NAVIGATING CHALLENGES & BRIDGING GAPS:

A REPORT ON SEXUAL AND REPRODUCTIVE HEALTH DATA AND INFORMATION IN SYRIA

> Syria's ongoing conflict has led to economic instability, high levels of inflation, and rising commodity prices, all of which have contributed to further reducing women's access to reproductive health services.

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ABBREVIATIONS

ANC	Antenatal Care
CBR	Crude Birth Rate
BEmONC	Basic Emergency Obstetric and Newborn Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CFR	Case Fatality Rate
CHW	Community Health Worker
cPHC	comprehensive Primary Health Care Centre
EPHS	Essential Primary Health Care Package
EmONC	Emergency Obstetric and Newborn Care
FP	Family Planning
HeRAMS	Health Resources and Services Availability Monitoring System
HIS	Health Information System
IM	Intramuscular Injection
IV	Intravenous Injection
MISP	Minimum Initial Service Package
MMEIG	Maternal Mortality Estimation Inter Agency Group
MMR	Maternal Mortality Ratio
MNH	Maternal and Newborn Health
MVA	Manual Vacuum Aspiration
PHC	Primary Health Care Centre
RMNCH	Reproductive, Maternal, Newborn, and Child Health
SBA	Skilled Birth Attendance
SPE	Severe Preeclampsia
SRH	Sexual and Reproductive Health
SDGs	Sustainable Development Goals
UHC	Universal Health Care
UNDESA	United Nations Department of Economic and Social Affairs
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VBAC	Vaginal Births After Caesarean Section
WHO	World Health Organization

EXECUTIVE SUMMARY

This desk review discusses the gaps and challenges in reproductive and maternal health data and services in Syria, focusing on the need for high-quality sexual and reproductive health (SRH) services for women and girls. It highlights the complexity of coordinating humanitarian responses in Syria, due to the fragmented territories and the presence of multiple governing authorities. The scope of this review includes methodology, limitations, background, contextual analysis, data availability, findings, and recommendations.

The prolonged conflict in Syria has led to a health care crisis for the country's 23.5 million inhabitants, with 16.7 million people needing humanitarian assistance in 2024—the highest number since the crisis began in 2011. More than half of those in need of assistance are women and girls. Because of the highly complex coordination architecture involved in the Whole of Syria response, a desk review was initiated to help stakeholders better understand the availability, quality, and application of sexual and reproductive health (SRH) data and programme information across the Whole of Syria. This comprehensive desk review focused on the collection and analysis of quantitative and qualitative data from available sources, including HeRAMS, 4W response monitoring, and small-scale surveys. This review also includes academic articles and grey literature from 2015 to 2023, which has been used to gather additional data and information on reproductive health in Syria.

Syria's ongoing conflict has led to economic instability, high levels of inflation, and rising commodity prices, all of which have contributed to further reducing women's access to reproductive health services. Syria, once on track to achieve the UN's Millennium Development Goals, now faces a health crisis with a weak and fragmented health care system, leading to a decline in coverage rates for key reproductive and maternal health interventions. While humanitarian organisations have worked to address gaps in health care provision, needs remain high, and the current approach has proved inadequate. Understanding the population's complex challenges and their implications on SRH is crucial to informing relief efforts and prioritising the rebuilding of the health care system.

UNFPA, WHO, and other partners have been actively providing humanitarian SRH support in Syria since the onset of the crisis. In 2023 alone, UNFPA delivered SRH services to over 1.1 million women and girls across the country, underscoring the prioritisation of SRH within the humanitarian response. This desk review has identified a wide range of SRH services being delivered in Syria, with key interventions being integrated into the response cycle through SRH working groups and prioritised funding. However, there are significant barriers impeding the provision of SRH services, including system-level challenges, financial constraints, informational limitations, and cultural factors. While the Minimum Initial Service Package (MISP) for SRH has been implemented to coordinate SRH services and address sexual violence, the available evidence of a comprehensive approach to reproductive rights is less clear. The findings of this review include insights into the ongoing needs of women and girls, the availability of SRH services, and various gaps in data.

Findings

- There are **4.1 million women and girls** of reproductive age in need of humanitarian assistance in Syria, including quality sexual and reproductive health services.
- **Over 500,000 women across the Whole of Syria are expected to become pregnant and give birth in 2024, 380,000** of whom are in need of humanitarian assistance, including antenatal care, safe delivery, postnatal care, and family planning services.
- **More than 56,000 women** are estimated to face complications during pregnancy and childbirth that will require emergency obstetric services.
- **There are 2.8 million adolescent girls aged 10-19 across the Whole of Syria:** two million of them are in need of humanitarian assistance, including access to SRH and Menstrual Health and Hygiene (MHH) services, dignity kits, and services that address GBV, including child marriage and forced marriage.
- **A quarter (25%) of all primary health care centres** are non-functioning—a significant increase from 16 percent in 2022.
- **Antenatal care (ANC) plays a critical role in reproductive, maternal, newborn, and child health.** However, there are significant challenges related to the accessibility and quality of ANC services in Syria, due to geographic barriers and gaps in health care facility coverage.
- In Government of Syria (GoS)-controlled areas, only around half of all public health facilities that should be functioning are currently providing ANC services. Data on ANC coverage and number of visits per pregnancy is lacking, but studies indicate concerning patterns of missed visits and insufficient ANC utilisation.
- **Seven out of 14 governorates** are below the standard threshold for the availability of health workers (per 10,000 population); five of these are located in Northern Syria (Al Hasakeh, Deir-ez Zor, Al Raqqa, Aleppo, and Idleb).
- All the districts in NWS fall well below the threshold for optimal levels of health care workers.
- Of the GoS-controlled areas' 1,228 partially and fully functional health facilities, only 17 (1.4%) offer basic obstetric and newborn care services (BEmONC). While the comprehensive obstetric and newborn care services (CEmONC) facilities also provide BEmONC services, these are mostly found at the hospital level and therefore typically located in cities and urban areas.
- **There is a lack of CEmONC facilities in two large governorates in Northeast Syria:** Al Hasakeh and Deir-ez Zor.
- In Northwest Syria (NWS), seven out of eight districts meet the global standard of having **at least four BEmONC facilities per 500,000 population.** However, the potential loss of funding could have the potential to significantly worsen the situation.
- **One in four women of reproductive age** throughout Syria suffers from anaemia.
- **One in five teenage girls (aged 15-19)** in Syria either has children, is pregnant, or is lactating.
- **One in two teenage girls (15-19)** suffers from anaemia.
- The risk of death associated with pregnancy is about a third higher among adolescents than young women **between the ages of 20 and 24.**

Gaps and Barriers to Providing SRH Services in Syria

Thirteen years into the Syrian crisis, the country's humanitarian SRH response is expanding beyond the MISP. However, guaranteeing the accessibility and quality of these services remains a challenge. Barriers to health care access persist, highlighting the need for continued efforts to improve SRH outcomes across the Whole of Syria. The findings of this review include the identification of various barriers to accessing and providing SRH services, categorised according to demand-side and supply-side barriers, issues related to service quality, and the type of enabling environment.

Demand-side Barriers

Insecurity and fear: In some areas, primarily in the north of the country, escalating violence and fear of attacks on health care facilities discourage women from seeking care, leading some to avoid health clinics altogether.

Agency and decision-making: Cultural restrictions and lack of awareness of rights hinder women's access to health care services.

Stigma and lack of awareness: The stigmatisation of certain services, coupled with low awareness of their availability, makes it difficult for women to seek essential care.

Supply-side Barriers

Geographic access: The destruction of medical services and the country's limited number of facilities, along with long distances and lack of affordable transportation, impede access to care.

Insecurity and accessibility issues: Insecurity and violence affect access to health care facilities, with barriers like road obstructions and roadblocks hindering travel.

Availability: The shortage of healthcare providers, attacks on facilities, and delays in moving supplies pose significant challenges to guaranteeing the availability of SRH services across Syria.

Affordability: Poverty and rising prices have impacted access to health care, with the high costs of services in the private sector rendering them inaccessible to most women.

Quality

Inadequately trained or motivated health care providers: The country's shortage of trained personnel and low salaries affect the quality of care.

Referral networks and pathways: The lack of clear referral pathways and inadequate secondary health care services contribute to delays in accessing lifesaving care, with **overcrowding in public facilities** exacerbating the issue.

Enabling Environment

Syria is in vital need of an enabling environment for the provision of SRH services, with a focus on enhancing data availability, coordination mechanisms, primary health care strategies, and essential health care service packages.

Data gaps: Limited monitoring mechanisms impede the assessment of intervention coverage and impact the quality and validity of data, creating key data gaps, including a lack of coverage rates, maternal mortality estimates, and recent population-based surveys.

Coordination: Challenges exist in the coordination of SRH efforts across Syria, with a variety of differing response models being implemented throughout the country and coordination difficulties between humanitarian and government-controlled areas. There is also a gap in Whole of Syria level SRH coordination.

Policy implementation for SRH: The Syrian MOH launched a National Primary Healthcare Strategy for government-led areas, with the goal of achieving Universal Health Coverage, SRH must be fully prioritized at all phases. Essential Healthcare Service Packages (EHSPs) have been developed for both government and non-government-controlled areas, ensuring the inclusion of a broad scope of key SRH programming—and with the understanding that effective implementation is crucial.

Overall, these barriers highlight many of the complex challenges facing SRH services in Syria, which include everything from security concerns and cultural barriers to issues of affordability, accessibility, and quality of care. Addressing these challenges requires a multifaceted approach that employs both demand- and supply-side interventions alongside efforts to strengthen health care infrastructure, enhance and expand the health care workforce, and implement supportive policies designed to facilitate access to SRH services.

Recommendations

These recommendations aim to improve SRH outcomes in Syria, addressing key challenges related to data availability and evidence collection, as well as challenges related to coordination and information-sharing:

- Prioritise comprehensive SRH data collection, collation, analysis, and use, including SRH WG dashboards, wherever they have not been implemented.
- Standardise methodologies for assessing SRH needs and enhancing of the ways in which these needs estimates are used for strategic decision-making.
- Prioritise operational research for SRH wherever evidence is lacking, including by increasing collaboration between humanitarian agencies and academic institutions.
- Carry out EmONC service mapping in GoS-controlled areas, detailing both the distance and travel time from the communities to the nearest health care facilities, in an effort to improve geographic access to these facilities.
- Conduct EmONC assessments across GoS-controlled areas and NWS to ensure that the quality of care is sufficient.
- Plan and implement surveys to address unmet family planning needs.
- Collect age-disaggregated data in order to better tailor services for adolescent girls.
- Enhance community outreach and surveillance in order to improve the accessibility and quality of SRH services.
- Improve the patient documentation process, including by standardising the mechanisms used to measure and track SRH services—for example, through the introduction of ANC cards and electronic monitoring.
- Raise awareness of the benefits of vaginal birth as a positive alternative to C-sections, while developing strategies to promote and improve the vaginal birthing experience and enhance the quality of services.
- Ensure adequate resource allocation and support for SRH coordination within the regional response.

