

Islamic Relief

ARE WOMEN ABLE TO ACCESS HEALTHCARE IN NORTH-WEST SYRIA?

A learning paper reflecting on women's needs and access to healthcare in north-west Syria.



Islamic Relief Syria Field Team 2021



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This paper is funded by the Swedish International Development Agency (SIDA).

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Executive summary

The devastating effects of the Syrian crisis over the past 12 years are impacting an ever-greater number of people. Access to healthcare services is a particularly acute challenge for many women. More than 50% of trained health professionals have left north-west Syria, while there has been a significant decline in the number of available healthcare facilities (18.8% decline in the 4th quarter of 2021 alone). As a result, many women and girls are unable to access healthcare services, a problem which is further exacerbated by protection risks and social customs that restrict their mobility.

Since 2012, Islamic Relief has targeted its assistance in north-west Syria predominantly on health interventions. This includes working with partners to provide free healthcare services. Islamic Relief programmes reach more than 500,000 people annually, the overwhelming majority of whom are internally displaced people (IDPs). In 2020, Islamic Relief Worldwide initiated a series of learning papers to understand the specific needs and barriers to accessing health services for women and girls and other at-risk groups. Data was collected from approximately 1000 participants in four health facilities in Harim and Idleb in north-west Syria.

Our findings indicate that customs and traditions are the major barrier preventing access to healthcare facilities for women and girls. They are socially required to be accompanied by a male guardian or a relative and are only allowed to seek help on their own in extreme circumstances. Women are expected to be seen by female doctors in most circumstances, presenting another significant barrier for women due to the lack of female doctors in north-west Syria. Education is also a key factor in access to healthcare. Women and girls with a higher education level are more aware of their health needs and better able to access healthcare facilities.

Study Objectives

The purpose of this learning paper is to provide a gendered analysis and build understanding of the factors affecting and limiting women and girls' access to healthcare in north-west Syria. The paper will capture perceptions and attitudes towards women and girls' health and identify barriers that restrict their access to healthcare facilities. The findings and recommendations are intended to support the development and design of Islamic Relief Syria's healthcare programmes, supporting these interventions to be more inclusive and accessible for women and girls in north-west Syria.

Access to healthcare for women and girls in north-west Syria

The Syrian crisis has been raging for nearly 12 years now, with no end in sight. The United Nations Human Rights Office estimates that more than 350,000 lives have been lost in the first ten years of the crisis.

This complex crisis has also caused one of the largest displacement waves of the 21st century. 36.5% of the population is internally displaced with millions more having fled Syria and sought refuge elsewhere. Many of those that remain in Syria face extremely challenging circumstances and have numerous and complex humanitarian needs. According to the 2022 Humanitarian Needs Overview, 14.6 million people in Syria are in need of humanitarian assistance, an increase of 1.2 million from 2021 – this number includes 7.2 million women and girls. 12.2 million are in need of health assistance, including 6 million women and girls.

These needs are compounded by the dire socioeconomic situation in north-west Syria, which has deteriorated further still as a result of lockdowns driven by the COVID-19 pandemic and, more recently, the Russian-Ukrainian conflict. (HNO 2022)

Health services in north-west Syria

As of May 2022, the total number of functional health facilities in north-west Syria is 372. This compares to 442 in the 4th quarter of 2021 (representing an 18.8% decline) and consists of the following: 170 primary healthcare facilities (PHCs), 63 hospitals, 45 mobile clinics, 42 specialised care centres and 52 other health facilities.

Alongside the decline in health facilities, the healthcare system continues to suffer from a chronic shortage of health professionals. It is estimated that more than 50% of trained health professionals in north-west Syria have left since the start of the crisis. An average of 13 health staff are now available per 10,000 of the population, just over 50% of the minimum of 22 health staff per 10,000 people deemed to be the emergency standard. In many districts, the actual number is less than 10.



Protection risks for women and girls

Women and girls' access to humanitarian aid is severely limited, which makes their needs even more critical and addressing those needs more challenging. A lack or loss of civil documentation impacts all population groups, but makes women particularly vulnerable. It limits the ability of widowed or divorced women to inherit property, secure custody of children, legally remarry, or register children that are born through subsequent relationships. It compounds a series of existing protection risks, further limiting their access to humanitarian assistance. Movement restrictions across communities, due to a variety of protection issues, impact people's ability to access services, in particular healthcare, which disproportionately affects women and girls.

