Responding to the Syrian crisis: the needs of women and girls

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Women and girls are disproportionately affected by conflict because of a lack of access to essential services, as learnt from humanitarian crises in recent years.[1,2] Poor access to sexual assault treatment and emergency obstetric care can contribute to negative health outcomes.[1] In Syria, women and girls are strongly affected by the recent conflict and, according to the UN Population Fund, about 1·7 million women and girls might need access to reproductive health services.[3] Because women often have an essential role in postconflict reconstruction, their basic needs should be met so they can emerge from this ongoing crisis as essential stakeholders in the recovery process.

The Syrian civil war has entered its third year, resulting in 6·8 million people who need humanitarian assistance, with 5·1 million people internally displaced and 79% of refugees living in urban settings (not camps).[4,5] These estimates change daily as the fighting intensifies. Access to internally displaced people for international organisations is becoming more difficult in Syria.[6] The poor access to civilians restricts humanitarian assistance and is a violation of international humanitarian law, which could ultimately result in loss of life.[7] Numbers of displaced Syrians are expected to continue to rise.[8] The Regional Response Plan for Syria,[9] released in June, 2013, requests the humanitarian community to respond to this crisis. At present, only 40% of the total funding requested for Syria has been received.[4] Inclusion of long-term planning of comprehensive reproductive health services is imperative to reduce risk factors for reproductive-health-associated causes of morbidity and mortality.

Previous crises in Afghanistan and Sierra Leone have shown that women and girls are at an increased risk of exposure to gender-based violence, particularly sexual violence, deteriorating mental health, and maternal and newborn complications.[10] These risks are related to a rise in female-headed households, which cause additional burdens for women as caregivers and providers, and to diminished access to reproductive health services, including family planning and emergency obstetric care.[1] Women and girls can face stress-related mental illness due to hardships associated with war, which can be compounded by displacement. If adequate psychosocial services are not in place, then women face long-term consequences related to anxiety and post-traumatic stress disorder.[11] Additionally, prolonged emergencies can weaken health systems, with long-lasting effects on maternal and infant mortality, as seen in countries previously affected by conflict.[10,12]

As in most conflicts, Syrian women and children comprise the largest proportion of displaced people, at present about 78%.[3] Similar to the Iraqi crisis, a recent assessment from Jordan noted that Syrian women view reproductive health to be a crucial issue, but that barriers prevent them from accessing services.[13,14] An assessment in Egypt reported that primary health care is expensive and not easily accessible for Syrian refugees.[5] In Lebanon, Syrian refugee women have reported that they attend few antenatal care visits and delay pregnancy because of high out-of-pocket costs associated with these services.[15] Additionally, the effect of the refugee influx has been felt in the host community and health sector. A report described a 50% increase in patient caseload at health clinics in Lebanon and an increase in ambulance wait times because of a high demand for transport.[16] In view of the high cost of referral care in Lebanon, up to 75% of the cost is covered by UN High Commissioner for Refugees. For vulnerable people, provision is made for coverage to be increased to up to 90% and, for some disorders, is up to 100%. All victims of torture or survivors of sexual and gender-based violence will be covered for up to 100% after the incident. By contrast, the UN High Commissioner for Refugees in Jordan pays 100% of the costs for patients referred from Zaatri camp or for those who are unregistered. Urban refugees in Jordan identified the scarcity of female doctors, distance to clinics, and high costs for private clinics and transport as obstacles to people obtaining care.[17] This situation is similar to that of Iraqi refugees in Jordan, where reports of expensive transport and private clinics, and scarcity of knowledge of free services, had prevented women from obtaining reproductive health services.[14] The fact that more than three-quarters of the refugee population are women and children emphasises that humanitarian organisations should be aware of findings of assessments as they work to improve reproductive health services.

The humanitarian community acknowledges the importance of protection for women and girls fleeing Syria.[8] The defence of vulnerable populations is often seen as the responsibility of only those agencies with a mandate for protection. However, protection issues occur in areas such as health, livelihood, education, and food security. The risks to refugee women and children are substantial, and gender-based violence might be exacerbated as the situation in Syria continues. The scarcity of adequate shelter in this crisis because of high rent in urban centres, congested camps, and informal settlements (which are rapidly increasing in Lebanon) increases risks for women, particularly those in female-headed households.[8] For example, in an assessment of urban refuges in Jordan, nearly half of female-headed households had no monthly income and depended on donations.[15] In the community, women and girls face harassment, including offers for transactional sex and marriage, and, in the home, they might face domestic violence by male relatives as frustrations intensify.[13]

Inside Syria, about 1·7 million women of reproductive age are in need of assistance and do not have access to reproductive health services.[3] The human rights violations occurring in Syria, such as attacks on civilians and hospitals,[6] affect women's access to safe deliveries, and antenatal and postnatal care. Recent reports document that a growing proportion of total deliveries are done by caesarean sections in Homs (66%), Aleppo (60%), and Damascus (52%) because of safety concerns and fears of having an unattended birth. Similarly, more women are giving birth at home than were before the crisis.[18] Both caesarean section deliveries and at-home births pose risks that can threaten the life of the mother and newborn baby.