> The prolonged conflict in Syria has led to a health care crisis for the country's 23.5 million inhabitants, with 16.7 million people needing humanitarian assistance in 2024—the highest number since the crisis began in 2011.

INTRODUCTION

The 2024 Humanitarian Needs Overview (HNO) estimates that there are 16.7 million people in need of humanitarian assistance—more than half of whom are women and girls, including roughly 4.1 million who are of reproductive age. All of these women and girls require access to high-quality sexual and reproductive health (SRH) services. Because of the complex coordination architecture involved in the Whole of Syria response, a desk review was initiated in order to better understand the availability, quality, and use of SRH data and programme information across the Whole of Syria. A broad review of existing SRH data, data collection tools and processes, available programme assessments, and reports was conducted to better understand the status of reproductive health needs and services throughout the country. This review also aims to identify which data, sources, and assumptions are currently being used to generate estimates related to SRH needs across different operational and coordination hubs. Finally, it also reviews how data is being used and incorporated into broader humanitarian needs assessments, and how it ultimately informs humanitarian response efforts.

The nature of the Syrian conflict has shaped the structure of the humanitarian response: with the conflict resulting in fragmented territories governed by different authorities, it has been challenging to implement a unified approach to coordination. The Whole of Syria approach was introduced in 2014 to ensure a coordinated humanitarian response for all people in need across Syria. Within this structure, there is a multi-layered approach to coordination, with three hubs each managing three coordination systems. The presence of multiple coordination hubs adds its own unique set of challenges, particularly when it comes to ensuring that a harmonised approach being implemented, and that standards and data are aligned across these hubs.

UNFPA, WHO, and other UN partners document the needs they see and are addressing on the ground. The NGO community responsible for implementing these humanitarian programmes provides further insights into the country's humanitarian needs, and the voices of women and girls themselves tell us these needs are both vast and urgent. While it is well-known that far too many women and girls are lacking access to quality sexual and reproductive health services in Syria, there is still far too much that is not known. The humanitarian community lacks a holistic understanding of the scope and scale of SRH needs for women and girls across Syria. Not enough is known about how many women and girls lack access to SRH services, where these gaps are, who is being left behind in the response, and why they're being excluded. By gaining a deeper understanding of current data gaps and weaknesses, more work can be done to identify what SRH data and information needs to be available in order to ensure more effective humanitarian and early recovery responses.

This review examines key areas of SRH, across much of the continuum of care, that can enhance knowledge and understanding about the needs of women and girls in Syria. An analysis of the identified gaps and barriers can help implementers and coordinators prioritise and inform humanitarian programming, advocacy efforts, and resource mobilisation.

BACKGROUND

The long-term and cumulative impacts of the Syrian conflict have generated a health care crisis for the 23.5 million people living in Syria. In 2024, the number of people in need of humanitarian assistance reached 16.7 million—the highest figure since the crisis began in 2011. More than half of these people in need are women and girls.[1] In order to protect their rights, including their right to health, it is vital to understand the key barriers that restrict the availability and accessibility of quality care for millions of women and girls across Syria.

Throughout the country, there are 4.1 million women and girls of reproductive age who are in need of humanitarian assistance, including quality sexual and reproductive health services.[2] This includes over 500,000 women across all of Syria who are expected to become pregnant and give birth in 2024—380,000 of whom are in need of humanitarian assistance including antenatal care, safe delivery, postnatal care, and family planning services. Of these, more than 56,000 are likely to face complications that will require emergency obstetric services. There are 2.8 million adolescent girls aged 10-19 across Syria, two million of whom are in need of humanitarian assistance, including access to SRH and Menstrual Health and Hygiene (MHH) services, dignity kits, and services that address GBV, including child

1 OCHA Syrian Arab Republic: 2024 Humanitarian Needs Overview (HNO) 2024, February 2024.
2 HNO 2024, 25% of 16.7 million PiN

marriage and forced marriage.[3] The February 2023 earthquakes further exacerbated the needs of women and girls, with thousands of buildings—including hospitals and maternity facilities—ending up damaged or destroyed. Essential reproductive health medical supplies were also destroyed in the earthquake, further reducing women's access to SRH services.

Recent increases in violence and hostilities provide a stark reminder that, even after thirteen years, humanitarian needs are high—and growing. These needs are fuelled by high inflation, currency depreciation, and rising commodity prices. Since February 2023, the Syrian pound has lost half its value against the US dollar. Over 12.9 million Syrians require food assistance, with the cost of a food basket doubling since January 2023 and quadrupling over the past two years.[4] More than half the population now lives in poverty, with 7.9 million people falling into poverty since the beginning of the crisis.[4] These structural and economic realities further reduce women's access to reproductive health services.

Before 2011, Syria was a lower middle-income country on track to achieve the Millennium Development Goals. By 2008, it had achieved 85% of its MDG4 target and 68% of its MDG5 target.[5] Syria's maternal mortality ratio fell from 107/100,000 in 1993 to 56 in 2008. Likewise, its infant mortality rate dropped from 34.6 deaths per 1,000 live births to 18 during the same period.[5] The country's health care system was largely functional and led by the public sector, with a growing private sector and limited reliance on civil society organisations.[6]

The targeting and destruction of healthcare facilities, attacks on health workers, and an exodus of well-trained health professionals have led to the partial collapse and fragmentation of the health care system.[7] The fracturing of the health care system has had detrimental effects and considerable consequences on the accessibility of SRH interventions.[8] The availability and quality of maternal and newborn health (MNH) care is considered a litmus test for a functional health care system. It is generally understood that if the system works for women and children, it will work for most people. At the same time, studies have shown that women's health is disproportionately affected by conflict situations, as they are often heavily dependent on a functional health system. Coverage and availability of key reproductive and maternal health interventions have declined because of the ongoing crisis, with restricted access, growing poverty, and changes in health-seeking behaviours driven by the worsening security situation. [8,9,10]

While health actors—including humanitarian organisations—have worked to fill the gaps in the provision of health care, needs remain high, and the current approach remains inadequate. Syrians continue to endure one of the greatest human tragedies of modern times, which affects all aspects of their lives. Understanding the complex and multifaceted challenges the population is experiencing, and the implications of these challenges on SRH, is crucial to informing humanitarian and development relief efforts and setting priorities for the rebuilding of health systems throughout the country.

Box 1. Displaced Women and Children

Of the 7.2 million internally displaced persons (IDPs) in Syria, over five million are out-of-camp IDPs, and more than half are women, residing in urban centres as well as rural suburbs. This group consists of people displaced by conflict and insecurity—many of whom are living in a state of protracted displacement or have been displaced multiple times, and face heightened protection risks. People with no other option but to live at IDP sites are the most vulnerable, least visible, and most underserved. In Northwest Syria, there are 1.9 million IDPs residing at 1,537 IDP sites. In North-east Syria, approximately 165,000 individuals live at 253 IDP sites; 57% of these individuals are under the age of 18, and 56% are female. Populations at IDP sites continue to have a variety of unmet needs across multiple sectors, with 65% of IDP households reporting an inability to access all health services. (HNO 2024)

3 MISP calculation using 16.7 multi sectoral PIN

4 UNFPA funding overview, Regional Syria Crisis Response, January 2024

5 United Nations Development Programme. Syrian Arab Republic Third National MDGs Progress Report, 2010. http://www.undp.org/content/dam/rbas/report/MDGR-2010-En.pdf.

6 Akik C, Semaan A, Shaker-Berbari L, Alameddine Z, Saad GE, Lopes K, et al. Responding to health needs of women, children and adolescents within Syria during conflict: intervention coverage, challenges and adaptations. Conflict Health. (2020) 14:37 10.1186/s13031-020-00263-3

7 Fouad FM, Sparrow A, Tarakji A, Alameddine M, El-Jardali F, Coutts AP, et al. Health workers and the weaponisation of health care in Syria: a preliminary inquiry for the lancet–American University of Beirut Commission on Syria. Lancet. 2017;390(10111):2516–26.

8 Akbarzada S, Mackey TK. The Syrian public health and humanitarian crisis: a 'displacement' in global governance? Global Public Health. 2018;13(7):914–30.

9 DeJong J, Ghattas H, Bashour H, Mourtada R, Akik C, Reese-Masterson A, et al. Reproductive, maternal, neonatal and child health in conflict: a case study on Syria using Countdown indicators. *BMJ Glob Health.* (2017) 2:e000302. 10.1136/bmjgh-2017-000302

10 The MMR just prior to the war was estimated nationally at 52/100,000 live births in 2009 (UNDP), the latest available figure was from 2015 showing the MMR increased to 68/100,000 live births. (WHO/UNICEF). The MMEiG estimates show a MMR of 21 in 2010 and increasing to 30 after the war and staying at 30 with the latest 2020 estimate. Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Geneva: World Health Organization; 2023

SUMMARY OF METHODOLOGY

A comprehensive desk review was carried out to gather evidence on the reproductive health of women in Syria. Employing a broad approach, this research covers academic peer-reviewed articles and grey literature from electronic databases and relevant sources, focusing on the period between 2015 and 2023. Search criteria included keywords such as reproductive health, maternal health, family planning, emergency obstetric care, and MISP, in conjunction with Syria. The information collected was organised thematically into categories, including ANC, family planning, EmONC, STIs, quality of care, human resources for health, and access to health care. The availability of coverage rates and the identification of SRH needs were collected and synthesized. A total of 41 documents were retrieved: 25 peer-reviewed articles and 16 reports. All articles identified for this review are descriptive in nature, and only one evaluation of interventions or programmes was found. (See Annex 4 for a list of articles and reports.)

Through a review of the existing data across Syria, it was found that relevant population-based, representative quantitative data is scarce in Syria. The last Multiple Indicator Cluster Survey (MICS) in Syria was carried out in 2006, and no other household survey has been completed since. The most recent unmet need survey was done in 2011. Furthermore, health information system data is very limited or unavailable across large areas of the country and was not found during this review. As a result, the Health Resources and Services Availability Monitoring System (HeRAMS), response monitoring through the 4Ws, programmatic data, and small-scale surveys and assessments were used to address the objectives of the desk review. Annex 2 provides a list of primary data currently collected on SRH. Identified gaps and barriers were listed and organised to provide a structured framework for discussing the reasons behind these gaps and potential solutions.

(See Annex 1 for a full description of the methodology.)

DATA AVAILABILITY

Gathering reliable data in conflict settings presents a significant challenge when attempting to producing credible insights and robust social analysis. This is especially true for the Syrian crisis, where a fluid security situation, frequently displaced population, and multiple accessibility restrictions have hindered dependable and reliable data collection. The absence of a unified health information system, combined with poor reporting and data sharing by implementing partners, has exacerbated the situation.[12,10] Political constraints also limit the scope and detail of information that health systems and humanitarian actors can report and share.

In 2017 and 2020, comprehensive reviews done across Syria—including GoS-controlled areas, NWS, and NES—found insufficient data on coverage rates of key reproductive, maternal, newborn, and child health (RMNCH) interventions and

health indicators, and there were significant health-related knowledge gaps.[8,11] There is no indication that this has changed. There is limited information on trend data and where available, it is difficult to assess whether observed changes are real or a product of the changing nature of, or lack of availability or agreement on, denominators.[12] In general, there is a lack of representative primary data being collected and reported, as well as inconsistencies across sources, measurement challenges, and an inability to determine the relevant denominators in the current setting.