Women and girls also continue to be disproportionately affected by gender-based violence (GBV). The prevalence of GBV, the impunity enjoyed by perpetrators and the absence of functional institutions that guarantee women's and girls' rights and safety, are all factors that negatively impact women and girls, limiting their freedom and eroding their resilience. Inequitable gender norms relegate women and girls to positions of subordination and are used to justify the use of violence against them across Syria. Social norms and family restrictions prevent many women and girls from accessing the job market. Women and girls are subjected to increased denial of economic resources and education, movement restrictions, exploitation, forced and child marriage, intimate partner and family violence, technology facilitated violence and physical, psychological, emotional, sexual, and social violence (HNO 2022).

Islamic Relief response: Health Programme

Islamic Relief has provided assistance to the health sector in north-west Syria since 2012, working with partners and local stakeholders to provide health services free of charge. These services include the provision of medicine, surgical consumables, emergency trauma items, thalassemia treatments, open-heart surgeries, haemodialysis and primary and secondary healthcare. These services reach more than 500,000 people annually in north-west Syria, the vast majority of whom are IDPs.

Learning exercise

This learning paper follows a 2020 learning paper that examined the referral service which had been newly introduced at the supported health facilities. The 2020 learning paper contributed significantly to increasing access to health facilities for the most at-risk people in north-west Syria, including persons with disabilities (PWDs), women and elderly beneficiaries. It is hoped that this learning paper will deliver a similar contribution in identifying and addressing the barriers to accessing healthcare among women and girls in north-west Syria.



Methodology

a. Sample size and description

A total of 627 males and 275 females were surveyed for this learning paper. The surveys took place in the Harim and Idlib districts in Idlib governorate in north-west Syria. Participants were randomly selected from attendees of healthcare facilities that provided primary healthcare services mainly free of charge. The health facilities were supported under the SIDA-funded project implemented by Islamic Relief Syria. The surveys were undertaken over a period of seven days by a team of volunteers (men and women) at four health facilities:

1. Babisqa, Harim
2. Deir Hassan, Harim
3. Bartakli, Harim
4. Ram Hamdan, Idlib

All participants were interviewed by a surveyor of the same gender to ensure the information was as accurate as possible and to prevent any potential harm and stigma arising from the perceived mixing between men and women.

The information collected was predominantly qualitative as the study's objective is to identify specific barriers (attitudinal, social or others) in north-west Syria to women and girls' access to healthcare.

The healthcare facilities at which the data was collected were selected as they were deemed more suitable than the more expensive private health centres that were less likely to provide a representative sample of women and girls and those most in need in north-west Syria. Three of the four selected health facilities serve mostly IDPs.

b. Demographic distribution

There were a total of 902 respondents to the survey. Men and women over the age of 18 were the main survey respondents. The survey reached a very small percentages of boys (0.18% of all males interviewed) and girls.

Of the 627 respondents that were male, 60% were aged between 18 and 39 years, 35% were aged between 40 and 59 years and 5% were aged over 60 years.

Of the 247 respondents that were female, 10% were aged under 18, 65% were aged between 18 and 39 years, 23% were aged between 40 and 59 years and 1.8% were aged over 60 years.

228 of the female respondents and 570 of the male respondents were internally displaced. IDPs, many of whom live in camps, are highly represented in the sample as they are the population with the most severe humanitarian needs.

c. Research limitations

The sample size for those aged over 60 is small and unrepresentative of the overall population in north-west Syria. Only 1.8% of female and 4.9% of male respondents are aged above 60, whereas, according to the Syrian Response Coordinators Group, approximately 10% of people in north-west Syria are in this age bracket. This presents a barrier to fully understanding the significant needs of people aged over 60. The percentage of beneficiaries aged over 60 from the targeted centres is similar to that of the general population (7-10% of all beneficiaries) and there appears to be a reluctance on the part of those aged over 60 to participate in this survey.

PWDs appear to be overrepresented in the sample. 55% of female respondents and 57% of male respondents are PWDs. The extent of the overrepresentation of PWDs is challenging to determine as the exact size of the PWD population in north-west Syria is not clear. It is expected to be higher than the global average of 15-20% due to the large amount of injuries caused by the crisis.

