REPRODUCTIVE HEALTH matters

COMMENTARY

Systemic violence against Syrian refugee women and the myth of effective intrapersonal interventions

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Abstract: *Since the uprising in Syria in March 2011, over 4.3 million Syrians have fled to neighboring countries. Over a million have sought refuge in Lebanon, constituting almost a quarter of the Lebanese population and becoming the largest refugee population per capita in the world. With inequitable health coverage being a longstanding problem in Lebanon, Syrian refugee women's health, and specifically their sexual and reproductive health, is disproportionately affected. An increase in gender-based violence and early marriage, a lack of access to emergency obstetric care, limited access to contraception, forced cesarean sections, and high cost of healthcare services, all contribute to poor sexual and reproductive health. In this commentary, we conceptualize violence against Syrian refugee women using the ecological model, exploring the intersections of discrimination based on ethnicity, gender, and socioeconomic status, while critiquing interventions that focus solely on the intrapersonal level and ignore the role of microsystemic, exosystemic, and macrosystemic factors of negative influence. These social determinants of health supersede the individual realm of health behavior, and hinder women in taking decisions about their sexual and reproductive health.*

Keywords: Lebanon, Syria, sexual and reproductive health, refugee health, women refugees, ecological model

Introduction

Since the uprising in Syria in March 2011, over 4.3 million Syrians have fled to neighboring countries, of whom over a million sought refuge in Lebanon.[1] The number of Syrian refugees in Lebanon constitutes almost a quarter of the Lebanese population, which now hosts the largest refugee population per capita in the world.[2] Most victims of the conflict are civilians, a majority of whom are women and children.[3] In addition to being exposed to war and conflict, they are currently also deprived of the most basic needs, such as food, water, housing, education, healthcare, and protection.[4]

The experience of Syrian refugee women in Lebanon, facing institutionalized multi-systemic violence, is often lost in a reductive analysis of women in war and gender-based violence (GBV). Sexist, classist, and racist political agendas on the part of the hosting community, governmental institutions, and healthcare systems, as well as women's own interpersonal circles, are rarely addressed as underlying culprits negatively impacting Syrian women's sexual and reproductive health (SRH).[5]

Syrian refugee health in Lebanon

Even before the influx of Syrian refugees, the Lebanese public healthcare system was structurally weak, focusing solely on the provision of services while playing an insufficient role in prevention, planning, and accessibility. The Ministry of Public Health has spent over 54% of its national budget on the private healthcare industry, which has led to a majority of Lebanese citizens paying out-of-pocket.[6] Already inaccessible and unaffordable, the Lebanese public healthcare system was unprepared to accommodate large numbers of refugees.

Primary and secondary healthcare is currently available for Syrian refugees, but includes making out-of-pocket payments which most refugees cannot afford. The Office of the United Nations High Commissioner for Refugees (UNHCR) covers 75% of the cost of life-saving emergency treatments, delivery, and newborn care, and a few patients manage to get non-governmental organizations (NGOs) to reimburse the remaining 25%.[7] Meanwhile, as Syrian refugees struggle to pay healthcare bills, hospitals in Lebanon have resorted to

aggressive methods such as withholding corpses, holding newborns hostage, or confiscating personal IDs as a measure to enforce payment of the remaining 25% from refugees.[8]

Syrian refugee women are disproportionately affected by the situation in Lebanon, due to the increase in GBV (particularly intimate partner violence (IPV), early marriage, transactional sex, sexual assaults), as well as lack of access to emergency obstetric care, limited access to contraception,[9,10] forced cesarean sections,[3] and the high cost of healthcare services. These factors lead to fewer antenatal care (ANC) visits, delayed family planning, and all round poorer reproductive health.[9] Women are also at risk of stress-related mental disorders due to war, trauma, and displacement. Harassment and rape continue to take place in refugee camps, and early marriage is seen as a means of keeping daughters safe and protecting them from poverty.[10]

The social ecological model of violence prevention

The social ecological model takes into account multiple levels of influence on health behavior, emphasizing how individual, contextual, and sociocultural factors play out in creating a situation of inequitable health for marginalized populations.[11] In this commentary, we rely on Heise's approach to the ecological model, which she has used to conceptualize violence against women (VAW).[12] Within this framework, violence is perpetuated through four multilayered factors. The first is the *intra-individual level*, or one's personal history, which influences one's health behavior. The second is the *microsystem*, or one's immediate context, such as interactions with friends, family, and partners. The third is the *exosystem*, which in this case includes all the formal and informal institutions that influence Syrian refugee women's health behavior, such as their work context, social networks, UNHCR and the humanitarian aid system, the police, and the policies adopted by the Ministry of Health and municipalities in Lebanon. Finally, the fourth factor is the *macrosystem*, which represents the views and attitudes predominant in the culture.

In this commentary, we are concerned with the attitudes of healthcare providers, aid workers, landlords, employers, and the host community at large, all of which are influenced by the media and national and local policies (see Figure 1). The current paper elaborates on the *micro*-, *exo*-, and *macro*-system factors, and the ways in which they interact to negatively impact the health of Syrian refugee women in Lebanon. Rather than focusing solely on the *intra-individual* level, this model provides a comprehensive approach to understanding the health behavior of these women, while broadening the options for interventions.[11,14] In examining sexual assault, for example, Sallis et al argue that framing the impact of sexual assault simply from a post-traumatic stress disorder (PTSD) perspective, or any other trauma model of rape, risks pathologizing the victim and perpetuating ethnocultural biases.[11] Therefore, the utilization of the social ecological model helps us keep in mind that VAW does not occur in a social and cultural vacuum. It is a matter of social injustice rather than solely an individual wrong — where society at large, from the micro-level to the macro-level, makes these acts possible and even acceptable.[12,13] The utility of such a model provides multiple levels of intervention and analysis for shifting the focus and blame off the victim and onto the pervasiveness of larger systems.[13]

This commentary reflects the observations of two Master's level graduates, in Sexual and Reproductive Health Research (RY) and Social Psychology (CM), who have worked for over the last two years within a local NGO that focuses on sexual and reproductive health and rights (SRHR), sexuality, and gender in Lebanon. Through phone and face to face interviews via the NGO's SRH referral hotline with over 300 Syrian refugee women, and based on interactions with other local and international NGOs and healthcare providers, it was apparent that often the interventions targeting the SRH of Syrian women need to address structural obstacles rather than dwelling on intrapersonal interventions. In this commentary, we examine how the social ecological model can highlight institutionalized violence and, specifically, violence against Syrian refugee women in Lebanon and illustrate the multitude of factors (i.e. *microsystem*, *exosystem*, and *macrosystem* factors) which impact their SRH.[13,14] These social determinants of health supersede the intrapersonal realm in hindering the choices women have in taking decisions regarding their SRH.[5] We will solely be investigating systemic violence against Syrian women's bodies, whilst recognizing that other refugees — Palestinian, Sudanese, Iraqi, and Kurdish — living in Lebanon also face harsh realities impacting their health.