The accountability and responsibility for collecting and reporting data on sexual, reproductive and maternal health (SRH) is not clear. It is currently fragmented between governments, local health directorates, and humanitarian partners. Often, available data is limited to government-controlled areas, and sometimes it is limited to GoS-controlled areas and Northeast Syria (NES)—and therefore incomplete and unsuitable for comparison. The situation in Northeast Syria (NES) is complex, and while the humanitarian responses are sometimes overlapping, the data is separated, with some included in government-controlled area data and some included in data reported by humanitarian partners operating under the NGO Forum.

In the absence of representative primary data and coverage rates for key SRH indicators, reliable estimates become even more important for advocacy, fundraising, and programme planning. If stakeholders can standardise and agree upon the inputs and assumptions used, these SRH estimates can be clearly developed across Syria. At present, estimates of need are clearly calculated for Whole of Syria, however when looking for disaggregated estimates for NWS, NES and GoS areas separately, the processes and assumptions are fragmented. Gaining better understanding and agreement on how each of the estimates are calculated and used may improve the transparency, availability, and coordination of SRH estimates across all of Syria.

In response to security constraints and a widespread focus on purely humanitarian responses, agencies have continued to use response monitoring to track humanitarian assistance. Humanitarian partners tend to use less conventional methods to collect quantitative data, such as conducting rapid assessments with local community members. Although the reliability of these assessments and the resulting data is uncertain, they have been a practical and feasible option for obtaining information within the current context.

Health monitoring systems are in place across a large proportion of Syrian health facilities, including HeRAMS, the 4Ws, monthly data tools that partners report against the HRP, and the national health information systems in government-controlled areas. However, the value of these systems is limited for SRH. They cannot be used to generate population-level indicators, because the healthcare facilities' catchment population is not reliably estimated, publicly available, or disaggregated by age and gender. There is a lack of representative data at the national level, hub level, and governorate level, as HeRAMS generally only includes data from public facilities, which may also be incomplete. In areas with growing populations, the private-sector health care system is significant, and the lack of available data from the private sector has created large gaps in the effort to collect representative data. There are promising initiatives, like DHIS2 in NWS, where SRH data has been integrated into the health care information system; however, this initiative is still in the early stages of implementation.

The 4Ws currently includes three indicators for SRH: numbers of ANC visits, number of vaginal deliveries, and number of C-sections. For indicators related to SRH, HeRAMS has collected information on the availability and utilisation of SRH services at health centres, including management of STIs, family planning, antenatal care, normal deliveries, essential newborn care, postnatal care, and tetanus shots. Health centres provide reporting for HeRAMS on a quarterly basis, and the information is disaggregated by governorate. Key indicators provided by these health centres include: the number of reported STI cases, the number of women receiving family planning services, the number of pregnant women receiving ANC services, and the number of ANC visits. However, the last report to include data on all of these indicators was published in 2021. Over the last couple of years, only ANC visits and deliveries have been reported. (See Annex 2 for additional information.)

Overall, the existing data on SRH does not appear to be robustly collated or comprehensively analysed, and it is missing several key components, including data that has been disaggregated by age and gender. In NWS, the SRH WG and Health Clusters have been collecting and collating important SRH data; however, there are still key gaps in this data

as well (see ANC findings). Key SRH indicators from HeRAMS, the 4Ws, and the SRH WG are disaggregated by gender, but there is very little disaggregation by age, and none according to the internationally standardised age groups, e.g. 10-14, 15-19, and 20–24. The 4W data, for example, is organised into two age categories: under 18 and 18 years of age and older. Therefore, it is not possible to analyse information specifically on adolescents, or to do analyses on younger adolescents (10-14) versus older adolescents (15-19), or on young women (20-24), as the adult data is also not able to be disaggregated—or, if this information has been collected, it has not been shared or made available.

The SRH working groups (SRH WGs) for GoS-controlled areas do not include dashboards or public data; the Health Cluster data, however, does include dashboards and public data. For NWS, the SRH WG dashboard data is collected monthly using a KOBO tool, then cleaned and reflected in the dashboard. However, the data that is consolidated and analysed through this process cannot provide a comprehensive picture of the status of all SRH interventions across NWS. Further attention should be given to these data, in order to identify gaps and areas for improvement, including programme feedback loops, advocacy, and more, in addition to providing deeper insights into what is working well. That said, the data from the NWS WG is the most complete response data on SRH available across all three hubs, and there is potential to leverage this information for knowledge-sharing with the Whole of Syria health cluster, in order to improve key data available across WoS. (Find more information on the primary data being collected on SRH in *Annex 3*.)

LIMITATIONS

Disaggregated coverage rates are required for conducting a data-driven, evidence-based gap or bottleneck analysis. Due to data limitations this was not possible. Despite this constraint, there is sufficient knowledge about the service gaps in many areas of Syria, particularly NWS and NES, based on in-depth discussions with various stakeholders in Syria and published data.

The scope of the desk review was not meant to be a comprehensive review of programmes nor was it able to review all intervention gaps across all of Syria. Nonetheless, a review of the data and information provided an important opportunity to highlight current high-level gaps and challenges in the SRH response and to provide recommendations for further discussions and actions to be undertaken by each hub and Whole of Syria.

> Through a review of the existing data across Syria, it was found that relevant population-based, representative quantitative data is scarce in Syria.

FINDINGS

UNFPA, WHO, and other partners have been providing humanitarian support on SRH since the beginning of the Syrian crisis. While it is well-documented that the early response efforts were primarily focused on trauma care and providing basic food and shelter, humanitarian agencies were nonetheless able to successfully advocate for the prioritisation of reproductive and maternal healthcare, including the introduction of the MISP, including antenatal, delivery, and postnatal care, based on clearly identified needs.[12] In 2023, UNFPA delivered sexual and reproductive health services to over 1.1 million women and girls in Syria, reaching 235,000 adolescent girls and providing cash and voucher assistance to over 7,000 women. It is clear that SRH has been prioritised in the humanitarian response. Key interventions have been integrated into the response cycle and are seen as an important component of the humanitarian response, as indicated through SRH WGs, funding priorities, and priority indicators.

This desk review has found that there are a wide range of SRH services being delivered in Syria. The review highlights several key findings, all of which warrant further study and follow up. The findings are presented according to the availability and uptake of key SRH interventions across the continuum of care, including ANC, skilled birth attendance, emergency obstetric care (EmONC), and family planning. While other services—such as those for adolescent girls, postnatal care, sexually transmitted infections (STIs), the clinical management of rape, and abortion and post-abortion care—are touched upon, there is significantly less information available on these subjects, and thus they are discussed in less detail. Nonetheless, these topics offer a glimpse into the nature and complexity of healthcare challenges faced by women in Syria.

> There is little evidence that reproductive rights are regarded as fundamental rights across all programming and interventions. Human rights discussions, particularly concerning the right to health, are notably absent in most of the programme documentation that has been reviewed. There is ongoing advocacy work being conducted on the right to health by OHCHR and other human rights actors, who have noted that Syria's fragile and heavily impacted health care infrastructure is both a humanitarian issue and human rights concern. The availability and accessibility of SRH for women and girls is crucial, not only to ensure an effective response, but also for duty-bearers to fulfil their human rights obligations under international law.

Early in the humanitarian response, humanitarian health care workers in Syria adopted the Minimum Initial Service Package (MISP), a set of guidelines for SRH service delivery in crisis settings. The MISP was implemented to facilitate the coordination of SRH services, prevent and manage the consequences of sexual violence, reduce rates of HIV transmission, prevent unintended pregnancies, and minimise maternal and neonatal morbidity and mortality. It is the minimum initial package of services included as part of the SPHERE Standards and has been recognised by the IASC as meeting "life-saving criteria," and should be implemented until the situation allows for an expansion into more comprehensive SRH services.

In accordance with the IASC Guidelines for Health Cluster Coordination, the Health Clusters in NWS, Government of Syria-controlled areas, and the NES NGO Forum have established Sexual and Reproductive Health Working Groups (SRH WGs) to support the coordination of the MISP and SRH interventions.[11] A strong coordination platform provides an important opportunity for focused discussions on the specific constraints that arise in the humanitarian response, and potential solutions to these issues. The humanitarian community is accountable for SRH interventions that have been mainstreamed across the larger humanitarian response and monitored through the 4Ws and HeRAMS (see data availability section). The Health Cluster operating across Government of Syria-controlled areas, NWS, and the WoS is led by WHO. UNFPA has been given the responsibility of leading and establishing SRH working groups in NWS, and of coordinating with the MoH in GoS-controlled areas, under the umbrella of the Health Cluster. The NGO Forum led coordination in Northeast Syria has a SRH WG led by Expertise France.

Thirteen years into the crisis, the SRH response aims to expand beyond the MISP. While the work of building up health care systems has been ongoing in various forms across Syria, there are steadily increasing efforts to create a nexus between a purely humanitarian response and one that is engaged in system-building. However, in some areas, it has

11 Health Cluster, IASC, WHO, 2009. Health Cluster Guide: A Practical Guide for Country-Level Implementation.https://reliefweb.int/report/world/health-cluster-guide-practical-guide-country-level-implementation-health-cluster-june-2009#:~:text=This%20Guide%20suggests%20how%20the,care%20as%20quickly%20as%20possible.

been necessary to revert to minimum services, especially when new crises further destabilise the already-fragile health system. While the review found that SRH services are being delivered in Syria, the accessibility and quality of these services remain challenging and inconsistent. Barriers that are impeding the provision of SRH services have also emerged during the process of gathering data; these are discussed further in the analysis section of this report. Such barriers include systematic challenges, challenges at the humanitarian response level, financial constraints, informational gaps, and cultural factors. These findings highlight the need for continued efforts to further strengthen the provision of SRH services and improve outcomes for women and girls.

Box 2. SRH in Emergencies

Within the Inter-Agency Standing Committee (IASC) Cluster System, the World Health Organization (WHO) is the Cluster Lead Agency (CLA) for health. There is no official IASC Area of Responsibility (AoR) or sub-cluster for Reproductive Health, and at the global level, this responsibility sits with IAWG (outside of the Cluster System). However, a Global Health Cluster SRH Task Team was recently established to ensure that SRH priorities are systematically addressed across all phases of humanitarian responses, and that SRH coordination is consistently included in cluster coordination at both the global and country levels.[12]

To date, a Whole of Syria SRH coordination effort has not been established, which has contributed to the lack of coordination between active hubs in Syria. SRH has received less attention and investment within the UNFPA regional response hub, and this is reflected in the limited inter-agency SRH coordination across the Whole of Syria when compared to GBV responses. As mandated by the Inter-Agency Standing Committee, UNFPA has a clear role as a coordinator and provider of last-resort care, and holds accountability for GBV as the cluster lead agency for the GBV Area of Responsibility. However, UNFPA's role in terms of SRH has no formalised equivalent.

