) which make them highly exposed to STDs. one of the coping mechanism, 75.8% of women are beating their children more than usual (Reese Masterson et al. 2014). Stress secondary to violence against women was statistically associated to menstrual irregularity, severe pelvic pain, RTIs symptoms and self-rated health (Reese Masterson et al. 2014; Usta & Masterson 2015).

3.2.2. Outcomes:

This section presents the health outcomes. It will be defined as the self-rated health as perceived from displaced Syrian women in Lebanon versus

health professional evaluation to their health. Also, this chapter measures the satisfaction towards the received services by evaluation: travel time, technical care and communication with health providers.

Due to their living conditions and situation as refugees witnessing war which includes losing belongs and relatives, displaced Syrian women are exposed to stress factors including violence. In fact IPV increases in displacement sittings as men are not able to fulfil their duties as responsible of households (Yasmine & Moughalian 2016). It is common that Female underwent stress to feel fatigue and weakness (Steve Bressert 2016). In addition to the risk to develop gynaecological problems, while 53.3% of Syrian women whom experienced violence, reported RTIs symptoms when only 27.2% were medically confirmed as it is (Reese Masterson et al. 2014). There is no statistics related to STDs prevalence among the female refugees in Lebanon despite the high exposure to SGBV. STDs, especially among SGBV survivor needs to receive more interest from the medical actors and the government. It presents a risk factor for the host population, also reduction of Human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS) was one of the achieved MDGs in 2015 (Ammar et al. 2016) which increase the importance of monitoring STDs rates among refugees.

There was no available data about maternal mortality rates among the Syrian refugees separated from statistics of the host countries. Concerning neonatology mortality rate, nn Turkey it reached 18 per 1000 live births (Büyüktiryaki et al. 2015) in 2015 compared to 7 per 1000 live birth in Syria for the same year (WorldBank 2017c). As the refugees in Turkey have similar SES (more details in Chapter 5) as in Lebanon, they share same background, health believes and practices, the assumption is that neonatology mortality rates increased in Lebanon as well.

There is no study where the question “are you satisfied with the available services?” was directly asked. However by interpreting the different perceptions of women to SRH services, an image can be draw. Table 3 shows a significant number of women that find health services are unavailable and inaccessible either for material barriers or by lack of awareness. Female refugees are not satisfied with the requested fees in addition to long distances to reach the facilities. This feeling can be explained by the changes related to the health system approach (out-of-pocket) and the expensive related fees compared to the quasi free SRH services in Syria. Also they have difficulties to communicate with local health providers without being subject of mistreatment or feeling shame. Indeed, the lack of trust on the medical staff that can be seen in the low PNC (GoL and UNHCR 2017) and the abstinence on the use of contraceptives as the Syrian women perceive the aid workers as untrained and don't feel involved in the procedures (Yasmine & Moughalian 2016). The outcomes confirm the findings from previous sections.

Table 3: perception of Syrian women in Lebanon to SRH services, 2014 (Reese Masterson et al. 2014).

	N (%) or Mean (\pm SD)*
Perception of RH service availability:	
Available	171 (37.8)
Unavailable	202 (44.7)
Don't know	76 (16.8)
Perception of RH service accessibility:	
Easily accessible	146 (32.3)
Inaccessible/difficult to access	177 (39.2)
Don't know	47 (10.4)
Perceived barriers to access (n=177):	
Price	88 (49.7)
Distance/transport	45 (25.4)
Fear of mistreatment	14 (7.9)
Security concerns	11 (6.2)
Shame/embarrassment	11 (6.2)
Other	8 (4.5)

*percentages may not sum to 100% due to missing data.

Chapter 4 : Health and social response

This chapter presents a description of the role of the Lebanese health system and the various interventions targeting factors influencing SRHR of Syrian refugee women. The findings will be presented using the environment component from the Andersen's model. First, factors related to the health care system including the national policies and the coordination of interventions, and how this impacts the health outcomes of Syrian refugees in Lebanon afterwards the external influencing the situation of refugees.

4.1. Health care system

An overview of the health care system is presented in this section. It includes the coordination of interventions, resources (financial and human) and locations of interventions

Before starting introducing the actual Lebanese health care system and the refugee crisis, it is important to notify that the system was sensitive to some events such as civil war or political issues that will be discussed in the following section.

In the beginning of the Syrian war the government did not adopt any specific policy regarding refugees. Afterwards, all interventions were under the coordination of UNHCR including the financial management of funds related to the Syrian crisis (Ammar et al. 2016). Since the arrival of refugees in 2011, the utilization rate of health services increased by 50% (GoL and UNHCR 2017). In fact, the primary health care is free of charge to refugees (GoL and UNHCR 2017). UNHCR is responsible to cover the health needs of displaced Syrians. However, due to the lack of funds some conditions were applied: UNHCR prioritizes obstetric care and life saving. In addition, SGBV survivors are 100% covered.

Lebanon as a small country with limited resources depends on the international support to face the Syrian crisis (GoL and UNHCR 2017). However, the humanitarian community is facing difficulties to assure the needed funds from year to year. In 2013 less than 50% of needed funds were collected to drop to 33% in 2014 (Ammar et al. 2016). By July 2017, only 13% of the required funds are met (UNHCR 2017d). Funds' scarcity will narrow the interventions as well as beneficiaries selection criterias. With the support of donors, MoPH managed to meet expectations to supply medicines in spite of the increased demand. The MoPH is delivering health care to refugees through 53 contracted hospital with UNHCR (GoL and UNHCR 2017). They are distributed across the country as shown in the below figure 9.

There is an oversupply of physicians before the start of the crisis (Kassak et al. 2006). In fact this constitutes a positive step toward a better

absorption of Syrian refugees and the increased workload. However, it is not the same situation regarding the number of nurses and paramedical staff in general, there is a shortage on those profiles (Ammar et al. 2016). Nurses and paramedical staff are involved in the process of health care delivery as the physicians. For this, UNHCR empowered health facilities in vulnerable areas with 81 medical staff of different profiles including 40 nurses and midwives (UNHCR 2015b). In fact, there is a discrepancy on the health work force between regions which makes some areas more vulnerable than others (Kassak et al. 2006). It happens that high percentage of Syrian refugees is located in the same vulnerable areas.