Since the formation of the UN Department of Humanitarian Affairs in 1991, the Sphere Project and other global initiatives were founded to establish standards for humanitarian assistance.[19] The Minimum Initial Service Package for Reproductive Health (MISP), which prioritises lifesaving measures to prevent excess morbidity and mortality at the onset of a humanitarian emergency, has become a recognised humanitarian standard as part of their targeting of the health-care needs of women of reproductive age. Overall, MISP aims to improve coordination of reproductive health services, prevent and respond to sexual violence, prevent maternal and neonatal morbidity and mortality, reduce HIV transmission, and plan for comprehensive reproductive health services as part of primary health care.[10] Case studies from crises in Goma (Congo) and Afghanistan have shown the challenges in the implementation of MISP services due to scarcities in trained staff and resources needed to meet minimum standards in humanitarian emergencies.[20]

Collection and analysis (by sex and age) of reproductive health data are crucial to understand the scope and magnitude of the health situation, characterise unmet needs, identify at-risk populations, and target scarce resources to where they are needed most. Additionally, with most Syrian refugees residing outside camps, data are urgently needed for the status and coverage of reproductive health in urban settings so that interventions can be better targeted. Data availability and use is far better in camp-based settings with health information systems. In Jordan, data from Zaatri camp indicated that, in the first 3 months of 2013, only 29% of women had four or more antenatal visits at the time of delivery.[4] This information assists in the design of lifesaving interventions and in the planning of comprehensive MISP services for women and girls.[20]

The realities of a continuing acute emergency, in addition to the situation of Syrian refugees who have crossed the border into neighbouring countries, challenge the implementation of services, including MISP, mainly when attempting to scale-up and expand services. As the Syrian crisis continues, the humanitarian response will be faced with provision of both comprehensive reproductive health services and additional MISP priority services for the newly displaced. Other priorities include the importance of maintaining of a contraceptive supply chain, continuing training of staff, and provision for community education. The use of syndrome-based treatment for sexually transmitted infections is essential, since infections, if left untreated, can lead to serious long-term health effects. The continuation of antiretroviral drugs to those on treatment for HIV needs to be maintained to prevent drug resistance, and the provision of culturally appropriate sanitary materials to women and girls could become a part of hygiene non-food-item distribution.[10] Despite the complexities of the situation, relief agencies emphasise that the focus on women is a key strategy in the effort to improve the health of the Syrian community.[8]

Reproductive health needs are increasingly being recognised in crises. Although guidelines and standards now exist, the 2004 Global Evaluation of Reproductive Health in Crises reported gaps in funding, institutional capacity, and access to effective interventions.[12] The Syrian crisis is complex; the refugee numbers continue to increase and the strain on host communities is exacerbated. The long-term implications for reproductive health services have been noted by host governments and UN agencies in an effort to support the continued, rather than sporadic, provision of essential services. These services include human resources for health-care provision, health technologies and pharmaceuticals, health-information systems, and health-care financing.[5]

Despite the increased complexity of these settings, the humanitarian community has improved the status of reproductive health in displaced populations.[20] Reports from the Iraqi crisis have improved the humanitarian response for refugees overall.[14] Nevertheless, lessons learnt from more than a decade of emergencies[20] emphasise that health systems are under substantial strain, and that attention must be given to the integration of services within national health systems to support host governments with equity between host and refugee populations.[5] Recommendations to support women and girls include new approaches for reaching hard-to-access populations within Syria, and improved coverage of out-of-camp refugees. Additionally, increased access to cash assistance, in place of in-kind support, is needed to mitigate risks for sexual exploitation and abuse. Expedited registration of refugees needs to be continued to ensure continuing access to life-saving reproductive health services and to offer protection for women and girls who are at increased risk for abuse. Despite the opening of additional refugee camps in neighbouring countries, long-term strategies must address the growing tensions about access to livelihoods and services in host communities.[5] Ultimately, because of the extended nature of the conflict, the humanitarian response and development agendas need to be integrated to provide opportunities to strengthen health, education, and sanitation infrastructure to accommodate the refugees and host communities.

Contributors

SS, HW, and BT developed the original ideas and drafts for the Viewpoint, and SK, AB, and MA contributed further ideas. SS and HW wrote the Viewpoint. All authors edited the Viewpoint.

Conflicts of interest

We declare that we have no conflicts of interest.

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