In emergencies, UNFPA normally adopts an informal leadership role for SRH, through the establishment of SRH working groups under the health cluster led by the World Health Organization (WHO). This includes ensuring that data on SRH is sufficiently collected, reported, and analysed by the health cluster, and that health needs for women and girls are included in the HNO, HRP, overall intersectoral coordination, and beyond.

SRH WGs have been activated within the humanitarian response across all three hubs. UNFPA is leading SRH WGs under the umbrella of the WHO-led health cluster in Northwest Syria in Gaziantep, and in the Government of Syria-controlled areas, where there are working groups in Damascus, Aleppo, Homs, Hama, and Latakia. A new working group is currently being set up through the UNFPA sub-office in Qamishli. There is also an active, NGO-led SRH WG for the Northeast Syria NGO Forum.

12 https://healthcluster.who.int/our-work/task-teams/sexual-and-reproductive-health-task-team

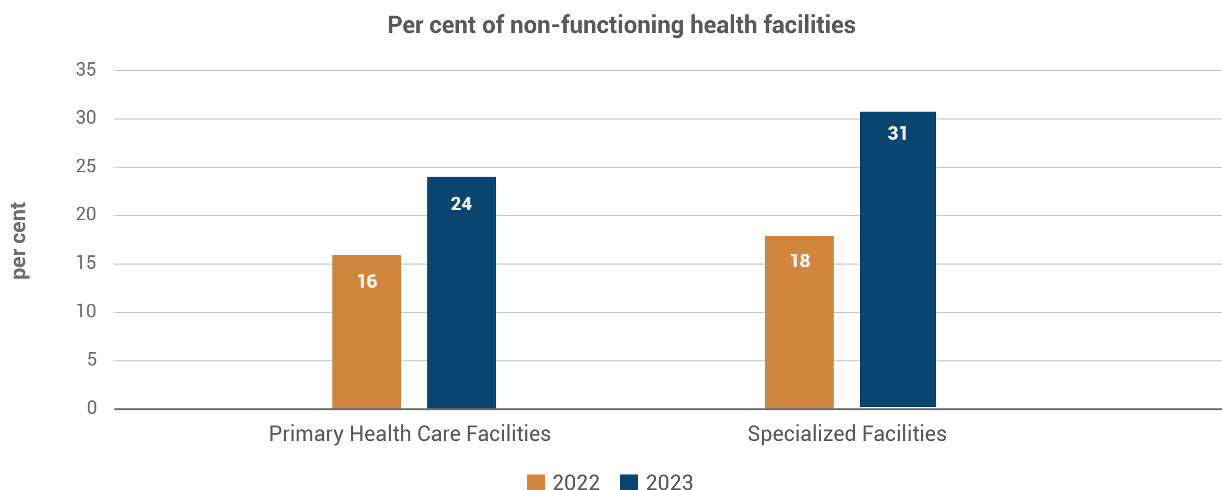
> The latest HNO states that the accessibility and functionality of basic health services remain a huge challenge.

ACCESSIBILITY AND FUNCTIONALITY OF HEALTH SERVICES

The latest HNO states that the accessibility and functionality of basic health services remain a huge challenge. Nearly 40 per cent of primary and secondary health care facilities are either non-functional or only partially functional, affecting over 4.8 million people in need of lifesaving health services.[1]

Currently, 152 of the country's 270 sub-districts—home to 11.76 million people—are underserved and operating below the minimum standards for hospital beds, health care workers, and functional primary health care centres per 10,000 people.[1] Furthermore, according to the WoS health sector HeRAMS report of Q2, 2023, the proportion of primary health care (PHC) and specialised facilities that are currently non-functioning increased significantly from 2022 and 2023.[13] For PHC facilities in particular, this figure increased from 16 per cent to nearly a quarter of all PHC facilities in 2023. While the 2023 data has not been fully analysed, last year's HNO reported notable decreases in the number of hospitals and health facilities providing either basic or comprehensive emergency obstetric and neonatal care (BEmONC providers dropped by 32% and providers by 21%) and blood bank services (-15%)—all essential, lifesaving services for women.[14] Some of these facilities were undoubtedly affected by the February earthquakes; however, it is not known how many of these facilities have been rebuilt or repaired and are functional again. Annual reporting for HeRAMS, which reports more comprehensively on SRH in public health centres and maternal health services in public hospitals, hasn't been available since 2021.

Figure 1. Increases in Non-functioning Health Facilities from 2022 to 2023 across Syria



13 Whole of Syria Health Sector HeRAMS Quarter 2, Aug 2023.
14 WHO, Health Sector Needs, HNO 2023 https://reliefweb.int/report/syrian-arab-republic/health-sector-needs-hno-2023

With many health facilities either non-functional or operating at reduced capacity, accessing SRH services becomes increasingly difficult for the population. This lack of access poses serious risks to the reproductive health and rights of individuals, including limited access to contraceptives, antenatal care, and skilled attendants during childbirth, further elevating the risks of maternal mortality and jeopardising the overall health and well-being of women and newborns.

According to the 2023 health cluster analysis, the availability of SRH and MNH services in the public health centers and hospitals in the Government of Syria-controlled areas is extremely low. Considering the multifaceted nature of the challenges faced in these areas—including economic hurdles, sanctions imposed on the country, emigration of health workers, and infrastructure damage—it is evident that the provision of essential health services, including SRH and Maternal and Newborn Health (MNH), has been severely impacted. On average, the availability of SRH services in public health centres is around 36%, but there is considerable variation, from the low rates found in Northern areas (5% in Raqqa, 23% in Hasakeh, 26% in Deir Ez Zor, and 0.4% and 15%, respectively, in the GoS-controlled areas of Idleb and Aleppo) to the higher rates found in Damascus and Tartous (61%) and Latakia (53%). In Northwest Syria, the SHR WG estimates that only about 30% of PHC facilities are providing outpatient SRH services, comparing data from HeRAMS against the SRH WG service mapping.

ANTENATAL CARE (ANC)

Of the 50 internationally necessary and recommended reproductive, maternal, newborn, and child health interventions, 16 are expected to be implemented as part of ANC, and 12 as part of postnatal care (PNC).[15] ANC and PNC are long-established and logical entry points for SRH.

According to the Whole of Syria HeRAMS snapshot from Q3 2023 (the most recent data available), 83% of partially and fully functioning facilities (1,257 of 1,516) offer ANC across Syria. Mapping of health facilities providing ANC per population, reveals substantial gaps and geographic barriers that limit access to ANC for many pregnant women.

In GoS-controlled areas, the HeRAMS dashboard data from Q4 2023 shows that 954 out of the 1,228 (78%) partially and fully functional health facilities offer ANC services.[16] However, because roughly a third of all facilities are not operational, this proportion overestimates that coverage: only a little more than half of all public health facilities that should be functional are currently providing ANC services in these areas. The dashboard provides information on the number of pregnant women receiving ANC services, disaggregated by governorate.

However, data on the proportion of pregnant women receiving ANC during their pregnancy is unavailable, as is data on the number of ANC visits each woman receives during her pregnancy for the Whole of Syria or any of the hubs. Until recently, international guidelines recommended a minimum of four ANC visits during pregnancy; in 2016, the WHO increased this recommendation to eight visits.[17]

The literature review conducted for this assessment provided some information that is helping to fill in the data gaps on ANC. During a 2017 study conducted in Northwest Syria, a concerning lack of ANC and PNC visits was reported, with 85% of respondents not receiving any ANC visit during the first trimester, 82% lacking visits in the second trimester, and 44% who reported having no visits during the third trimester.[18] A total of 31% of women reported having no ANC visit throughout their entire pregnancy. The data from the SRH WG in NWS shows a better picture and they are able to identify the number of women who have one ANC visit and those that have had 4 or more, however there is not a clear proportion of all pregnant women who received ANC 1 or ANC4.

For NWS, the SRH WG dashboard data is collected monthly using a KOBO tool; this data is then cleaned and reflected in the dashboard. While there is a dataset for each month of 2023 on the numbers of pregnant women receiving ANC1 and ANC4 visits, the coverage of--or proportion of--pregnant women reached is not available, as comparing this dataset against reported deliveries, or estimated numbers of births, cannot provide a coherent data point.

For example, the SRH WG data reported that there were 69,275 deliveries in 2023, which could be a denominator for ANC and PNC. However, the numbers of reported ANC1 and ANC4 visits are much higher than the total number of deliveries reported. It is difficult to ascertain whether all deliveries were unsuccessfully captured or whether the ANC1 visits were not reported accurately. An estimate of the number of births can be calculated using the MISP calculator, in order to provide an idea of how many pregnant women in need of humanitarian assistance require delivery with skilled attendants (or who need ANC, for example). Comparing the reported number of deliveries against the estimated number of births, the reported deliveries are just around half of what one would expect.

15 The Partnership for Maternal, Newborn and Child Health, Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health, 2011, Geneva, Switzerland.

16 The GoS HeRAMS dashboard for Public Health Centers, Q4 2023

17 WHO. WHO recommendations on antenatal care for a positive pregnancy experience 2016 https://www.who.int/publications/i/item/9789241549912

18 Terkawi, A., Bakri, B., Isadek , A., et al. Women's health in Northwestern Syria: Findings from Healthy-Syria 2017 study, Avicenna J Med 2019; 9(03): 94-106, ,

Figure 2. Available Data on Deliveries and ANC, 2023, NSW SRH WG dashboard

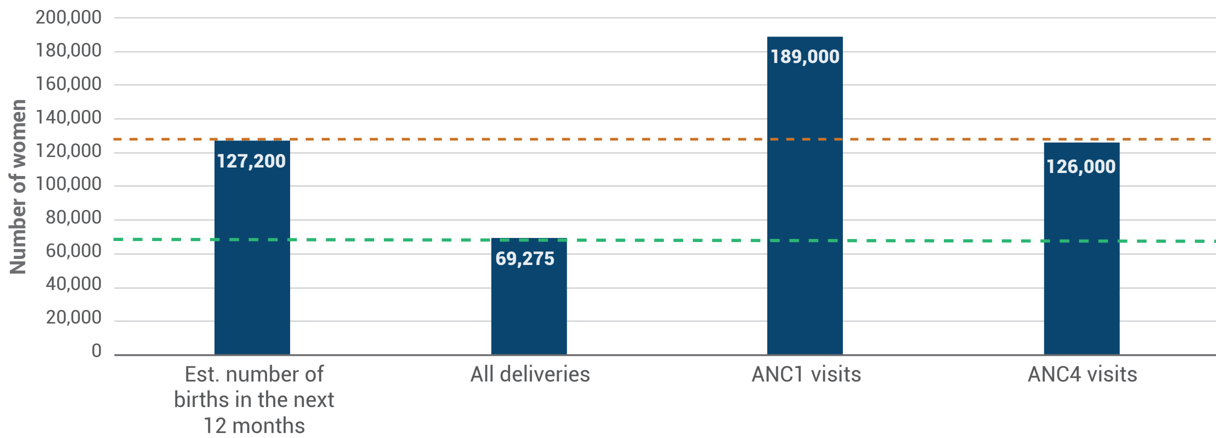


Figure 2 provides an example of some inconsistencies in the existing data. In a perfect world, the delivery, ANC1 and ANC4 figures would all be roughly the same (orange line); however, in reality there is often a tendency to see lower numbers for each subsequent visit, due to loss to follow-up. The ANC numbers reported are also high compared to the estimated number of pregnant women in need of humanitarian support (green line). The estimate was calculated using the NWS people-in-need figure.