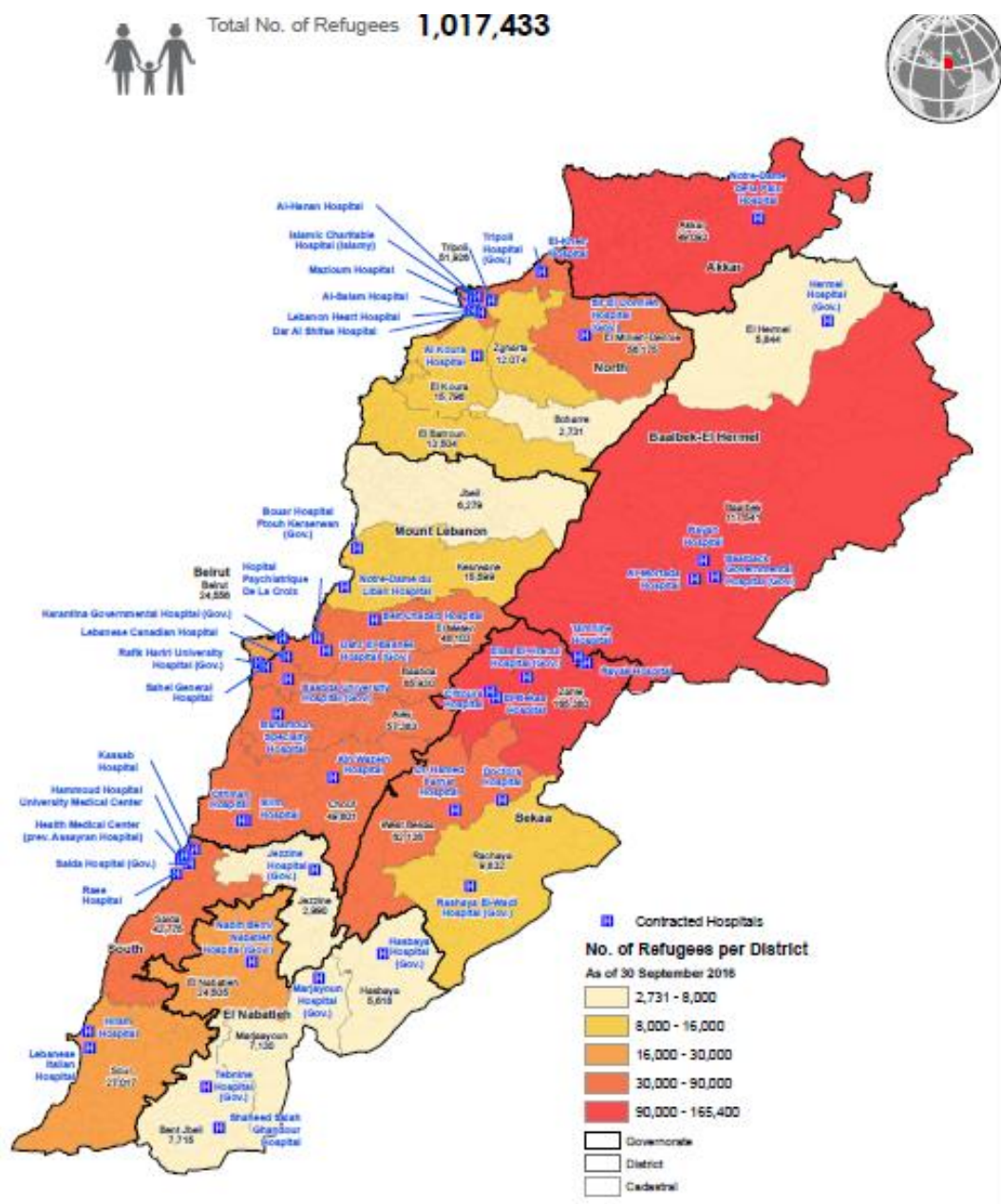


Figure 9 : contracted health facilities by UNHCR distribution in Lebanon, 2017 (UNHCR 2017b)

4.2.External environment

This section explains how the Lebanese health system was weakened in the past and how the outcomes still influencing the actual one. It includes a brief summary about the most marking events in each phase of the past of the health system till arriving to the most recent shock: the refugees flood.

According to Kronfol and Bashshur (1989) the actual problems of the Lebanese health system are not recent (Kronfol & Bashshur 1989). In fact, they argued that the history of the health system is divided to four phases. However I will add a fifth phase: the refugees' crisis. First, in pre-independence era: the government got involved and put attention on the health sector. However the most notable fact, that the French model system-Lebanon was under the French mandate- was duplicated and implemented in Lebanon. This system was characterized to be over controlling in addition to an administrative and bureaucratic workload (Kronfol & Bashshur 1989). Secondly, the phase of early independence: in this era, a national hospital network in addition to a referral system was established. The main goal of this approach was to empower the most vulnerable person. However the system was interrupted later on as it increased the stigmatisation within the community, the perception to the public health system as it is for people in need persisted (Kronfol & Bashshur 1989). As a result, the use of private health sectors flourished among the community. Third phase, was the period of reforms: the government promoted the social development and the National Social Security Funds was established (Kronfol & Bashshur 1989; WHO 2002) . According to Kronfol and Bashshur (1989) the Lebanese government failed to implement appropriate legislations. In fact, the burden of the bureaucracy increased in this phase. This era finished by the collapsing of the health system. The consequences still affecting the actual Health system (Kronfol & Bashshur 1989). The fourth and last phase, the war years and the predominance of the private sector: by 1975, Lebanon witnessed an intensive civil war. The private sector flourished as the public one was unable to supply the health needs to the population due to the increase demand secondary to war injuries and trauma cases. In addition, the health facilities were shelled, looted and destroyed. As a result, since then the health system care rely on the private sector (WHO 2006).

Despite the public and private sectors work under the umbrella of MoPH (WHO 2006), the role of MoPH remains unclear emphasized by an absence of a coordinated health policy sustained by the lack of a political willingness (Kronfol & Bashshur 1989) .

Since 2011, the health system has been facing a new external shock: refugees' influx coming from Syria. Due to the lack of knowledge of how to deal with such a problem, the government delegated the task to UNHCR (Dionigi 2016). The demand on health care increased by 50%

compared to pre-refugees arrival time (GoL and UNHCR 2017). Despite of the situation, Lebanon succeeded to achieve three goals from the Millennium Development Goals (MDG) set by the United Nations (UN) by the end of 2015: those goals are number 4,5 and 6 respectively to reduce child mortality to reach 8.3 per 1000 birth (WorldBank 2016b), Improve maternal health to reach 15 per 100.000 live births (WorldBank 2016a) and combat HIV/AIDS, Malaria and other disease (Ammar et al. 2016).

The presence of refugees in Lebanon created 2 different political opinions between supportive and opposing: the government received refugees and together with UNHCR , they tried to provide the basic needs (food, shelters, health access) (Dionigi 2016). After few years since the start of the war in Syria with no expected close ending to it, politicians start perceive refugees as danger to the country stability (Dionigi 2016) as refugees has been associated to increase of unemployment: unemployment rates rose from 4.59 % in 2011 to 6.01% in 2016 (Trading Economics 2017), 98% of the Lebanese strongly believe that the job opportunities are taken away by refugees (Cherri 2016). Also, increase in the criminality and living costs, insecurity (Cherri 2016; Dionigi 2016), increase on the national debt: it rose from 133% of GPD in 2013 to 144% in 2016 (UNDP 2016). Firstly, the perception of refugees as an external burden to the country may influence the political commitment toward the crisis response. Secondly, even if the political willingness' is present the limitation of resources cannot allow much to do.

By mid-2015, the government of Lebanon closed its borders as a step to reduce the number of refugees in the country coupled with the request of the government to UNHCR to stop all new registration (ECHO 2017). Since then, if displaced Syrians want to maintain a valid registration, they are obliged to find a Lebanese sponsor or to rely on UNHCR registration which needs to be renewed yearly-the condition to renew the registration is to sign a pledge to abide Lebanese law in addition to pay 200 dollars as administrative fees (GoL and UNHCR 2017). This new regulation exposed the Syrian refugees to more exploitation by the Lebanese nationals and the expensive fees compared to their low SES. As consequence the percentage of refugees without a valid registration increased by 13% only in 2016(GoL and UNHCR 2017).

The government of Lebanon is working to reduce the gender inequality gap by signing international conventions, -many related religion laws remain in disfavour of women such as protection from the early child marriage or protection against IPV (UNICEF 2011). This comes in disfavour with Syrian women females as they are already exposed to violence and early marriage. In fact, unofficial sources reported an increase on divorce rates and polygamy due female Syrians' presence-those marriages usually don't take legal status (no official contract), in this case children can be no registered and become stateless (Dionigi 2016). Women are also in risk to lose all legal rights.

Chapter 5 : interventions overview from neighbouring countries

This chapter presents the different interventions made by the neighbouring countries. Besides sharing borders, the similarity between those countries is overlapped by the same cultural and social background, religion and language-except for Turkey- this chapter will go through the interventions put in place by the different governments to tackle influencing factors (discussed in the previous chapters) of the SRHR outcomes of Syrian refugee women. The aim of this process is to take the best practices that can be adopted by stakeholders to be reproduced in Lebanon to enhance women's health.

5.1.Turkey

Unlike the Lebanese government, Turkey adopted a different approach and took the responsibility towards Syrian refugees fleeing the war in their country. Turkey received Syrian refugees and gave them the status of 'Guests'. The hospitality of the Turkish government went till to establish 26 camps in 11 provinces (UNHCR 2016d) and to sponsor the response (Gulcan Saglam 2015). The Disaster and Emergency Management Presidency of Turkey (AFAD) is the organizational body - working under the umbrella of the government- that is responsible to coordinate and plan interventions related to Syrian guests (Gulcan Saglam 2015; UNHCR 2016d).

Refugees or guests - as they are called by the Turkish government-reached more than 3 million by 2017 (UNHCR 2017e). Indeed, Turkey is the country with the highest number of refugees in the world (UNHCR 2016d). 10% of Syrians in Turkey live in camps whilst 90% of refugees are living in urban areas. Syrian guests in Turkey fall under the Temporary Protection Regulation; according to it, Syrians have right to free education, health and labour market (UNHCR 2016d).

According to the last update of UNHCR in 2017, 46.6% of refugees in Turkey are women (UNHCR 2017e). 40% of them are living outside camps and 500.000 among them are estimated to be in reproductive age and in need of SRH services (Gulcan Saglam 2015). In fact 73% of the women living in urban areas live in houses. The demographic characteristics of Syrian women living inside and outside the camps are almost similar, with the tendency to have women with higher education in camps as it is shown in the table 4.

