

# Challenges to understanding the reproductive health needs of women forcibly displaced by the Syrian conflict

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West *et al*'s article in this journal issue looks at barriers to the uptake of family planning among Syrian women living in Jordan in one of the largest camps for Syrian refugees worldwide.<sup>1</sup> The article makes a contribution to a growing but still limited literature on sexual and reproductive health (SRH) in humanitarian settings. The gap has been particularly acute for those forcibly displaced by the Syrian conflict that started in 2011. In particular, there has been limited published literature on the internally displaced within Syria<sup>2</sup> – currently estimated at over 6.5 million individuals.<sup>3</sup> The sparse literature tends to be on those living as refugees in neighbouring countries including Lebanon and Jordan, where registered Syrian refugees now make up approximately 1 in 6 and 1 in 12 of residents, respectively. Unlike the Syrians fleeing the conflict to Europe, among whom men predominate, these refugee populations in neighbouring countries have a high proportion of women and children. This poses a high demand on reproductive health services; it is estimated that in Lebanon and Jordan in 2015, 25% of registered Syrian refugees were women and girls of reproductive age and of these 2% were pregnant.<sup>4</sup> Moreover, as a middle-income country before the conflict, the health profile differs from low-income settings, where much of the research on SRH among refugees has been focused to date. Nevertheless, one study on the burden of a range of SRH problems reported by Syrian refugees in Lebanon suggests that it is considerable.<sup>5</sup>

Methodological and other challenges have prevented gaining a full understanding of the reproductive health needs of those forcibly displaced from the Syrian conflict so that services can be

tailored accordingly. In Syria, safety and access concerns, as well as diminished capacity for research, are key factors. A key conceptual challenge, as in all refugee research, is what the comparator populations should be when assessing refugees' SRH needs and access to services. Refugees are themselves a select group – often from the most deprived communities and most conflict-affected communities in Syria. Adult refugees bring with them the healthcare seeking patterns and expectations developed in Syria – a country that before the conflict had extensive and publically provided healthcare services. West *et al* find, for example, that refugee women had a high level of acceptability of family planning,<sup>1</sup> and note this is not surprising given that they come from a country that had a contraceptive prevalence rate nationally of 54% before the conflict.

The common language and culture of the Syrian refugees and host populations in Lebanon and Jordan means it is challenging to identify and access those living among host populations for research purposes. This makes it difficult to measure the coverage of needed, evidence-based interventions. In these countries many refugees live outside formal camps, an estimated 75% of refugees in Jordan<sup>6</sup> (even though the Jordanian government set up official camps for Syrian refugees), and nearly 100% in Lebanon where most reside in local Lebanese communities as well as in informal tented settlements. There are also difficulties in sampling given the mobility of refugee populations and where no sampling frame exists. Many studies, including West *et al*'s, are understandably based on small and convenience samples, often the beneficiaries of



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camp or non-governmental organisation services.<sup>7</sup> When data are restricted to multiple small-scale assessments it is difficult to assess overall population needs in a timely way needed to inform intervention.

Nevertheless, qualitative studies such as West *et al*'s study have an important role to play in eliciting refugee experiences of healthcare and their perceptions of gaps in existing services. Two key findings were the fact that no healthcare provider (HCP) had talked to the women interviewed for their study at any point about family planning use, and that women prefer speaking with a female HCP about these topics. This latter finding was confirmed by a review of the implementation in Jordan of the Minimum Initial Services Package developed by the Inter-Agency Working Group on Refugee Reproductive Health (IAWG)<sup>8</sup> and recommended for all humanitarian settings.<sup>9</sup> This suggests that sensitisation of HCPs and increased availability of female HCPs would be valuable steps. Knowledge of available SRH services (which are culturally sensitive in many contexts but arguably particularly in the Middle East region) is a critical gap for refugees. Both in Lebanon and Jordan, studies have found that many Syrian refugees – particularly those living outside official camps – are not aware of the SRH services available to them, and their associated costs, or may not have the mobility to access them. This is likely to be particularly true for adolescent Syrian refugees (married and unmarried) who are particularly under-researched. Evidence from both Jordan and Lebanon suggests that rates of early marriage among Syrian refugees are on the rise, although there is a lack of rigorous population-based studies.

In Jordan, refugees outside camps typically use the same services as local populations, so strengthening these government services that both host and refugee populations rely on is arguably the best and most sustainable way forward, particularly given the protracted and complex nature of this crisis. A recent report shows that refugees in Jordan have similar contraceptive access to Jordanians in host communities.<sup>6</sup> Indeed, in the areas of Jordan and Lebanon bordering Syria, many refugees are from the same origins and sometimes even the same families as their Lebanese or Jordanian host communities, and border-crossing was frequent before the conflict. A recent decree (February 2016) by the Jordanian Ministry of Health making all governmental maternal and child health services including family planning free of charge for all fully registered Syrian refugees<sup>6</sup> is a critical step, but will require international support to be honoured. Middle-income countries facing their own economic and health problems cannot be expected to shoulder this burden.

West and colleagues rightly argue for the involvement of refugees in their own healthcare. Indeed, highly trained doctors, midwives and other HCPs are among the Syrian refugees in Lebanon and Jordan.

However, both countries do not allow Syrian refugees to work except in certain limited sectors not including the health sector, and thus finding ways to engage these individuals is critical and would increase understanding of population needs.

There is also a need to develop and support research capacity in the conflict-affected countries such as Lebanon and Jordan. Researchers in such countries are in a prime position to collaborate with existing governmental and service providers to maximise the chances that findings from research can inform positive change in services and programmes. Research on refugees in Lebanon and Jordan has recently proliferated, potentially posing a burden on the refugees; for ethical reasons it is essential that such research is translated into improved services for these populations.

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