Findings

a. Differences among age groups

Respondents in older age groups expressed a greater degree of access to healthcare. In response to the question “If the date of the vaccine of her children at the medical centre is set, should a woman go to the vaccine centre?” twice as many respondents (80%) from the over 60 years bracket stated that there was no problem for women to attend the vaccine centre compared to respondents from the 18-39 years bracket (40%)

However, men tend to prevent women from going to the vaccine centre without an accompanying relative or friend. One respondent, when asked about agreeing to his wife attending a vaccination centre, responded that he would not let his wife go out of the house without him under any circumstance, including for vaccination, underscoring the restrictions imposed by some males on their female family members.

When different age groups were asked “Would it be acceptable for a woman to get treated by a male doctor?”, the younger the men are, the greater the likelihood that they will prevent their female family members from being treated by a male doctor. 10% of men aged between 18 and 39 years responded that they would categorically deny a female’s access to a male doctor for any reason, compared to just 3% of respondents in older groups (60 years and over).

b. Findings according to themes

Availability of medical services: location and distance

60% of females and 77% of male respondents stated that there are medical services available nearby. This disparity demonstrates that female respondents perceive the distances to medical services as greater, which likely reflects the fact that women lack access to means of transportation, such as motorcycles or cars.

Furthermore, not all women are able to access those centres. 46% of female respondents, as opposed to 31% of male respondents, stated that the main reason for women not being sent to

medical centres was the distance of those centres, demonstrating that distance is perceived as a bigger barrier by women.

Female respondents expressed worse perceptions than men of the conditions faced by other women in the community. For example, women view their access to healthcare as more severely limited: female respondents stated that women have less control and face a higher likelihood of severe consequences if women do not comply with the demands of their husbands or guardians.

Both male (89%) and female (78%) respondents expressed awareness of the importance of specialised medical services, as opposed to traditional or home remedies.

Female respondents stated that it takes less time to access pharmacies than to see the doctor in the health centre. Pharmacies are available to access most of the day while the medical centres usually close at 2pm. Almost twice as many female respondents expressed their reliance on pharmacies compared to male respondents, reflecting the importance of pharmacies above primary medical facilities for women and girls’ access to healthcare.

Social attitudes

The findings from this study demonstrate that it is socially unacceptable for women to be treated by male doctors. Only 17% of male and 7% of female respondents stated that it is completely acceptable for women to be treated by a male doctor. 8% of male and 19% of female respondents indicated that it is not acceptable under any circumstance, demonstrating the stigma associated with this issue in north-west Syria and that men and women perceive the control of women differently. The majority of respondents (75% of males and 73% of females) would accept a female being treated by a male doctor only in the case of an emergency and if a female doctor is unavailable.

44% of male and 52% of female respondents stated that the reason for not allowing a female to be treated by a male doctor is social and relates to acceptable norms within north-west Syria. 28%

of women and 32% of male respondents stated that it is related to their own family values, while just 16% of female and 18% of male respondents stated that it is due to the patient's comfort or preference to be treated by a male doctor. There is also an apparent relationship between education levels and access to health facilities. The lower the educational level of both male and female respondents, the more likely it is that women will be prevented from seeing a male doctor.

Many respondents also reflected the prevailing view in their communities of female access to healthcare. When asked if he would let his wife go to a health facility, one male respondent stated that "in the customs and traditions of the area, it is not acceptable to present his wife to men" and that he would even let his wife give birth at home, without the presence of a midwife, should no female doctor be available.

Male dominance in decision making

When questioned about what actions they would take if their husband is away from home and they begin to feel labour pains, 70% of female respondents stated that they would usually stay at home and wait for the assistance of relatives. 45% of male respondents provided the same response, demonstrating the extent of male dominance over decision making in the family even in their absence. Only 25% of female respondents stated that they would be allowed to bring a midwife home, while 46% of male respondents stated that men would allow a midwife to come to their home.

This is likely to be explained by the differences between male and female perceptions of control. Women perceive themselves to be less in control, even when it comes to matters such as labour and childbirth. In these societies, men exercise control over the family's decisions and women are often prevented from accessing medical support, unless under many restrictions.

Both female and male respondents demonstrated awareness of the impact on women's health of giving birth to more children. Despite this awareness, men tend to prioritise the observation of social norms even when they may conflict with a woman's health needs. In many situations in north-west Syria, coercive behaviour by men can interact with limited awareness of women's healthcare needs, leading to dangerous situations

for women who lack any decision-making power within the family.