Table 4: Demographic characteristic of Syrian women in Turkey, 2014 (AFAD 2014)

	Inside camps (%)	Outside camps (%)
age group (year)		
≤ 1	3,6	3,1
2-6	16,4	16,8
7-12	16,8	14,9
13-18	16,4	14,8
19-54	42,4	44,3
55-64	2,7	3,7
≥65	1,8	2,5
level of education		
Illiterate	17,5	24,5
Literate	6,1	9,9
Primary School	38,5	31,5
Middle School	21,9	17,7
High School	10,9	9
University and higher	5,2	7,3
Marital status*		
married	66,6	66,9
single	28,5	27
Divorced	0,9	1
Widow	4,1	5,1
Occupation		
Housewife	48,7	69,4
No occupation	38,3	17,1
Occupation	13	13,5

*Women above 15 years old

Upon arrival to Turkish territories, refugees need to get registered to be able to benefit of social and health support. The government took an interesting decision to refresh the registered data base (UNHCR 2016d). In fact this decision is very important to have real figures of the target refugee population and better resource allocation. Actually, the registration is used by the government for better targeted interventions. For example, the coverage on all sectors increased in the Southeast of

Turkey where more than 80% of Syrian guests are registered (UNHCR 2016d). Despite the fact that 32% of Syrian women in Turkey they don't own registration paper, an average of 67% is satisfied with the provided health services (AFAD 2014).

As a strategy to promote and facilitate the Turkish health service utilization by Syrian refugees, translators were included in the health facilities to improve the communication. Also, AFAD took care to include the Turkish language in the educational curriculum and to encourage to teach it in the informal schools (UNHCR 2016d). Recently, an integration of the Syrian medical staff within the national health system was achieved with the financial collaboration of ECHO (WHO 2017c). This step will allow reducing the workload of health services, shortage of the Turkish medical staff. The recruited Syrian medical staff - 380 doctors and 360 nurses and midwives- are relocated to practice in health centres delivering services to refugees (WHO 2017c). Indeed, it will help to mitigate the language barriers and to encourage refugees to use health services especially by women that prefer to be treated by a health professional (preferably female practitioner) of the same background and language. The services are free of charge.

The government is providing free basic social and health needs to its guests living in camps. In fact 90.7% of women and their relatives living inside camps compared to 59.5% of women living in urban areas, had access to health services (AFAD 2014).

An interesting fact, there is no significant discrepancy in places of delivery among Syrian guest residing inside and outside camps as it is shown in the table 5. In fact, those results can reflect the availability and the affordability of health services and the trust toward the health system by Syrian refugees. Statistics showed that 60% and 80% of women living inside and outside camps respectively are satisfied with the received health services (AFAD 2014).

Table 5: place of delivery of Syrian women, Turkey 2014 (AFAD 2014)

Where the delivery was performed	Inside the Camps		Outside the Camps		Total	
	Number	Percentage (%)	Number	Percentage (%)	Number	Percentage (%)
Home	1	0.6	1	2.9	2	1.1
Camp	4	2.6	0	0	4	2.1
Hospital or clinic	150	96.2	33	97.1	183	96.3
Other	1	0.6	0	0	1	0.5
Total	156	100	34	100	190	100

Similarly to Lebanon, Syrian refugees have difficulties to secure basic social and health needs due to low SES. Indeed, 90% of refugees living in urban areas are living under the Turkish poverty line (UNHCR 2016d). As consequences, harmful coping mechanisms such as early marriage, polygamy, early school dropout, begging in the street or child labour were

adopted by the Syrians guests (UNHCR 2016d). The government tackled the early marriage and the polygamy by targeting women’s committees (AFAD 2016) to increase the awareness in addition to an outreach program to reach women and young girls living in urban areas (UNHCR 2016d).

Since recently, refugees got the right to have work permits (UNHCR 2016d). The government took this decision, aiming to improve SES of refugees and to promote the self-resilience. By increasing the chances to improve the financial status of Syrian households, the access to health services increases including the access to SRH services, reduction on the IPV and limit the adaptation of the bad coping mechanism such as early marriage or early school dropout.

5.2 Jordan

Jordan also made a proof of generosity and opened her borders to receive Syrian refugees. Despite Jordan is not a country that figures on the list of States Parties to the 1951 Convention relating to the status of refugees and the 1967 Protocol (UNHCR 2011). Indeed, the Kingdom set 5 camps to host refugees (Doris Carrion 2016). The country received the comers from Syria and gave them the status of Asylum seekers instead of refugees status - Syrians can benefit from the temporary protection for 6 months and they need to renew the registration after this period (Ay et al. 2016; Doris Carrion 2016).

In addition to already existing 1 million Iraqi refugees and 2 million Palestinian (Ay et al. 2016), Jordan registered 661.114 person Syrian refugee (UNHCR 2017c), whilst the real number of refugees is estimated to be around 1.27 million (JCAPA 2016). Figure 10 shows that women present 50.5% of total refugees with around 30% of female aged between 12 and 59 years of the total population are in need of SRH care.

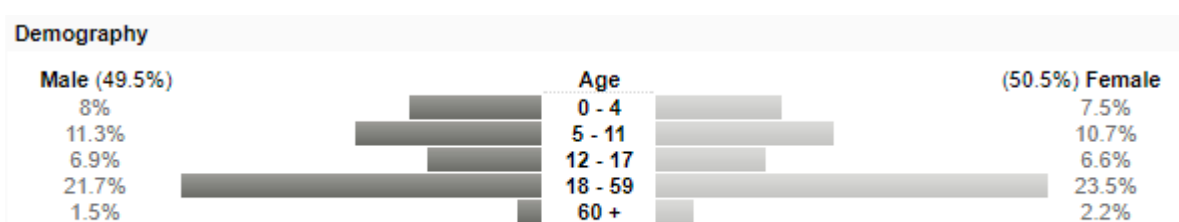


Figure 10 : Syrian refugees distribution according age in Jordan, 2017

Same as in Turkey and Lebanon, the majority of refugees live outside camps: as 21% and 79% of the population lives inside and outside camps respectively. Figure 11 and 12 show respectively the age distribution of the population. There are similarities between women age

in both settings. Women aged between 18 and 59 in urban settings are slightly higher compared to the ones in camps.

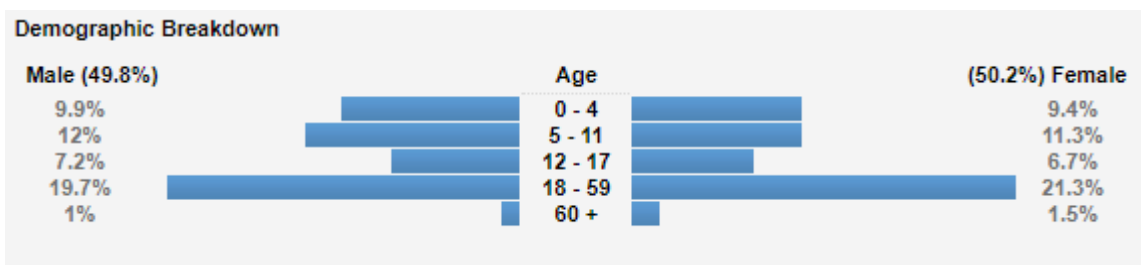


Figure 11 : Population age distribution inside camps, Jordan 2017 (UNHCR 2017d).

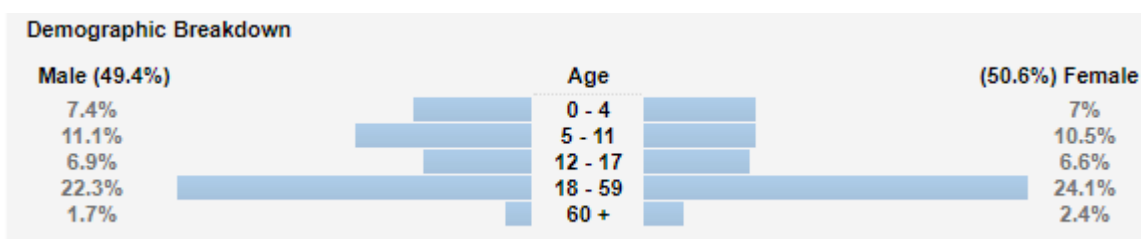


Figure 12 : Population ages distribution outside camps, Jordan 2017 (UNHCR 2017d).

93% of Syrian refugees living outside camps are living under the Jordanian poverty line (JCAPA 2016). The refugees live in sub-standardized houses coupled with the overcrowd, details are provided in table 6

Table 6 : Housing conditions of Syrian refugees out of camps (GoJ 2017).

Concerned refugees *	Housing/living conditions
28 %	Substandard shelters including 8% living in informal shelters
14%	Living in 1 room
12%	Overcrowding (more than 4 person per room)
20%	Accommodation don not provide basic protection
28%	Leaking roofs, damp or mouldy buildings
Total=102%**	

*this table don't include refugees living in houses of the local community

** The total does not present the total refugees caseload in urban areas as some conditions overlap with others.

In the used articles in this thesis, none took the access to water as a major problem. However it is important to underline the fact that Jordan is the poorest country in water sources (WHO 2010). In areas with high Syrian population condensation water consumption increased by 40% (GoJ 2017). The association between the lack of access to water and the risk of RTIs was described in the previous chapter.