While the data that has been consolidated and analysed is unable to provide a full picture of the status of all SRH interventions for NWS, more analysis of this data should be done, in order to identify data gaps and areas for improvement, as well as to see what is working well. This data is the most complete SRH data available across all three hubs, and there is potential knowledge that can be derived and shared with the Whole of Syria health cluster coordinators and UNFPA in order to improve key data availability across WoS.

Facility assessments in Aleppo and areas in Northeast Syria have identified critical gaps in ANC services. Few ANC cards were observed being filled out during visits, which hinders the continuity of care for pregnant women, especially when moving between health providers. During a UNFPA-led focus group discussion with women from Deir Ez-Zor in Northeast Syria who had recently delivered at a facility with a midwife, almost all reported receiving ANC from a doctor at a different facility than where they delivered. The ANC card serves as a link between providers and a vital tool for assessing potential risks, such as high blood pressure or anaemia. It is also a vital record, documenting a woman's medical history, including pre-existing conditions and complications from previous pregnancies. In the absence of a functional data system, these records become even more crucial.

An assessment in Aleppo revealed that only around half of all healthcare workers measured the blood pressure of pregnant women. Iron folate availability was limited, and there were substantial gaps in recording instances of anaemia. Out of more than 3,000 women receiving ANC, only 91 were tested for anaemia.

The 2024 Humanitarian Needs Overview (HNO) for Syria highlighted ongoing issues of malnutrition and anaemia among women and girls. Alarming statistics indicate that one in four women between the ages of 15 and 49 suffers from anaemia, and an even more concerning prevalence among teenage girls, with one in every two girls affected. Additionally, one in 10 women exhibit wasting, which further increases risks during pregnancy. The prevalence of wasting among women and girls varies across different governorates in Syria, with up to seven governorates reporting a prevalence above five per cent. Some areas in northern Syria have reported wasting prevalence as high as 10 per cent. One in five teenage girls (aged 15-19) in Syria either has children, is pregnant, or is lactating. Teenage mothers have a higher likelihood of wasting, and of having children between the ages of 6 and 59 months who suffer from wasting.

There are examples of programmes that are working well and successfully reaching pregnant and lactating women (PLW) with preventive and curative services that can be expanded upon and scaled up. It is important to identify and prioritise systematic ways of ensuring that pregnant and lactating women are assessed for malnutrition, anaemia, and other risk factors during pregnancy, and that these conditions are being sufficiently treated and/or managed as part of clear birth plans. The recent data show that there are currently systematic gaps in these kinds of services.

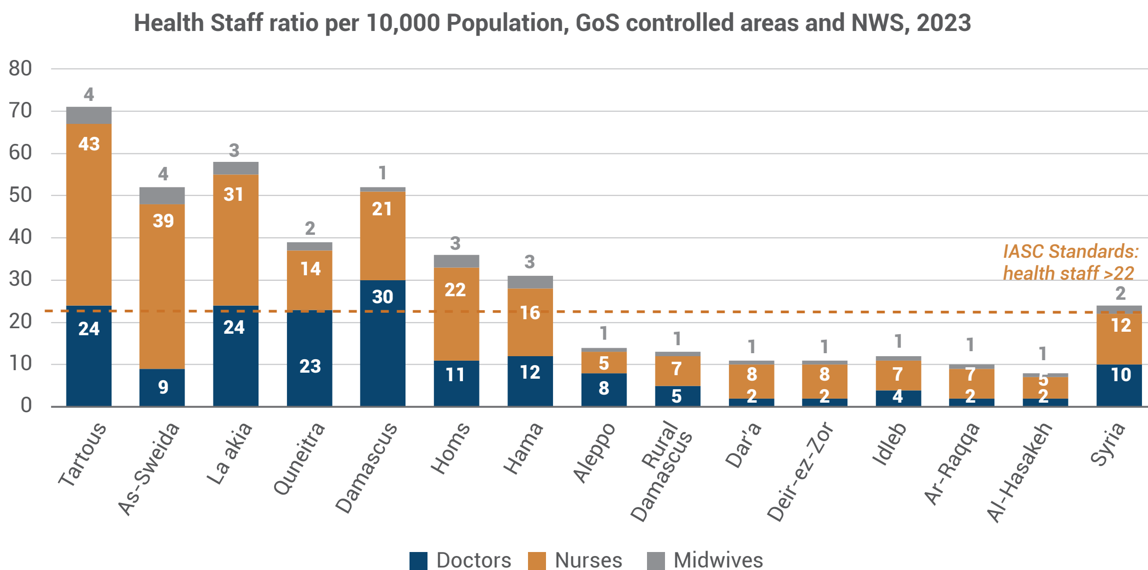
Clear, standardised, and integrated packages of ANC services are necessary. If these are available across the hubs, their implementation may require closer focus, with more systematic monitoring and quality improvement measures put in place. Stronger community outreach and community-based surveillance and monitoring are also needed. The Gaziantep cross-border HeRAMS has reported that there are a number of health facilities providing community-based health services—primarily comprising community-based screenings and referrals, including for ANC and malnutrition. There is a potential opportunity to set up better community-based surveillance for improved follow-up across primary health facilities and throughout the community.

HUMAN RESOURCES FOR SRH

The number of health workers available per 10,000 population is a key indicator used to monitor the availability of human resources in the health sector. This figure is broken down by doctors, nurses, and midwives, but there is no consensus about the optimal levels of each cadre within the Syrian context. Sufficiently trained and equipped health workers are essential to providing comprehensive SRH services. However, Syria is facing major gaps concerning the quality and quantity of available health workers, which negatively affects the accessibility and availability of health care services. Seven out of 14 governorates are still below the standard threshold of health worker availability per 10,000 population, including four governorates (Al Hasakeh, Deir ez-Zor, Dara'a, and Al Raqqa) in Northeast Syria (NES). Data collected in NWS shows that all the districts are heavily below threshold for optimal levels of health care workers.[19,20] It should also be noted that the HeRAMS data reports positions of staffing, not individuals; at the hub level, human resource mapping is necessary to help address planning needs.

In NES, there are currently no functional medical schools, further hampering efforts to increasing the capacities and numbers of qualified health staff.[21] UNFPA is supporting midwifery education in both NWS and in GoS-controlled areas in order to increase the health care workforce; it is vital for these efforts to continue. Meanwhile, across the country, a new wave of health worker attrition has been observed due to the economic crisis: currently, public-sector doctors earn the equivalent of just over 35USD (466,000 Syrian Pounds) a month, leaving them unable to afford even the cost of transport to their jobs, where face-to-face care is essential.[22]

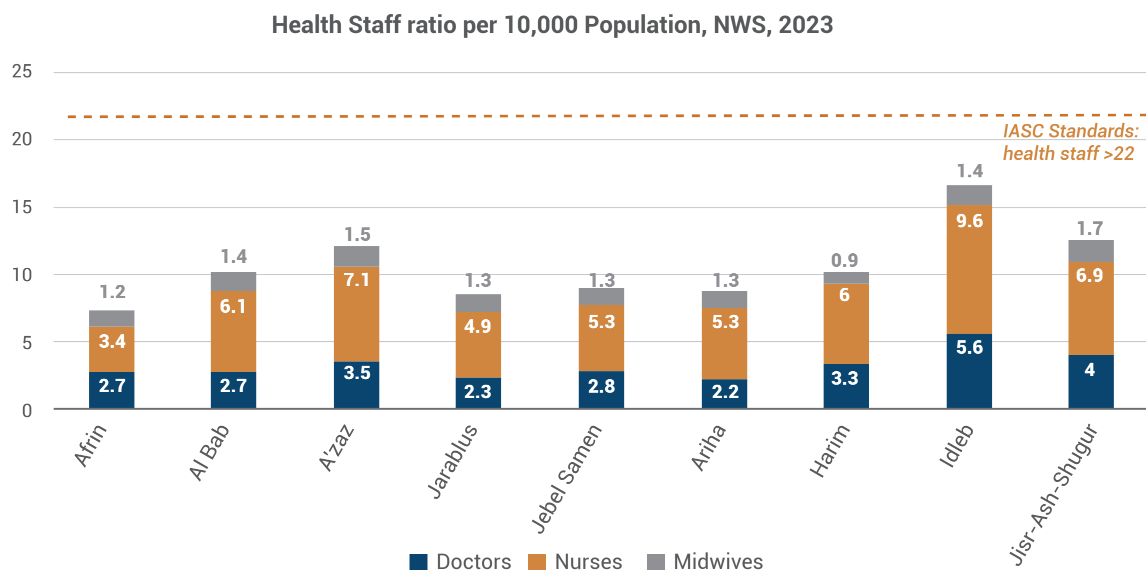
Figure 3. Half of all governorates in Syria have shortages of health care workers.



Source: Whole of Syria Health Sector HeRAMS Quarter 3, December 2023.

19 Whole of Syria Health Sector HeRAMS Quarter 3, Dec 2023.
20 Gaziantep Cross Border, Health Sector HeRAMS Quarter 3, 2023.
21 Presentation by WHO Health Cluster lead
22 https://www.salaryexplorer.com/average-salary-wage-comparison-syria-doctor-physician-c211d13

Figure 4. All districts in Northwest Syria are understaffed



Source: Gaziantep Cross-border, Health Sector HeRAMS Quarter 3, 2023

SKILLED ATTENDANCE AT BIRTH

A Skilled Birth Attendant (SBA) is defined as an accredited health professional—a midwife, doctor, or nurse—who has been educated and trained to proficiency in the skills required to manage uncomplicated pregnancies, childbirth, and the immediate postnatal period.[23] They are also trained in the identification, management, and referral of complications in women and newborn babies.

Skilled birth attendants also must have an enabling environment to operate in, which includes access to medications, supplies, appropriate policies, and a functional referral system.[24] The proportion of births attended by skilled personnel remains a key international indicator of universal health care coverage and a measure of a health system's ability to provide adequate care during birth.[25] Skilled Birth Attendance is only recognised as being available when both a skilled birth attendant and the necessary enabling environment are in place.

23 WHO. Making pregnancy safer the critical role of the skilled attendant: a joint statement by WHO, ICM and FIGO. Geneva: World health organization (WHO). Department of reproductive health and research (RHR); 2004. Available at: http://www.who.int/maternal_child_adolescent/documents/9241591692/en/index.html

24 Adegoke AA, Hofman JJ, Kongnyuy EJ, van den Broek N. Monitoring and evaluation of skilled birth attendance: A proposed new framework. Midwifery 2011;27(3):350-9. doi: 10.1016/j.midw.2011.03.006

25 WHO World Health Statistics Monitoring Health for the SDGs Reports 2016 -2020

Box 3. Opportunities for Task-shifting in Northeast Syria (NES)[26]

Midwives play a crucial role in the provision of SRH in Northeast Syria, yet there is a lack of clear legal frameworks guiding the scope of their practice, leading to variations in practice across different geographic areas and health care facilities. A mixed-methods study was done to investigate the role and scope of practice being performed by midwives, with an aim of identifying opportunities for task-shifting. The study included a midwifery practice survey, as well as Focus Group Discussions (FGD) with midwives, obstetrician-gynaecologists, and midwifery supervisors. Key Informant Interviews (KIIs) were also conducted with a wide range of stakeholders, including policy-makers.