The main social drivers preventing access to specialised healthcare are customs and traditions. Men often seek solutions for illnesses or health problems that align with the customs of a community, such as medicinal herbs or other forms of traditional medicine, as opposed to more suitable healthcare services.

The impact of customs and traditions is evident in the low vaccination rates for many children. 11% of female respondents stated that they did not plan to vaccinate their children, due to a lack of confidence in the vaccine effectiveness. Yet difficulty in accessing healthcare centres prevent much larger numbers of women from vaccinating their children. As a result of fear of women attending healthcare centres without an escort, 56% of women do not vaccinate their children or postpone their vaccination dates.

Female reliance on men and their wider family is also evident in the ability of women to get their children vaccinated. All female respondents stated that they rely on their family support system to access vaccination services. 47% of female respondents stated that they will ask their brother-in-law to accompany them to the medical centre, while 53% will have their mother-in-law accompany them.

35% of male respondents stated that they do not allow their wives to go out and vaccinate the children unaccompanied and are ready to postpone vaccination dates of their children if nobody is able to accompany their wives. This attitude not only endangers the health of the women but also that of the children.

The reasons stated by male respondents for preventing women leaving their homes to go to vaccination centres are the distances to the centres, the lack of transportation and the fear of harm due to the security situation inside north-west Syria.

There is a clear difference between female and male responses on this topic. Only 33% of female respondents stated that they would go alone with the child, whereas 60% of male respondents stated they would allow their wives to go out with the child alone. This suggests that men are able to compromise and understand needs when faced

with the prospect of a risk to their children's lives. 56% of female respondents stated they will wait for the next campaign (vaccination teams open vaccination clinics periodically for community members to receive vaccinations) compared to 35% of male respondents. Social fear prevents women from accessing services even for their own children's benefit.

79% of female respondents stated that their husband allows them to travel to the health centre by ambulance, compared to 90% of male respondents. These responses demonstrate that women view their ability to access healthcare less favourably than men and perceive greater barriers preventing them from accessing healthcare services. From the perspective of women interviewed for this study, women's access to healthcare is greatly restricted.

Access to education

16% of female respondents stated that girls receive education in their communities, compared to 42% of male respondents. Based on gender analysis research looking at access to education in north-west Syria, conducted by Islamic Relief Syria in the past, it has been found that the education level of girls is significantly lower than boys.

87% of female respondents stated that girls who do not attend school stayed at home, compared to 59% of male respondents. As with access to healthcare, the responses of women to this study reveal that women view the ability of girls to access education in their communities less favorably than men.

Just 1% of female respondents stated that girls are married only once they are 18 years of age or older, compared to 17% of male respondents. Statistics demonstrate that girls getting married under 18 is very common in north-west Syria, this is reflected in all the female respondents (including 28 girls) indicating that they are married.

The causes of child marriage are varied. They include the fear of parents for their daughters' future and their belief that they need a breadwinner to care for them because they have not received an education nor trained for any profession. The extreme poverty that many

community members face also forces them to find whatever coping mechanisms they can to reduce their spending.

Control over income

The majority of female respondents work to generate an income. 70% of male respondents and 72% of female respondents stated that women work in their area. 52% of female respondents who work give their income directly to their husband, while the remaining 48% stated that they spend it on their household and children's needs. Only 35% of male respondents stated that women give their income to their husband.

A high proportion of men across all age groups deny women control over income, even when that income has been earned by the woman. A woman obtaining the right to work does not necessarily mean that they have the right to freely spend the money that they earn. Women are particularly restricted from spending any part of their salary on themselves.

If the woman does not give her income to her husband or male guardian, most respondents stated that the husband would take the salary by force or prevent the woman from working.

Acceptance of the use of force against women who do not give their income to their husband or male guardian is greatest among older age groups.

Physical abuse and the use of force by men against women who refuse to give them their income can include all forms of GBV. Female respondents to this survey spoke about a range of forms of power that a man exerts to pressure his wife to give him the salary that she receives.

General mobility

Gender roles are divided in line with traditional social customs. Women tend to specialise in housework while men work outside the home.

A lack of trust in the communities in which they live and the unstable security situation in north-west Syria causes most men to prevent their wives from leaving the house and most women to consent to this ban.

Available resources to increase awareness on women's health issues



a. Toolkits and training available in north-west Syria

There are numerous training toolkits available inside north-west Syria and which are already being implemented. However, training toolkits inside north-west Syria must abide by certain rules and social norms to avoid causing any harm to beneficiaries, aid workers or community members.