Same as in Lebanon and Turkey, refugees adopted harmful coping mechanisms such as early school leaving, insufficient food intake, child labour or child marriage. In fact, the underage marriage increased from 12% in 2011 to 32% in 2014 (JCAPA 2016). Jordan has a different regulation from Turkey: In case refugees need to move out of camps they need to have a Jordanian citizen as a sponsor (JCAPA 2016). This regulation is a risk factor to expose women and young girls to exploitation by the local community.

Humanitarian activities are coordinated by the Jordan Response Platform for the Syria Crisis (JRPS) under the umbrella of the Ministry of Planning and International Cooperation (GoJ 2017; UNHCR 2016b). In addition to the UNHCR registration valid for 6 months, Syrian refugees need to register with the Ministry of Interior in a matter to get a second card called service card. By owning the 2 cards, refugees are allowed to access to the primary and secondary care in the public sector for free. However, this access is valid only for 6 months and thereafter, they are asked to pay fees same as foreigners (Ay et al. 2016).

The Jordanian regulation regarding the health access of registered Syrian refugees (the 2 types of registration) can be resumed in 3 phases (JCAPA 2016):

- a. From 2011 till November 2014: free primary health services (JCAPA 2016).
- b. From November 2014 till February 2016: urban refugees need to pay same fees as foreigners due to lack of funds (GoJ 2017).
- c. February 2016 till present: maternal and child health services including family planning are free (UNFPA 2016).

The policy statement made by the end of 2014 exposed more than 60% of refugees living outside camps to health access vulnerability (UNHCR 2015a). The following policy change in 2016 was made as a reform to reduce the worsening SRHR outcomes related to the unaffordability of services by poor refugees, emphasized by a shortage of health work forces (GoJ 2017).

Table 7 presents the place of deliveries of Syrian women. The choice of the place is mainly related to the SES conditions of the household and the distance from health facilities (UNHCR 2014).

Table 7 : place of deliveries (UNHCR 2014).

Facility type	Public	Private	Charity	Home
Percentage	51.8%	30.4%	15.6%	2.2%

Syrian women refugees aged between 15-24 years old, are less educated than the same age group of their Jordanian peers. As shown in table 8, low education is common among this age interval (JCAPA 2016). The same source shows that poverty is highly common among Syrian Married

Women of Reproductive Age (MWRA) with 86% compared to 40% of Jordanian women.

Table 8 : education among MWRA of Syrian women compared to Jordanians (JCAPA 2016).

	Jordanian MWRA	Syrian MWRA
Age: 15-24	10%	25%*
No education	4%	7%
Primary education	42%	19%
Secondary education	27%	5%

*Estimation

To cope with the increase of students that increased with the arrival of Syrian refugees, a second shift was implemented in 200 educational institutes in urban refugees areas in addition to the future plan for 4 school complexes inside the camps (GoJ 2017). Indeed, an increase of 12% by the end of 2016, compared to the previous year among the total caseload school aged children (117,306 boys; 118,998 girls); However, classes finishing late evening coupled with far distances present an obstacle for girls to attend schools (GoJ 2017). Teachers received trainings for a better adaptation to the new situation in addition to the integration of psychological services. To help families to get over the financial barriers, direct financial support were distributed (GoJ 2017).

Also, Jordan took the initiative to program out of classroom support for a better integration of Syrian children in addition to the implementation of Education Management Information System (EMIS) over the kingdom (GoJ 2017): this system will help to evaluate real needs, better resources allocation and higher response effectiveness.

The food insecurity or vulnerability was fluctuating in previous years: It reached 72%, 85% and 48% in 2016, 2015 and 2014 respectively -The increase between 2014 and 2015 can be explained by the poor SES of refugees and the instability of the intervention contrary to the recorded decrease between 2015 and 2016 (GoJ 2017). However this sustainability cannot be permanent or applicable to all sectors as only 19% of needed funds for 2017 are available (UNHCR 2017c).

By the end of October 2016, near 32.000 work permits were issued allowing Syrian refugees to work (GoJ 2017). Among the total released work permit only 1% was for female-it is important here to mention that 94% of female refugees are out of labour forces (UNHCR 2016b).

Before closing this section it is important to mention that due to the common borders with Iraq- a country witnessing war and instability since years- this fact creates an additional burden to the Jordanian humanitarian response.

5.3 Iraq

Till the end of June 2017, Iraq hosts 242558 Syrian refugees - male are higher compared to female refugees with 53.8% and 46.2% respectively as shown in figure 13 (UNHCR 2017b). Upon entry a visa valid for 15 days is given to Syrian comers-after this period, Syrians are requested to apply for asylum. However the complicated and long administrative procedures stand between Syrians and a legal status (UNHCR 2017a). Refugees without legal documentation can be pushed back to Syria due to the country security situation (UNHCR 2017a).

96% of refugees live in the Kurdish area of the country when the remaining 4% are distributed between the centre and the south (UNHCR 2016b). The Kurdistan Region Government (KRG) built 9 camps to host refugees. However, one of the camps was closed lately due to security reasons secondary to the internal conflict that the country is witnessing (UNHCR 2016b).

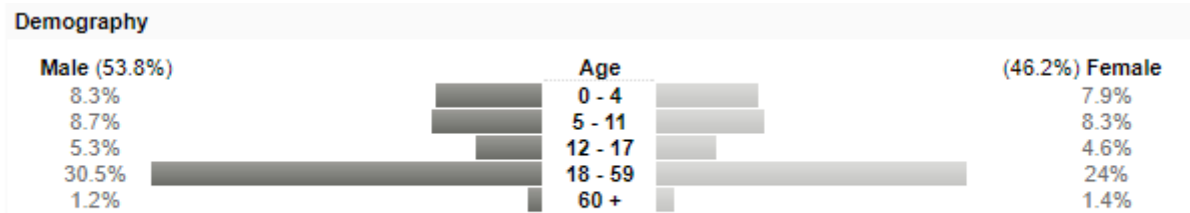


Figure 13 : Syrian population in Iraq, 2017 (UNHCR 2017c).

Similar to all above countries, the majority of refugees live in urban settings: the population living outside camps presents 62% from the total refugee overload compared to 38% living inside camps (UNHCR 2017b). The Figure 14 and 15 show the population distribution in and outside camps according to age. Women inside camps are higher than the ones in urban areas. However, women within the reproductive age group-12 to 59 years old- are the same (UNHCR 2017b).

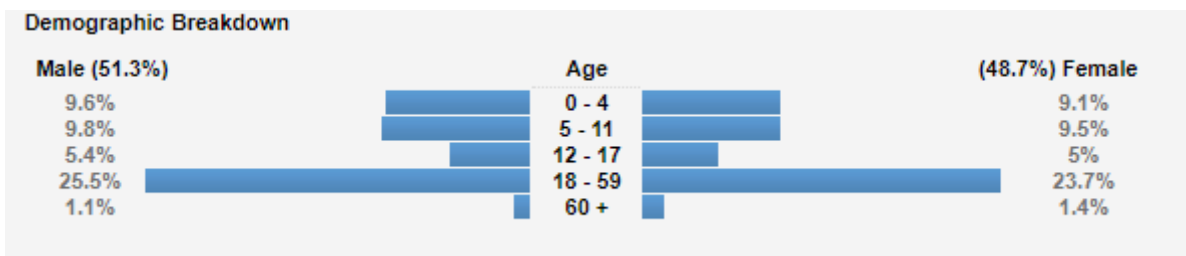


Figure 14 : Population inside the camps, Iraq 2017 (UNHCR 2017c).

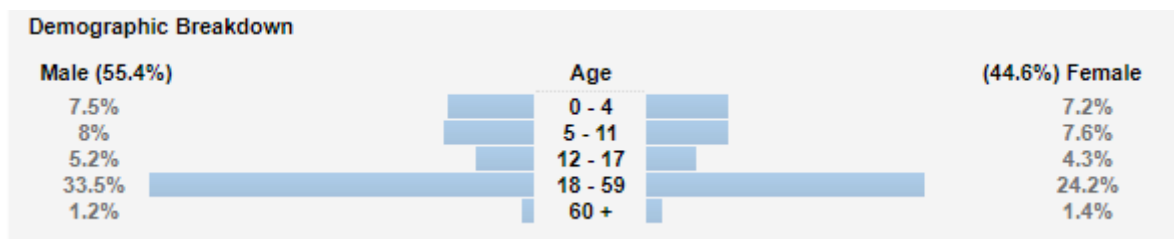


Figure 15 : Population outside camps, Iraq 2017 (UNHCR 2017c).

By May 2015, a Joint Crisis Centre was created to coordinate the governmental - from national and Kurdish government- interventions related to Syrian refugees in Iraq. Meanwhile, UNHCR is playing the coordinator role between all humanitarian actors (UNHCR 2016b). In fact, the humanitarian response includes access to health care, provision of shelters, food and education-public schools and universities with the right to work since 2011 (UNHCR 2016b). In fact, 80% of male refugees compared to 7.6% of females aged between 14 and 64 had a job, in Irbil (UNHCR 2016b).