Findings:

- Most midwives work in a single primary setting (73.6%), while about one-fourth work at multiple sites (26.4%). Most respondents were attached to a health care facility, with nearly equal distribution across hospitals, comprehensive primary health care (cPHC) facilities, and primary health care (PHC) facilities. A total of 17.8% of midwives also conduct home visits for deliveries and other forms of maternity care.
- The majority of midwives (79.3%) reported completing midwifery school, but with considerable variation in qualifications and registrations.
- Midwives provide services across the entire continuum of care, including Antenatal Care (93.7% of respondents), Postnatal Care (90.2%), Skilled Birth Attendance (85.1%), Family Planning (82.2%), and basic Gynaecological Services/Reproductive Health Care (75.3%). However, fewer midwives provide all designated signal functions of Basic Emergency Obstetric Care (BEmONC), with less than 10% providing all seven functions.
- There is a significant proportion of midwives who were trained and consider themselves competent, but who are not providing certain components of care because they are not being permitted to do so.
- Both midwives and obstetrician-gynaecologists express uncertainty about the core definition of a midwife's scope of practice and lack awareness of any formal documents defining this role. Decision-making on midwives' scope of practice largely depends on the health care facility or organisation where the midwifes works, with verbal instructions provided by managers or supervisors.
- Most midwives support task-shifting, especially among more experienced individuals, with an expressed desire for expanded roles, such as assisting in complicated deliveries and managing obstetric emergencies.
- Obstetrician-gynaecologists also see potential for task-shifting but stress the need for additional training and supervision, particularly for complex procedures.
- Both midwives and obstetrician-gynaecologists acknowledge challenges in the implementation of task-shifting, including legal frameworks, opposition from some health care actors, and the need for consensus among professional associations and health committees.

Overall, there is agreement on the potential benefits of task-shifting to address health care workforce shortages, but it is widely recognised that there are many complexities involved in its implementation. The study underscores the urgent need to define the scope of practice for midwives and address health care provider shortages through task-shifting, while also highlighting opportunities and considerations for initiating this process, including the need to develop supportive regulatory frameworks and to provide competency-based training where required.

> Skilled Birth Attendants are trained in the identification, management, and referral of complications in women and newborn babies, and must have an enabling environment to operate in.

26 Al Daher, H., Al Dabgh, M., Khalid, D., van den Broek, N. Midwifery Scope of Practice and Opportunities for Task Shifting in Northeast Syria (NES). Expertise France, 2024.

EMERGENCY OBSTETRIC AND NEWBORN CARE

Emergency Obstetric and Newborn Care (EmONC) is crucial for the estimated 10–15% of all women who experience life-threatening complications during pregnancy, birth, or the postpartum period.[27] There are two levels of emergency obstetric care: basic and comprehensive. The most frequent complications are well-known and can be prevented or managed with effective health care. These include haemorrhage, sepsis, eclampsia, complications of obstructed labour, and complications from abortion. There are existing, effective, and affordable interventions that can be put in place to manage these complications. These signal functions have been bundled into a package known as emergency obstetric care.[28] For a health care facility to be considered fully functional, the signal functions must be available 24 hours a day, 7 days a week.

Table 1. Signal Functions of Basic and Comprehensive Emergency Obstetric Care

Basic Emergency Obstetric and Newborn Care (BEmONC)	Comprehensive Emergency Obstetric and Newborn Care (CEmONC)
1. Administer parenteral antibiotics (IV or IM)	8. Perform surgery (Caesarean section)
2. Administer uterotonic drugs (IV or IM), e.g. parenteral oxytocin	9. Provide blood transfusion
3. Administer parenteral anticonvulsants for preeclampsia and eclampsia (IV or IM), e.g. magnesium sulphate	
4. Manually remove the placenta	
5. Perform manual vacuum aspiration of retained products of conception	
6. Perform assisted vaginal delivery (vacuum extraction)	
7. Perform basic neonatal resuscitation	

IV: intravenous injection IM: intramuscular injection
A BEmONC facility is one in which all functions 1-7 are performed.
A CEmONC facility is one in which all functions 1-9 are performed.

The availability and modality of emergency obstetric care varies across Syrian territories, and in many areas, both are unclear. At the current level of provision, skilled birth attendance and basic obstetric and newborn care services (BEmONC) should be provided at the comprehensive primary health care (cPHC) level and comprehensive obstetric and newborn care services (CEmONC) should be provided at the hospital level, both should be available 24/7. More than a decade into the crisis, Syria is still quite far from realising Objective Four of the MISP: preventing excess maternal and newborn morbidity and mortality through the availability and accessibility of BEmONC and CEmONC services. Realising Objective Four not only saves lives but is also integral to advancing global goals and commitments, including the Sustainable Development Goals (SDGs) and Universal Health Care (UHC).

The maternal mortality ratio (MMR) estimates for Syria by the United Nations Maternal Mortality Estimation Inter-Agency Group (MMEIG) show that Syria's MMR declined significantly from 2000 to 2010 but rose back up to 30 per 100,000 live births after the start of the crisis in 2011, where it has stayed. The MMEIG is composed of WHO, UNICEF, UNFPA, the World Bank Group, and the United Nations Department of Economic and Social Affairs, Population Division (UNDESA/Population Division)—all of whom collaborated with external technical experts to develop data estimates for the years from 2000 to 2020. These estimates allow for internationally comparable country-level estimates and trends related maternal mortality.

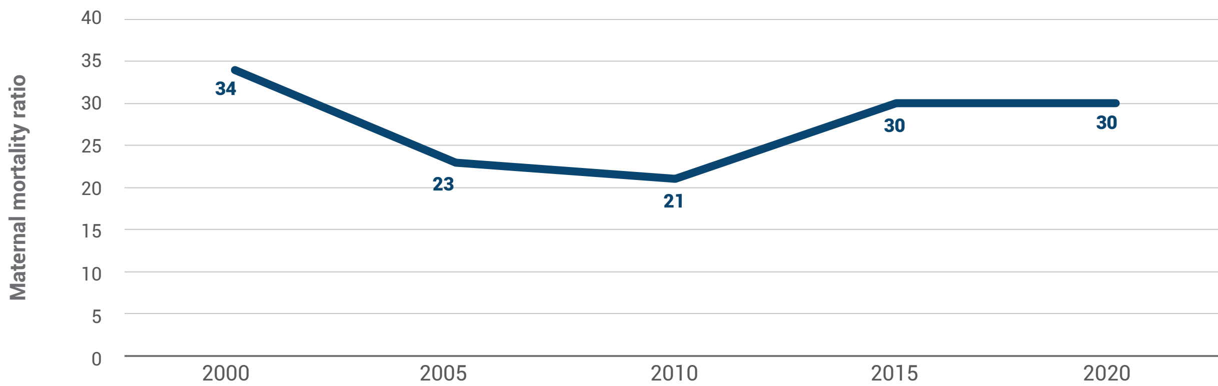
> For an EmONC facility to be considered fully functional, all seven or nine signal functions must be available 24 hours a day, 7 days a week.

27 A. Paxton, D. Maine, L. Freedman, D. Fry, S. Lobis, The evidence for emergency obstetric care. Int J Gynecol Obstet, 88 (2) (2005), pp. 181-193

28 UNICEF, World Health Organization, United Nations Population Fund. Guidelines for monitoring the availability and use of obstetric services. New York, N.Y.: United Nations Children›s Fund; 1997.

> According to the Government of Syria HeRAMS dashboard data from Q4 2023, only 17 of the 1,228 (1.4%) partially and fully functional health facilities offer basic emergency obstetric care services.

Figure 5. Maternal Mortality in the Syrian Arab Republic, 2000-2020[29]



BASIC EMERGENCY OBSTETRIC CARE AVAILABILITY

According to the Government of Syria HeRAMS dashboard data from Q4 2023, only 17 of the 1,228 (1.4%) partially and fully functional health facilities offer basic obstetric care services.[30] The 17 BEmONC facilities listed are located in Dara'a (four facilities), Deir Ez-Zor (one facility), near Raqqa (one facility), and distributed throughout the Hama and Homs governorates (11 facilities). While the CEmONC facilities also provide BEmONC services, these are primarily provided at the hospitals, which are typically located in cities and urban areas. The latest GoS HeRAMS data did not include the number of births at BEmONC facilities—only the number of normal (vaginal births) that took place at public hospitals.[31]

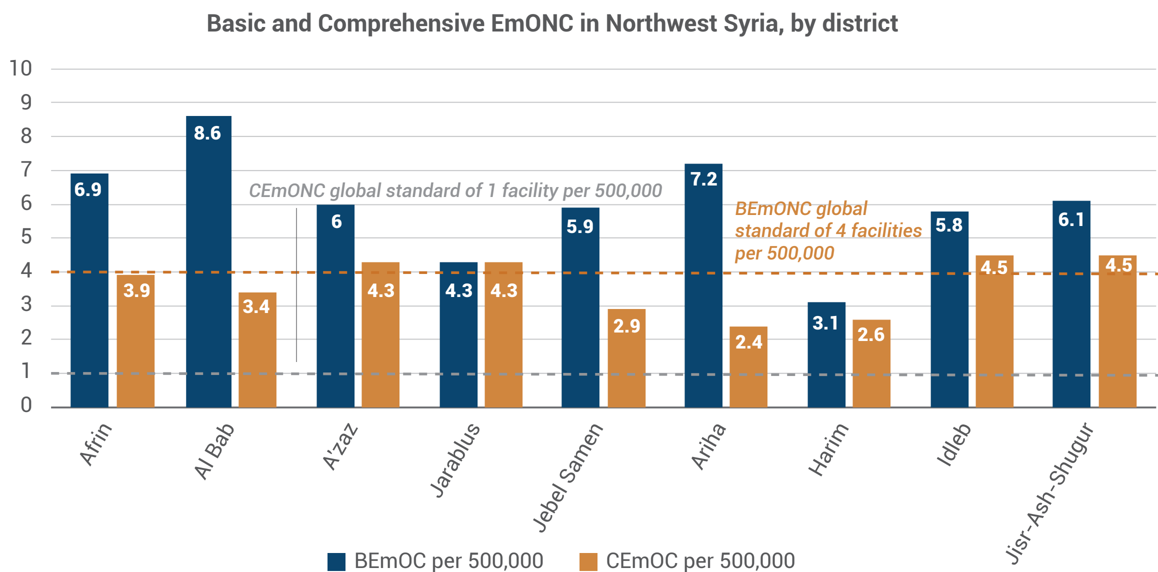
A study on the scope of midwifery in NES found that while midwives provide services along the full continuum of care, less than 10% were able to offer all seven signal functions of BEmONC.[28]

It should be noted that site-specific EmONC assessments of most facilities have not been conducted. While 17 facilities have been labelled as BEmONC facilities, it is unknown how many of the facilities are actually able to meet the BEmONC standards, i.e. are able to perform the seven signal functions listed in the table above. The same is true for the CEmONC facilities. At NWS EmONC facilities, the implementing partners self-report their status with regard to the signal functions.