It is important to note that the recourse to legal action is severely limited inside north-west Syria due to the absence of state institutions, such as the police and judiciary. The high incidence of GBV is often perceived as ordinary among communities in north-west Syria, preventing survivors from obtaining support or help. Further, the widespread prevalence of firearms inside north-west Syria due to the crisis increases the potential for arms to be used in the case of family feuds or intimate partner violence.

Toolkits available in north-west Syria include:

- GBV awareness raising toolkit -GBV-SC
- My safety, my wellbeing
- Amal initiative - CARE UNFPA

Trainings available in north-west Syria include:

- Young mother club care – UNFPA
- Young parents club – UNICEF
- Emotional support platform

Recommendations

- Awareness raising campaigns aimed at both men and women regarding the dangers of women not receiving healthcare should be implemented.
- A male awareness team should aim to raise awareness among male community members, alongside a female awareness team to raise awareness among women and girls.
- Health committees should be established comprised of members from the community and referral workers, who are trusted by the community, to help identify and reach women and girls in need of specialist healthcare services and increase their access to these services.
- Awareness raising toolkits should include education resources targeted at women and girls to help bring about a change in customs and traditions and improve their access to healthcare.
- A self-care programme for women and girls should be established to increase awareness of the need for self-care.
- Awareness raising efforts should be targeted towards younger age groups.
- Awareness raising efforts should place strong emphasis on gender equality to reduce male authority and dominance.
- Targeted programmes for women should include an emotional support programme that helps women form friendships and increases their sense of safety.
- All awareness raising efforts should seek to build greater understanding of human rights and women's rights.
- Community committees consisting of protection workers, health workers, community leaders and decision makers should be prioritised. Efforts should be made to build their capacities within protection and health training and integrate protection measures into health programmes. High-risk cases should be monitored and linked to a safe referral path, including the activation of referral vehicles.
- Greater efforts should be made to raise awareness of children's rights and the importance of vaccination.
- Outreach teams should establish referral pathways to integrate women into alternative education, psychological support and empowerment centres as an alternative to schools or literacy courses for women.
- Wider efforts should be made to educate both men and women about women's rights and build understanding and awareness of gender-based violence. This should include programmes that educate and inform both men and women about the seven awareness subjects regarding gender issues to increase knowledge of and access to gender-based violence services that save lives. These should include mutual support as a means to prevent gender-based violence and build awareness that domestic violence is a form of gender-based violence.
- Greater efforts should be made to integrate women into education.
- Men should be involved in prevention programmes to increase their understanding and capacity to support women.

Annex 1: Questionnaire

The survey aimed to capture the perceptions of interviewees regarding female health, its importance and access of females to healthcare in their communities, as well as other perceptions on associated issues. The data was collected through KOBO by a volunteer who received training on basic communication skills as well as the meaning of each survey question. The responses were gathered and analysed through a data base Excel file.

1. How do women in this community receive medical services?
2. Are there medical centres near you?
3. Why aren't women sent to the medical centres?
4. Your husband is away from home, you are pregnant and have been exposed to labour pain - what do you do?
5. Do you accept calling an ambulance to take your wife to the birth centre?
6. If you are not at home, who will be responsible for providing for the needs?
7. What prevents women from leaving the house?
8. Did your children receive vaccines?
9. If the date of the vaccine of her children at the medical center is set, should a woman go to the vaccine center?
10. If there is no way to communicate with her husband or relative to obtain permission to leave, and the vaccination campaign is carried out today while you are absent, what is the solution in your opinion?
11. In the same situation if there are no relatives to accompany her, what should the woman do?
12. In the community do girls receive education in your regions and to which stage?
13. If girls don't go to school, what places do those girls go to?
14. Is there a community centre that girls can go to?
15. Do women work in your area?
16. What do working women in your community do with the income that they earn?
17. What happens if a woman doesn't give her husband or male guardian her income?
18. At which age do girls generally get married in your community?
19. At what age do boys generally marry in your community?
20. What are the types of abuse that women mostly face in your area?
21. Do you think that giving birth to a lot of children affects the wife's health?
22. Would it be acceptable for a woman to get treated by a male doctor?
23. If men refuse to get women and/or girls in their household treated by male doctors, what are their reasons?



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