Until 2016, the health services inside camps were under the coordination of medical NGOs followed by a handover to the department of health for integration to the national health system. Meanwhile agencies from UN are in charge of incentives' payment and medicines (UNHCR 2016b). The health service inside camps remains for free when urban refugees have to pay nominal fees to access to all level care same as Iraqi citizens (UNHCR 2016b).

Iraq has to deal with 3 million displaced Iraqi (IDPs) influx since early 2014 secondary to conflicts and the security instability; 1 million of IDPs are located in Kurdish area in addition to 96% of Syrian refugees (UNHCR 2017a) . As a result the public sectors had difficulties to deal with the high demand; the health sector suffered from the lack of medicines and the shortage of health workers when the education system teachers left schools because they were not receiving salaries (UNHCR 2016b). Also, the number of teachers did not increase compared to the student's number. In the other hand there is low school enrol rate among Syrian Students: an average of 67% and 56% of attendance rates inside and outside camps respectively. Female students have an average of 64% for primary 22% for secondary education (UNHCR 2017a). Distance from education facilities plays a role to reduce the school attendance.

As a solution to face the school dropout 2 major measures were put in place. First, Cash support to students' families. Second, use of technology (e-learning) to reach student out of school or having many barriers such distance (UNHCR 2017a).

The government was very realistic toward the long term refugees' presence in the territory and took the initiative to allow to the Syrian refugees to switch from tents to durable buildings; in collaboration with the specialised partners, 66% of refugees' camp lives in durable shelters.

In fact 95% of refugees are living on individual shelters with private kitchen and WASH facilities while the urban refugees are living in a variety of sub-standardized houses (UNHCR 2016b).

The government adopted a strategy targeting the most vulnerable refugees living outside camps with regard to the protection and socio economic criteria's. The assistance includes seasonal and multipurpose cash distribution. In the other hand the distribution of non-food items targets all the Syrians covering old and new comers (UNHCR 2016b). However, the sustainability of the support remains fragile as only 31% of the needed funds for 2017 are collected (UNHCR 2017b).

In summary, the findings confirm the assumption that Syrian refugees in Turkey, Jordan and Iraq are facing same barriers as the refugees in Lebanon (in different levels). However each of the country sharing borders with Syria had a different approach to mitigate those barriers. The next chapter will present a discussion of interventions and recommendations based on the learnt lessons and experience of Turkey, Jordan and Iraq.

Chapter 6 : Discussion

The findings showed that Syrian women in Lebanon have many barriers to access to health service which led to poor SRHR outcomes. They are highly exposed to violence (several types), low ANC and PNC attendance, increase in neonatal mortality, increase in RTIs, limited use of contraceptive and tendency to practice unsafe abortion come align with previous studies from previous displacement crisis (Austin et al. 2008; Gagnon et al. 2002) . Lack of financial sources was identified as a main barrier as women could not pay consultation and transportation fees. In addition to the lack of awareness of available services and support programs (UNHCR 2016a). Refugees went to harmful solution as a coping mechanism. The underage marriage dramatically increased, early school dropout among children and early enrol in labour market, imbalanced food intake, increase of IPV were reported (GoL and UNHCR 2017; UNFPA 2017b).

This thesis also discussed the different interventions and approaches adopted by the Lebanese government. However, not all the wished results were obtained. In fact, different approaches-proven to be more efficient from the neighbouring countries should be considered. In this section, a discussion of main findings will be done and how the Lebanese response regarding the women health can be optimized.

In this thesis, the definition of "refugee" from IOM was used because it provides clearly the difference between the various statuses attributed to Syrians in the different countries presented in this review. Also, IOM definition allows understanding rights of "refugee" compared to "displaced", "guest" or "asylum seeker". Lebanon did not officially give the refugee status to Syrians. However, in all the official reports released by UNHCR or in collaboration with the government of Lebanon the term 'Refugee' was used in a same meaning as 'Displaced'. The same was observed from reports regarding Syrians in Turkey, Jordan and Iraq. For those reasons, terms related to Syrians status was used as reference to refugee in this study.

So far, Syrian refugees have been relying on their savings but this cannot be a durable solution after more than 6 years since the start of the war. The research findings showed the poor social and economic status of refugees and the impact on basic needs and health service utilisation especially by women. Refugees were obliged to cope negatively with the situation by reducing food intake, early school dropout, early marriage and pregnancies, bad housing conditions in addition to the overcrowd, child labour, increase of IPV and limited utilisation of health services. The association with poor SRHR outcomes and invasion of females' rights was established in the above chapters. The current policy in Lebanon does not allow refugees to work officially to improve their financial situation, which makes them more exposed to exploitation while Turkey, Jordan and Iraq

promote the self-resilience of refugees. They allowed to them to integrate the labour market. In fact, this step will help partially to tackle the financial problems faced by the displaced population and to preserve dignity. It will result in the reduction of harmful coping mechanisms that influence SRHR of Syrian refugee women.

The Lebanese health system-already weak from previous events (Kronfol & Bashshur 1989)- suffers from the sudden and continuously increased demand related to displaced needs. One of the main faced problems is the shortage of paramedical staff in addition to the lack of female doctors. Indeed, displaced Syrian women in Lebanon perceived it as a barrier to use SRH services due to religious and ethics beliefs. As a solution, Turkey trained and integrated Syrian medical staff in the national health system. In addition to the increase of the trust -same cultural background and nationality- of Syrian women towards the health system and encourage the uptake of services. Other positive outcomes can be assumed:

- ✓ **Syrian medical staff:** allow to them to be inside the sector and opportunities to practice and keep their skills 'alive'. Also, they will be in line with medical updates and changes (technologies and new findings). In addition, empowerments to households of the recruited staff and by consequence increasing the self-resilience.
- ✓ **Host government:** immediate and cost effectiveness solution to reply to the increase demand, guaranty health care quality and health to achieve goals from the new millennium agenda. In fact, the Lebanese government does not need to invest to form new medical health forces (doctors and paramedical) with the risk of over staff once the war is over and Syrians are back to their countries. Also the risk of depletion of the Lebanese workers from the public sector to NGOs will be mitigated, knowing that there is a shortage on paramedical staff already. Finally, by giving legal labelling to Syrian medical staff practice will reduce the parallel informal system.
- ✓ **Syria:** those people can play a major role in the rebuilding and reform of the health system of their country after the crisis.

The Lebanese government adopted a policy against the establishment of camps for refugees contrary to neighbouring countries. From Iraqi and Turkish experience we could perceive how by having refugees located in one limited geographic space can help to focus interventions. It is unrealistic to ask the government of Lebanon to set up new camps for many reasons. I cite for example the high number of refugees compared to host population and the huge related investments. However targeting the most populated areas with Syrian displaced coupled with a strong outreach program to reach the dispersed population to reach the most vulnerable women or the ones located far from health structures, is more realistic and feasible like in Turkey. An efficient reporting/registration system is needed.

Despite the displaced Syrians in Lebanon do not have an official status of refugees, they benefit from social and health support in condition to register with UNHCR to have access to. However, only 2/3 of the estimated refugee population is registered with UNHCR. The reasons for not seeking registration change from person to another such as the fear to be pushed back to Syria due to missing personal papers or distance from the registration centres or the high expensive related to the renewal of the residency (GoL and UNHCR 2017). A good strategy to encourage the population to register is highly requested. In Turkey, AFAD showed how they could supply around 80% of refugees needs in areas with high registration rates. UNHCR, in collaboration with the partners, needs to put in place a strategy to mitigate barriers and the wrong understanding/perception of refugees toward registration. Till this happens, another system should be put in place to get as possible an overview of real needs and to reduce the exploitation of the refugees by the Lebanese sponsors. Humanitarian assistance should remain separated from all form of registration if refugees solicit help. The role of the humanitarian actors is to understand those reasons, mitigate them and meanwhile continue supplying support regardless of formalities.

Education should be tackled as essential influencing factor to SRHR outcomes. The former studies put in evidence that women with low or without any education are more exposed to exploitation, early marriage coupled with the risk of early child bearing, STDs in addition to high risk of poverty (Mkwanz & Odimegwu 2015). Unskilled women/girls have less chance to have good job opportunities and by consequences less chances to improve their SES. Iraq chooses to use technology to reduce barriers between Syrian students and access to education. This strategy is an innovative way getting more and more popular worldwide: the students can mitigate the financial and distance barriers, the class rooms will be less crowded (Stephanie Norman 2016). Also, parents should be involved in the learning process of their children. It is a way that allows targeting simultaneously children and parents as both are exposed to educative messages. In addition to the improvement of the educational curriculum, Syrian children will be more exposed to messages increasing their sexual education awareness.