In seven of the eight districts of NWS, the number of BEmONC facilities per 500,000 residents meets the global standard of four facilities per 500,000. The Harim district is the only district that is reported to be below this threshold, with only 3.1 facilities per 500,000.

29 The United Nations Maternal Mortality Estimation Inter-Agency Group (MMEIG)
30 Syrian Arab Republic (GoS) HeRAMS dashboard for Public Health Centers, Q4 2023
31 Syrian Arab Republic (GoS) HeRAMS dashboard for Public Hospitals, Q4 2023

Figure 6. Most districts in NWS have sufficient numbers of health care facilities providing EmONC.[20]



GEOGRAPHICAL DISTRIBUTION OF EMERGENCY OBSTETRIC CARE FACILITIES

It is essential that health care facilities designated to provide EmONC are distributed equitably geographically, considering both distance and travel time required for women to reach the health facility. A mapping exercise was carried out in 2021 by the NES NGO Forum's SRH WG on the availability of CEmONC and BEmONC.[32] The findings showed that there were only seven (out of 14) cPHCs in place that provided SBA; according to international standards, for the population size of NES, there should be at least 36-40 cPHCs capable of providing SBA and BEmONC. Furthermore, not all of these seven cPHCs provide all the components of BEmONC, including the provision of magnesium sulphate.

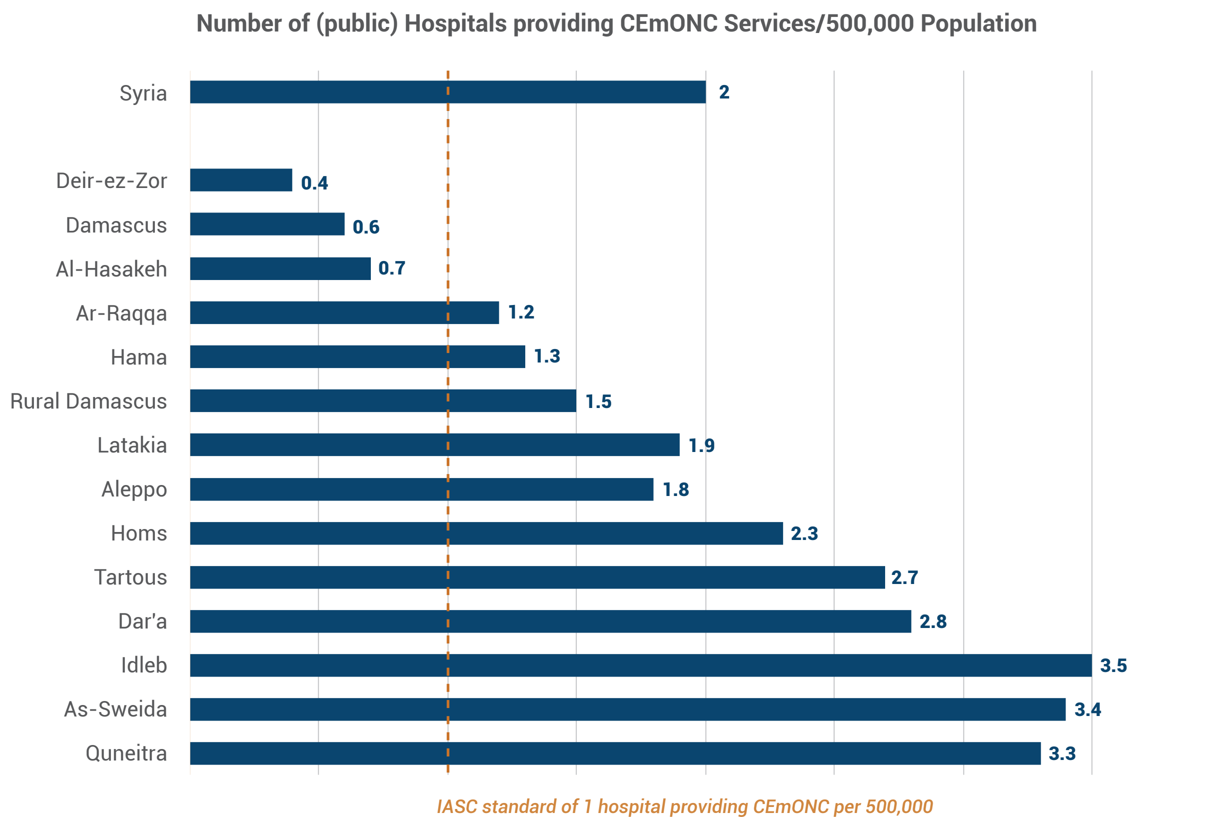
There is anecdotal evidence of women who presented at BEmONC facilities with severe preeclampsia (SPE) being turned away because the facilities were unable or unwilling to treat SPE, and subsequently died. It should also be noted that hypertension complicates 5% to 10% of all pregnancies globally and is associated with 14% of all maternal deaths. There is a wide spectrum of hypertensive disorders, which are often progressive and can escalate quickly in severity. Magnesium sulphate is the drug of choice for treating severe preeclampsia and eclampsia, for the prevention and treatment of convulsions.[33]

32 HERNES, Expertise France. 2021. Situation Analysis Maternal and Newborn Health (MNH) – Availability and Functionality of Healthcare Facilities in Northeast Syria (NES)
33 https://iawg.net/resources/basic-emergency-obstetric-and-newborn-care-bemonc-in-crisis-settings-select-signal-functions

COMPREHENSIVE EMERGENCY OBSTETRIC CARE AVAILABILITY

According to the Whole of Syria 2023 HeRAMS data, CEmONC was available in 40% (84 out of 208) of the functioning public hospitals in the country. This represents a 5% increase in CEmONC services from 2022 to 2023.[34] The data show that, overall, Syria has two CEmONC facilities for every 500,000 persons, which is above the internationally acceptable level of one CEmONC facility per 500,000. However, at the governorate level, the data indicates that there are three subnational areas that fall below the acceptable level: Damascus, Al Hasakeh, and Deir ez-Zor. The last two of these governorates are located in Northeast Syria, where it is known that access to CEmONC is a current and growing challenge.

Figure 7. CEmONC services are available in most areas of Syria, with clear gaps in NES and Damascus



Source: World Health Organization. Snapshot on WoS Health Resources and Services Availability Monitoring System (HeRAMS) Q3 2023: July-September

The number of facilities providing CEmONC has not been specifically disaggregated for GoS-controlled areas, but the GoS HeRAMS data for 2023 shows that less than half (46%) of all public hospitals in GoS-controlled areas are providing MNH services, with vast inequalities in many northern parts of the country: 33% in Hasakeh, 19% in Deir Ez-Zor, 24% in Aleppo, and 0% in GoS-controlled Idleb—compared to 100% in Quneitra, over 90% in Tartous, and 76% in Latakia. However, only 29% of all public hospitals in Damascus provide MNH services.[35]

The 2021 EmONC mapping in NES indicated that there are a total of 24 hospitals, 10 of which provide skilled birth attendance and C-sections. In principle, the overall number of hospitals is adequate, with a minimum of nine to 10 facilities required to provide CEmONC for the population size. However, the majority of the region's existing health care facilities are not fully functional and are only able to provide certain signal functions of EmONC. For example, there is currently no identified central blood transfusion service.[32]

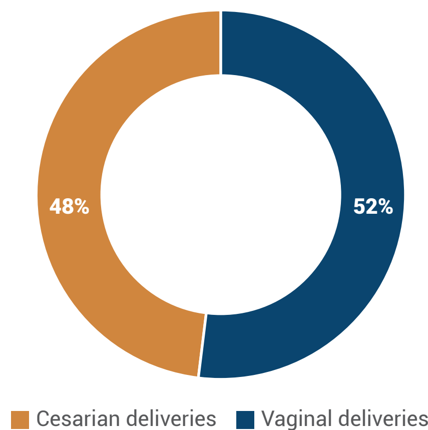
34 World Health Organization. Snapshot on Whole of Syria Health Resources and Services Availability Monitoring System (HeRAMS) Syrian Arab Republic. 2023 Q3 : Jul-Sep
35 Damascus controlled areas Health Cluster HeRAMS Public Health Centres (PHC). Interactive dashboard: link.

CAESAREAN SECTIONS AS A PROPORTION OF ALL BIRTHS

Caesarean sections are critical to saving lives in situations where vaginal deliveries pose risks, and health systems must ensure timely access for all women in need. However, unnecessary surgical procedures can be harmful, both for the woman and her baby. For nearly 30 years, the international health community has considered the ideal rate for caesarean sections to be between 10% and 15%. In 2015, the WHO recommended that every effort be made to provide caesarean delivery to women in need, rather than striving to achieve a specific rate.[36]

Before the war began in 2011, Syria had an accessible and extensive public health care system with a medicalised pattern of care, including excessive levels of medical interventions, such as caesarean sections.[37] The national C-section rate was 26.4% pre-conflict.[12] Even though many additional maternal health problems emerged or were exacerbated throughout the ongoing conflict, the prevalence of caesarean sections remains high, and there is consensus that the proportion of deliveries by C-section increased during the conflict.[12]

Figure 8. Breakdown of Caesarean Sections and Vaginal Births Reported in Government of Syria-controlled Areas, via the 4Ws, 2023[38]



In regions where CEmONC is available and where the security situation is relatively stable, C-sections seem to be commonly performed. Akik et al. found through their study that key informants reported C-section rates of 40% at the facility level; in Damascus, the reported rate in the private sector was 80%. An analysis of HeRAMS data from 2014 to 2018 shows an increased C-section rate at public health facilities nationally.

It should be noted that the population-level C-section rates, i.e. the number C-sections for the number of births in the identified population, is different from the C-section rate at the health care facility level, i.e. the institutional C-section rate (number of c/s at the institution over the number of births that occur in the same health care facility during the same period). The institutional rate is likely to be higher (25-35%). There is a lack of comprehensive data available to provide reliable, robust information about population-level C-section rates across Syria.

The limitations of this indicator include the fact that the status of all deliveries is not known. There are significant data gaps in many areas, due to women delivering in private-sector facilities, and the data collected by HeRAMS is analysed separately for hospitals and PHC facilities, where vaginal births are also taking place. Other limitations include gaps in reporting and data collection. The data from Damascus (and all GoS-controlled areas) is also challenging to fully comprehend, as a large portion of women are receiving SRH services, including delivery services, through the private sector. Data from the largest public maternity hospital in Damascus found that the C-section rate had increased from 29% to 51% in 2017.[39] The 4W data for 2023 shows that 48% of reported deliveries from public facilities were delivered by C-section in the Government of Syria-controlled areas reporting data.