In fact, the best strategies can be proposed but without any minimum funds availability, it is impossible to plan and to implement durable interventions. It was proven from Jordan experience how food security was reduced from 2015 to 2016 because the government maintained the dedicated funds for this purpose. This should be applicable to all sectors. However, only 13% of needed funds for 2017 are collected so far (UNHCR 2017d). New strategies for fund raising are crucial.

The findings were analysed using the Andersen's conceptual model. The various findings matched with the components of this model which allowed structuring an overview of SRHR outcomes of Syrian refugee

women in Lebanon and by consequence the health service utilisation. However, this model lacks a psychological and mental health component as a predisposing characteristic. This review showed how SRHR outcomes got affected either by the psychological state of women or by the increase of IPV from spouses and/or male relatives that could not fulfil their role as the household head and chose violence against women as a coping mechanism.

Finally, men and boys should be equally involved in health awareness and sexual education. In the previous chapter, the men role was spotlighted how it can impact negatively women's SRHR. Men used violence against women and they impeded the contraceptives use. It is crucial that the aid intervention target gender inequalities and to mitigate them.

Chapter 7 : Conclusion and recommendations

This review made clear that Syrian refugee women face difficulties to access SRH services. The financial vulnerability of refugees was highlighted and how it impeded the access to health care either by not being able to pay consultation or the high transportation fees in addition to the lack of awareness of available services. Women were pushed toward harmful health habits: there were a reduction in food quantities and qualities, the underage marriage dramatically increased, children are forced to work instead of attending schools. Female are particularly exposed to sexual exploitation and harassment. Indeed SGBV case increased since 2011. As a result a reduction on SRH service was observed compared to pre-war time: ANC, PNC contraceptive use and self-abortion. Also neonatal mortality is assumed to be increased among the refugees.

As a non-member of 1951 Convention regarding refugees, the government of Lebanon received Syrians and tried to assure the basic needs and delegated UNHCR to coordinate the humanitarian response. However the lack of funds and the political oscillation of country leaders impeded to meet Syrians needs. The government provided free access to PHC, the international actors provided health and social support, financial support for refugees having a valid residency documentation. However, the support is not sufficient as an important percentage of registered refugees claims not receiving enough help to cover the household needs or not receiving at all any support. Since mid-2015, Lebanon closed her borders which increased the number of unregistered refugees and by consequence population in needed increased.

Turkey, Jordan and Iraq adopted different approaches to common problems in Lebanon. All those countries promote the self-resilience of refugees and went for long term intervention such in Iraq. In Iraq, refugees were allowed to build permanent shelters and to improve the housing conditions. Jordan realised the importance of full access to SRH services as thousands of refugee women lives and their babies were threaten. Jordan adjusted its political position and allowed free access to maternal health care. Turkey integrated Syrian medical in it health system to face the increasing demand of health delivery. Also, cultural, language and trust were mitigating with this new strategy. Women are more open toward the uptake of services.

In order to respond to SRHR needs of displaced Syrian women in Lebanon, social and health assistance should be considered to them and their environment. Despite, some services are in place to cover women and refugees needs, the findings showed that there are many barriers impeding the health utilisation and influencing the health behaviour of females. A revision of some strategies seems needed based on Turkey, Jordan and Iraq approaches. Also an increase of awareness among the

community about the existing services is requested in addition to the importance of registration.

Recommendations:

7.1.National level: government of Lebanon

- Integration of the Syrian medical staff: A system that eliminates/ limits tension between the local and refugee community-Syrians are perceived as taking away the job opportunities from the Lebanese-should be implemented. Syrian medical staff can work with NGOs to work for their peers refugees with “unattractive” salaries for the Lebanese medical staff. The salary of the Syrian staff should be calculated in a complementary way to the other received humanitarian support such food, cash support or education.
- The humanitarian response can take more advantages of the technologies: in addition to the e-learning and self-learning programs to the Syrians students that could not attend schools for whatever reason (financial, distance...), e-learning can be used also for the training of the medical staff on the Lebanese protocols and guidelines.
- Adopt strategies that promote self-resilience: self-resilience of refugees can be planned and legalized to avoid all forms of abuse and exploitation. Similar to medical staff salaries should be calculated based on the different received supports. Women should be highly involved and included as they are highly exposed to exploitation especially that the majority of households are headed by a women.
- A separation between political position and humanitarian intervention is needed to maintain the sustainability.

7.2.International level: INGOs and international civil society

- Humanitarian aid should be independent from all UNHCR registration: It is important to create another system that will allow following the number of refugees (e.g: community leaders, community health workers). First, the new reporting system should be associated to a strict monitoring and evaluation program to avoid corruption or the risk of local citizens to register as Syrian refugees. Second, assessments and group discussions should be used to understand refugees’ decision for not registering. Next, based on the findings, awareness campaigns to correct wrong understandings and involve refugees in the response interventions.
- UNHCR as the coordinator of the humanitarian interventions in Lebanon should increase and focus on advocacy regarding fund raising to meet the required budget to be able to fulfil the response related to the Syrian

crisis and assure refugees needs. International civil society should be involved to create more pressure on donors.

- Studies on knowledge gap: comprehensive studies and surveys are needed to fill the knowledge gap about the real SRHR needs of Syrian displaced women in Lebanon across all the country, this can be done by working on systematic and periodic reporting systems from all humanitarian actors including public facilities treating registered and unregistered refugee women with UNHCR. Also Surveys and assessments among the non-registered population should be promoted among reseachers and decision makers as they are the most vulnerable with less access to aid support.

References:

- AFAD, 2014. *Syrian Women in Turkey*, Available at: <https://data2.unhcr.org/en/documents/download/54512>.
- AFAD, 2016. Turkey Response to Syria Crisis - Syria - AFAD Republic of Turkey Prime Ministry Disaster and Emergency Management Authority. Available at: <https://www.afad.gov.tr/en/2601/Turkey-Response-to-Syria-Crisis> [Accessed July 21, 2017].
- Aljazeera, 2013. High birth costs force Syrians back home - Al Jazeera English. Available at: <http://www.aljazeera.com/indepth/features/2013/10/high-birth-costs-force-syrians-back-home-20131015516748508.html> [Accessed August 2, 2017].
- Ammar, W., Kdouh, O., Hammoud, R., Hamadeh, R., Harb, H., Ammar, Z., Atun, R., Christiani, D. and Zalloua, P. A., 2016. Health system resilience: Lebanon and the Syrian refugee crisis. *Journal of Global Health*, 6(2). Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5234495/>.
- Amnesty, 2016. Syria's refugee crisis in numbers | Amnesty International. Available at: <https://www.amnesty.org/en/latest/news/2016/02/syrias-refugee-crisis-in-numbers/> [Accessed March 12, 2017].
- Andersen, R. & Davidson, P., 2007. Improving access to care in America: Individual and Contextual Indicators. *Changing the US Health Care System*, (November), pp.3–33. Available at: https://www.researchgate.net/publication/237675193_Improving_access_to_care_in_America_Individual_and_contextual_indicators.
- Andersen, R.M., 1995. Revisiting the Behavioral Model and Access to Medical Care: Does it Matter? *Journal of Health and Social Behavior*, 36(1), p.1. Available at: <http://www.jstor.org/stable/2137284?origin=crossref> [Accessed August 14, 2017].
- Austin, J., Guy, S., Lee-Jones, L., McGinn, T. and Schlecht, J., 2008. Reproductive Health: A Right for Refugees and Internally Displaced Persons. *Reproductive Health Matters*, 16(31), pp.10–21. Available at: <http://www.tandfonline.com/doi/pdf/10.1016/S0968-8080%2808%2931351-2?needAccess=true>.
- Ay, M., Arcos González, P. & Castro Delgado, R., 2016. The Perceived Barriers of Access to Health Care Among a Group of Non-camp Syrian Refugees in Jordan. *International Journal of Health Services*, 46(3), pp.566–589. Available at: <http://journals.sagepub.com/doi/10.1177/0020731416636831> [Accessed August 14, 2017].
- Balsara, Z. P., Wu, I., Marsh, D. R., Ihsan, A. T., Nazir, R., Owoso, E., Robinson, C. and Darmstadt, G. L., 2010. Reproductive tract disorders among Afghan refugee women attending health clinics in Haripur, Pakistan. *Journal of Health, Population and Nutrition*, 28(5), pp.501–508. Available at: <https://www.jstor.org/stable/23500015>.
- Benage, M., Greenough, P. G., Vinck, P., Omeira, N. and Pham, P., 2015. An assessment of antenatal care among Syrian refugees in Lebanon. *Conflict and health*, 9, p.8. Available at:

<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=4349304&tool=pmcentrez&rendertype=abstract>.

Büyüktiryaki, M., Canpolat, F. E., Alyamaç, D. E., Okur, N. and Kadioğlu, Ş. G., 2015. Neonatal outcomes of Syrian refugees delivered in a tertiary hospital in Ankara, Turkey. *Conflict and Health*, 9(1), p.38. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/26697104><http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=PMC4687223><http://www.conflictandhealth.com/content/9/1/38>.

CDC, 2016. *SYRIAN REFUGEE HEALTH PROFILE Division of Global Migration and Quarantine Priority Health Conditions*, Available at: <https://www.cdc.gov/immigrantrefugeehealth/pdf/syrian-health-profile.pdf>.

Chaaban, J. & Cunningham, W., 2011. *Measuring the Economic Gain of Investing in Girls: The Girl Effect Dividend*, The World Bank. Available at: <http://elibrary.worldbank.org/doi/book/10.1596/1813-9450-5753> [Accessed March 13, 2017].

Cherri, Z., 2016. The Lebanese – Syrian crisis: impact of influx of Syrian refugees to an already weak state. , pp.165–172. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4948691/>.

CIA, 2017a. The World Factbook — Central Intelligence Agency. Available at: <https://www.cia.gov/library/publications/the-world-factbook/geos/le.html> [Accessed May 11, 2017].

CIA, 2017b. The World Factbook — Central Intelligence Agency. Available at: <https://www.cia.gov/library/publications/the-world-factbook/geos/sy.html> [Accessed May 27, 2017].

Dionigi, F., 2016. The Syrian Refugee Crisis in Lebanon. State fragility and social resilience. Available at: <http://www.lse.ac.uk/middleEastCentre/publications/Paper-Series/2016/FilippoDionigi.aspx>.

Doris Carrion, 2016. Country Profile Jordan - Hard Paths Ahead: Syrian Refugees in Jordan. Available at: <http://www.bpb.de/gesellschaft/migration/laenderprofile/234502/syrian-refugees-in-jordan?p=all> [Accessed July 26, 2017].

ECHO, 2017. Lebanon: Syria Crisis. , (March), p.3. Available at: https://ec.europa.eu/echo/files/aid/countries/factsheets/lebanon_syrian_crisis_en.pdf.

El-Masri, R., Harvey, C. & Garwood, R., 2013. Changing gender roles among refugees in Lebanon A family sit in a temporary shelter in an abandoned shopping centre, Tripoli, May 2013. Oxfam / Sam Tarling. , (SEPTEMBER).

EMHRN, 2011. Syrian Refugees in Turkey : A Status in Limbo. , 2011(October), pp.1–18. Available at: <http://www.refworld.org/docid/515010a42.html>.

Gagnon, A.J., Merry, L. & Robinson, C., 2002. A Systematic Review of Refugee Women’s Reproductive Health. *Refugee*, 21(1), pp.6–17. Available at: <http://www.evidenceaid.org/wp-content/uploads/2016/08/Gagnon-et-al-Refugee-Womens-reproductive-health-Can-J-Refugees-2002.pdf>.

GoJ, 2017. *Jordan Response Plan*, Available at:

<https://static1.squarespace.com/static/522c2552e4b0d3c39ccd1e00/t/58aec230a5790a797f1d0c1f/1487848020031/JRP+2017-2019+-+Final+Draft+-+230217.pdf>.

GoL and UNHCR, 2017. LEBANON CRISIS RESPONSE PLAN 2017- 2020. , (February), pp.1–36. Available at: <http://www.3rpsyriacrisis.org/wp-content/uploads/2017/01/Lebanon-Crisis-Response-Plan-2017-2020.pdf>.

Gulcan Saglam, 2015. The Problem with Turkey’s Syrian “Guests.” Available at: <https://muftah.org/the-problem-with-syrian-guests-in-turkey/#.WXDY2IjyjIV> [Accessed July 20, 2017].

Hally, S.S., 1998. NUTRITION IN REPRODUCTIVE HEALTH. *Journal of Nurse-Midwifery*, 43(6), pp.459–470. Available at: [http://onlinelibrary.wiley.com/wol1/doi/10.1016/S0091-2182\(98\)00056-1/full](http://onlinelibrary.wiley.com/wol1/doi/10.1016/S0091-2182(98)00056-1/full) [Accessed August 4, 2017].

IOM, 2011. *Glossary on migration*, Available at: <http://www.epim.info/wp-content/uploads/2011/01/iom.pdf>.

JCAPA, 2016. *Family Planning among Syrian Refugees in Jordan*, Available at: <https://jordankmportal.com/resources/family-planning-among-syrian-refugees-in-jordan>.

Kassak, K, M., Ghomrawi, H, M K., Osseiran, A, M, A. and Kobeissi, H., 2006. The providers of health services in Lebanon: a survey of physicians. *Human resources for health*, 4(1), p.4. Available at: <http://www.human-resources-health.com/content/4/1/4>.

Krause, S., Williams, H., Onyango, M, A., Sami, S., Doedens, W., Giga, N., Stone, E. and Tomczyk, B., 2015. Reproductive health services for Syrian refugees in Zaatri Camp and Irbid City, Hashemite Kingdom of Jordan: an evaluation of the Minimum Initial Services Package. *Conflict and health*, 9(Suppl 1 Taking Stock of Reproductive Health in Humanitarian), p.S4. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/25798190> [Accessed August 4, 2017].

Kridli, S.A., 2002. Health beliefs and practices among Arab women. *MCN, American Journal of Maternal Child Nursing*, 27(3), pp.178–182. Available at: https://www.researchgate.net/publication/11357085_Health_Beliefs_and_Practices_Among_Arab_Women.

Kronfol, N.M. & Bashshur, R., 1989. Lebanon’s Health Care Policy: A Case Study in the Evolution of a Health System under Stress. *Journal of Public Health Policy*, 10(3), p.377. Available at: <http://www.jstor.org/stable/3342798?origin=crossref> [Accessed August 14, 2017].

Mkwananz, S. & Odimegwu, C., 2015. Teen Pregnancy in Sub Saharan Africa: The Application of Social Disorganisation Theory. *2015 Annual Meeting April 30-May 2, San Diego, CA*. Available at: <http://paa2015.princeton.edu/uploads/151509>.

MSF, 2013a. *Misery beyond the war zone: Life for Syrian refugees and displaced populations in Lebanon*, Available at: <https://www.msf.org.uk/sites/uk/files/lebanon-report-light.pdf>.

- MSF, 2013b. Syrian Refugees in Lebanon: "Pregnant Women Often Have No Idea Where to Go" | MSF USA. Available at: <http://www.doctorswithoutborders.org/news-stories/field-news/syrian-refugees-lebanon-pregnant-women-often-have-no-idea-where-go> [Accessed March 29, 2017].
- Reese Masterson, A., Usta, J., Gupta, J. and Ettinger, A, S., 2014. Assessment of reproductive health and violence against women among displaced Syrians in Lebanon. *BMC Women's Health*, 14(1), p.25. Available at: <http://bmcwomenshealth.biomedcentral.com/articles/10.1186/1472-6874-14-25>.
- Roudi-Fahimi, F., 2003. WOMEN'S REPRODUCTIVE HEALTH IN THE MIDDLE EAST AND NORTH AFRICA. *The European Journal of Public Health*, 1(page 4), pp.1-5. Available at: <http://www.prb.org/Publications/Reports/2003/WomensReproductiveHealthInTheMiddleEastandNorthAfricaPDF234KB.aspx>.
- Salti, N., Chaaban, J. & Raad, F., 2010. Health equity in Lebanon: a microeconomic analysis. *International Journal for Equity in Health*, 9, p.11. Available at: <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2864280&tool=pmcentrez&rendertype=abstract>.
- Samet, J.M., Yoon, S.-Y. & Initiative, W.T.F., 2001. *Women and the tobacco epidemic: challenges for the 21st century / edited by Jonathan M. Samet, Soon-Young Yoon*, Available at: http://apps.who.int/iris/bitstream/10665/66799/1/WHO_NMH_TFI_01.1.pdf.
- Sami, S., Williams, H, A., Krause, S., Onyango, M, A., Burton, A. and Tomczyk, B., 2014. Responding to the Syrian crisis: The needs of women and girls. *The Lancet*, 383(9923), pp.1179-1181. Available at: [http://dx.doi.org/10.1016/S0140-6736\(13\)62034-6](http://dx.doi.org/10.1016/S0140-6736(13)62034-6).
- Stephanie Norman, 2016. 5 Advantages Of Online Learning: Education Without Leaving Home - eLearning Industry. Available at: <https://elearningindustry.com/5-advantages-of-online-learning-education-without-leaving-home> [Accessed August 8, 2017].
- Steve Bressert, 2016. The Impact of Stress | Psych Central. Available at: <https://psychcentral.com/lib/the-impact-of-stress/> [Accessed August 10, 2017].
- Trading Economics, 2017. Lebanon Population | 1960-2017 | Data | Chart | Calendar | Forecast | News. Available at: <https://tradingeconomics.com/lebanon/population> [Accessed August 9, 2017].
- UN Foundation, 2015. Sexual and Reproductive Health and Rights (srhr) and the Post-2015 Development Agenda. , 1. Available at: <http://www.unfoundation.org/what-we-do/campaigns-and-initiatives/universal-access-project/briefing-cards-srhr.pdf>.
- UNDP, 2016. About Lebanon | UNDP in Lebanon. Available at: <http://www.lb.undp.org/content/lebanon/en/home/countryinfo.html>

[Accessed May 11, 2017].

- UNFPA, 2017a. Adolescent pregnancy | UNFPA - United Nations Population Fund. Available at: <http://www.unfpa.org/adolescent-pregnancy> [Accessed August 4, 2017].
- UNFPA, 2016. Family planning. Available at: <http://www.unfpa.org/family-planning> [Accessed March 13, 2017].
- UNFPA, 2017b. New study finds child marriage rising among most vulnerable Syrian refugees | UNFPA - United Nations Population Fund. Available at: <http://www.unfpa.org/news/new-study-finds-child-marriage-rising-among-most-vulnerable-syrian-refugees> [Accessed March 13, 2017].
- UNHCR, 2017a. *3RP Iraq*, Available at: <http://reliefweb.int/report/iraq/iraq-3rp-regional-refugee-resilience-plan-2017-2018-response-syria-crisis>.
- UNHCR, 2016a. *At a glance Health access and utilization survey among Syrian refugees in Lebanon*, Available at: data.unhcr.org/syrianrefugees/download.php?id=13769.
- UNHCR, 2015a. *Jordan Refugee Response: Baseline Survey*, Available at: <http://reliefweb.int/report/jordan/jordan-refugee-response-vulnerability-assessment-framework-baseline-survey-may-2015>.
- UNHCR, 2011. List of OIC Member States Parties to the 1951 Convention Relating to the Status of Refugees and the 1967 Protocol. *Refugee Survey Quarterly*, 27(2), p.94. Available at: <http://rsq.oxfordjournals.org/content/27/2/94.short>.
- UNHCR, 2015b. *Refugee Response in Lebanon Briefing Documents*, Available at: http://www.europarl.europa.eu/meetdocs/2014_2019/documents/droi/dv/95_finalbriefingkit_/95_finalbriefingkit_en.pdf.
- UNHCR, 2016b. Regional Strategic Overview. *REGIONAL STRATEGIC OVERVIEW Regional Refugee & Resilience Plan*. Available at: <http://www.3rpsyriacrisis.org/wp-content/uploads/2017/02/3RP-Regional-Strategic-Overview-2017-2018.pdf>.
- UNHCR, 2017b. Syria Regional Refugee Response - Iraq. Available at: <http://data.unhcr.org/syrianrefugees/country.php?id=103> [Accessed July 30, 2017].
- UNHCR, 2017c. Syria Regional Refugee Response - Jordan. Available at: <http://data.unhcr.org/syrianrefugees/country.php?id=107> [Accessed July 26, 2017].
- UNHCR, 2017d. Syria Regional Refugee Response - Lebanon. Available at: <http://data.unhcr.org/syrianrefugees/country.php?id=122> [Accessed August 4, 2017].
- UNHCR, 2016c. Syria Regional Refugee Response - Regional Overview. Available at: http://data.unhcr.org/syrianrefugees/regional.php#_ga=1.141549490.1078984623.1486061310 [Accessed March 12, 2017].
- UNHCR, 2017e. Syria Regional Refugee Response - Turkey. Available at: <http://data.unhcr.org/syrianrefugees/country.php?id=224> [Accessed July 20, 2017].

- UNHCR, 2014. *Syrian Refugee Health Access Survey in Jordan*, Available at: <http://reliefweb.int/report/jordan/syrian-refugee-health-access-survey-jordan-december-2014>.
- UNHCR, 2016d. *TURKEY 3RP Regional Refugee and Resilience Plan 2017-2018*, Available at: <http://reliefweb.int/report/turkey/turkey-3rp-regional-refugee-resilience-plan-2017-2018-response-syria-crisis>.
- UNHCR, UNICEF & WFP, 2016. Vulnerability Assessment of Syrian Refugees in Lebanon 2016. , pp.1–118. Available at: <https://data.unhcr.org/syrianrefugees/download.php?id=12482>.
- UNICEF, 2011. *Lebanon MENA Gender Equality Profile*, Available at: <https://www.unicef.org/gender/files/Lebanon-Gender-Eqaulity-Profile-2011.pdf>.
- UNICEF, 2013. Statistics | At a glance: Syrian Arab Republic | UNICEF. Available at: https://www.unicef.org/infobycountry/syria_statistics.html [Accessed May 24, 2017].
- Usta, J. & Masterson, A.R., 2015. *Gender-Based Violence*, Available at: <http://link.springer.com/10.1007/978-3-319-16670-4>.
- WHO, 2006. Health System Profile Lebanon. *WHO*, 53(9), pp.1689–1699. Available at: <http://apps.who.int/medicinedocs/documents/s17301e/s17301e.pdf>.
- WHO, 2002. Older Population and Health System : A profile of Botswana. , pp.1–54. Available at: http://www.who.int/ageing/projects/intra/phase_one/alc_intra1_cp_lebanon.pdf.
- WHO, 2015. Syrian Arab Republic: WHO statistical profile. *World Health Organisation*, p.3. Available at: <http://www.who.int/gho/countries/syr.pdf?ua=1>.
- WHO, 2017a. WHO | Adolescents: health risks and solutions. *WHO*. Available at: <http://www.who.int/mediacentre/factsheets/fs345/en/> [Accessed August 4, 2017].
- WHO, 2010. WHO | Jordan: Water is life. *WHO*. Available at: <http://www.who.int/heli/pilots/jordan/en/> [Accessed August 5, 2017].
- WHO, 2017b. WHO | Preventing unsafe abortion. *WHO*. Available at: <http://www.who.int/mediacentre/factsheets/fs388/en/> [Accessed August 9, 2017].
- WHO, 2017c. World Refugee Day: WHO training enables Syrian doctors and nurses to provide health care in Turkey. Available at: <http://www.euro.who.int/en/countries/turkey/news/news/2017/06/world-refugee-day-who-training-enables-syrian-doctors-and-nurses-to-provide-health-care-in-turkey> [Accessed July 20, 2017].
- Worldbank, 2017. Health expenditure, total (% of GDP) | Data. Available at: <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS?locations=LB> [Accessed August 10, 2017].
- WorldBank, 2017a. Contraceptive prevalence, any methods (% of women ages 15-49) | Data. Available at: <http://data.worldbank.org/indicator/SP.DYN.CONU.ZS?locations=SY>

[Accessed August 13, 2017].

WorldBank, 2015. Education | Data. Available at: <http://data.worldbank.org/topic/education?locations=SY> [Accessed June 29, 2017].

WorldBank, 2017b. Health expenditure, private (% of GDP) | Data. Available at: <http://data.worldbank.org/indicator/SH.XPD.PRIV.ZS?locations=LB> [Accessed August 10, 2017].

WorldBank, 2016a. Mortality rate, infant (per 1,000 live births) | Data. Available at: <http://data.worldbank.org/indicator/SP.DYN.IMRT.IN?locations=LB> [Accessed May 23, 2017].

WorldBank, 2017c. Mortality rate, neonatal (per 1,000 live births) | Data. Available at: <http://data.worldbank.org/indicator/SH.DYN.NMRT?locations=SY> [Accessed August 15, 2017].

WorldBank, 2016b. Mortality rate, under-5 (per 1,000 live births) | Data. Available at: <http://data.worldbank.org/indicator/SH.DYN.MORT?locations=LB> [Accessed May 23, 2017].

WorldBank, 2017d. Out-of-pocket health expenditure (% of private expenditure on health) | Data. Available at: <http://data.worldbank.org/indicator/SH.XPD.OOPC.ZS?locations=LB> [Accessed August 13, 2017].

WorldBank, 2017e. Pregnant women receiving prenatal care (%) | Data. Available at: <http://data.worldbank.org/indicator/SH.STA.ANVC.ZS?locations=SY> [Accessed August 8, 2017].

Yasmine, R. & Moughalian, C., 2016. Systemic violence against Syrian refugee women and the myth of effective intrapersonal interventions. *Reproductive Health Matters*, 24(47), pp.27–35. Available at: <http://dx.doi.org/10.1016/j.rhm.2016.04.008>.

Zahan, N., 2014. Factors Influencing Women's Reproductive Health. *ABC Journal of Advanced Research*, 3(2), pp.38–46. Available at: <http://journals.abc.us.org/index.php/abcjar/article/view/412> [Accessed August 14, 2017].