A number of factors have been identified as drivers of these increased caesarean delivery rates. The security situation and the targeted attacks on health care facilities have been identified as notable drivers in areas of continued conflict. One study has shown a significant positive correlation between conflict-related events and the number of C-sections.[40] Patients often ask for elective caesarean delivery in order to avoid having a natural vaginal birth in an unsafe place at an unpredictable time. Key informants have indicated that many women demand that their delivery happen during the daytime, so as to avoid night time delivery, due to the precarious security situation. Doctors also prefer to reduce the time required for delivery, as the situation can be risky for doctors operating in conflict-prone areas.

36 WHO statement on caesarean section rates, 2015. https://www.who.int/publications/i/item/WHO-RHR-15.02

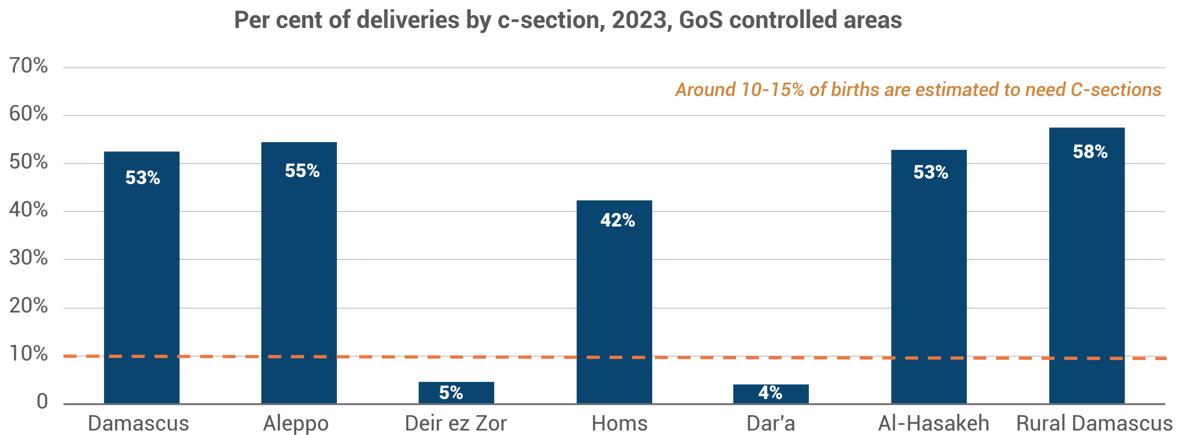
37 Khawaja M, Kabakian-Khasholian T, Jurdi R. Prevalence and determinants of C-section in Egypt: evidence from DHS. Health Policy. (2004) 69:273–81. 10.1016/j.healthpol.2004.05.006

38 GOS. 4Ws HRP Health Sector Interactive dashboard, 2023

39 l-Hammami H, Taleb MJ, Alsharif MN, Taleb MM. Prevalence of Cesarean Section at ALTAWLID Hospital during the Syrian Crisis. J Med Pharma Allied Sci. (2017) 6:947–53. 10.22270/jmpas.v6i12.746

40 Ekzayez A. The association between war exposures and health service utilisation in northern Syria: an observational study: London School of Hygiene and Tropical Medicine. 2017.

Figure 9. C-Sections in Government of Syria controlled areas, by governorate, 2023



Source: GoS, 4Ws HRP Health Sector Interactive dashboard, 2023

Other studies have reported that high C-section rates can be linked to health care providers' need and interest to manage their time and financial gain—particularly those who refer patients to private clinics. Likewise, following the exodus of skilled obstetricians and gynaecologists, delivery care has shifted to surgeons, whose differing perspective on safety and standards of care—as well as skill and education—may make them more likely to give women C-sections.[12]

A final, important component in explaining the high and increasing rates of C-sections is the increasing number of women with a history of a previous C-section, and the fact that many health facilities are not equipped to deal with vaginal births after caesarean sections (VBACS). Once a woman delivers by C-section, it nearly ensures that all subsequent deliveries for these women will need to be caesarean, with each additional C-section increasing the risk for the woman and child.

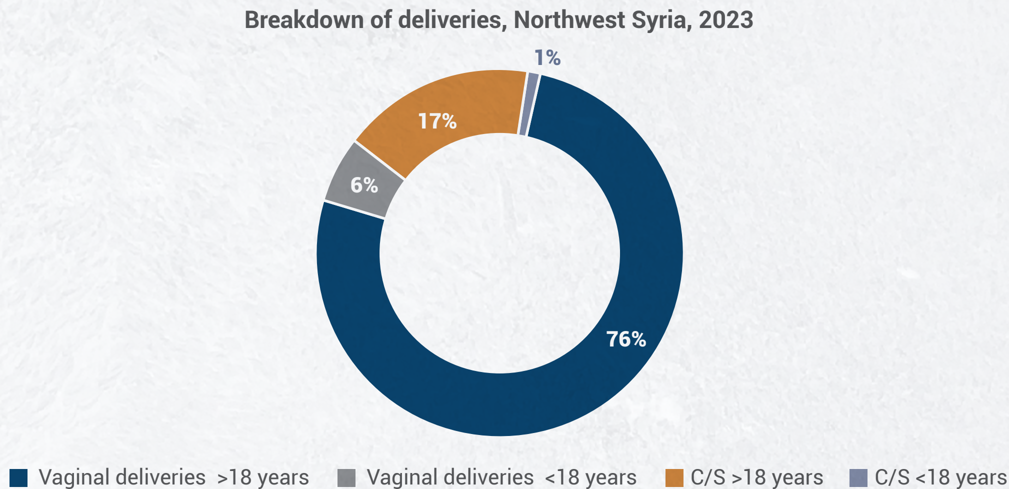
In Northwest Syria, a 2017 study reported a caesarean delivery rate of 30%, higher than both the WHO ideal rate and the rate before the war.[19, 41] However, a more recent study found trend data showing a decrease in caesarean sections, from 35% in March 2017 to 23% in July 2020, across the Syrian American Medical Society's (SAMS) maternal health facilities in Northwest Syria.[42]

The partners operating under the NWS SRH working group have been leading efforts to reduce the high C-section rate, including developing guidance materials and resources and introducing the Robson classification, a global standard for assessing, monitoring, and comparing C-section rates.[43] The data available from the Northwest Syria SRH WG dashboard shows that the caesarean delivery rate in 2023 was less than 20%. Additional research could be conducted to find out how this rate was reduced, and whether it was through improved availability of quality vaginal delivery options for women, a loss of access to C-section services, or a combination of both.

41 UNICEF. UNICEF data: Monitoring the situation of children and women. 2018. Available from: https://data.unicef.org/topic/maternal-health/antenatal-care/. [Last accessed 2018 Jun 17].
42 Basha S, Socarras A, Akhter MW, et al. Protracted armed conflict and maternal health: a scoping review of literature and a retrospective analysis of primary data from northwest Syria. BMJ Global Health 2022;7: e008001. doi:10.1136/ bmjgh-2021-008001
43 WHO. Sexual Reproductive Health and Research. Robson Classification: Implementation Manual, 26 November 2017.https://www.who.int/publications/i/item/9789241513197

The NWS SRH WG has disaggregated data on deliveries by age, which has revealed that around 6% of vaginal deliveries involve adolescent girls under the age of 18; there are few C-sections reportedly performed on adolescents.

Figure 10. Breakdown of Caesarean Sections and Vaginal Births Reported in Northwest Syria, via the 4Ws, 2023.



Source: NWS SRH WG dashboard, 4Ws reporting

In Northeast Syria, the facility-based C-section rate at NGO-supported health care facilities reporting to the Health Working Group (HWG) was reportedly between 24-31% in 2022 and 2023. Furthermore, private hospitals in Northeast Syria primarily provide C-section services, with limited to no availability of care for vaginal deliveries. A study was conducted in 2023 of the availability and quality of caesarean sections and normal vaginal deliveries (NVD) in Northeast Syria.[44] The study explored various factors that contribute to the high C-sections rates and low uptake of vaginal births. It was a mixed-method study that involved operating-theatre register reviews (n=3442 c-Sections reviewed), a KAP survey with obstetricians, and focus group discussions (FGDs) with women and midwives. The findings uncovered several potential reasons and rationales for the high rates of C-sections, including patient and family expectations, security concerns, financial implications for providers, lack of regulations, and poor conditions for supporting vaginal deliveries. Among FGDs, women and midwives reported that the decision-making processes for the modes of delivery were influenced by the health care provider and family members. Cultural and societal influences also play a significant role in shaping birth practices throughout the region.

The perceived quality of skilled birth attendance, including a lack of pain management, may also shift the rates of demand for vaginal delivery, leading first-time mothers to choose a C-section. Like in other areas of Syria, most facilities and providers in NES are not able to do VBACs, so once a woman has had a caesarean, her future births will also need to be done by caesarean section. Raqqa Hospital, however, will soon be capable of providing VBACs.

The study's findings and its authors report a need for improved infrastructure and staffing in labour rooms, in order to support vaginal births. Evidence-based practices like providing pain relief and companionship during labour and delivery are not in place. Vaginal birth is heavily associated with fear, anxiety, and risk, especially among younger women. Another study found that partographs are rarely used, as facilities and providers are often deemed too busy to use them. A UNFPA-led focus group discussion with women from Deir Ez-Zor reported that an absence of pain medication during and after childbirth was a common concern, and women were often advised to endure the pain. One respondent mentioned resorting to drinking mint for relief.

In GoS-controlled areas, only a little more than half of all public health facilities that should be functional are providing ANC services.

44 Al Daher, H., Al Dabgh, M., Khalid, D., van den Broek, N. Availability and Quality of Caesarian Section and Normal Vaginal Deliveries in Northeast Syria. Expertise France, 2024.

Box 4: Improving Maternal Death Surveillance in Humanitarian Settings in Syria

In 2017 a situation analysis was conducted to launch efforts to establish a maternal and perinatal death surveillance and response (MPDSR) system in government-controlled areas of Syria. Foundational elements identified included government commitments to reducing maternal mortality, a facility-led death review, quality improvement practices being established at select teaching hospitals, and a digitalised mortality surveillance system supported by WHO in 70+ public hospitals. Although the rapid mortality surveillance system has since expanded to hospitals affiliated with the Ministry of Higher Education and is positioned to cover at least some of the country's 300+ private hospitals in 2024, and while reporting tools have been updated to include designations for maternal and neonatal deaths, the system capacity remains limited when it comes to capturing deaths that occur in or are reported to participating health facilities (key informant interview participants noted that recent analyses suggest that the system only captures 12% of the total deaths).

The system is even further limited in its ability to capture maternal deaths, as the doctors involved in death certification and reporting at most facilities are not obstetricians/gynaecologists (only two maternal deaths were reported in 2023). It's also important to note that the system does not extend to areas of Northeast and Northwest Syria that are outside of government control. Stakeholders participating in key informant interviews expressed an eagerness to link and strengthen these foundational components through a cohesive MPDSR system, and highlighted ongoing efforts to encourage the Ministry of Health to formalise a national technical working group that will take responsibility for MPDSR, noting that there are many opportunities and pathways for the MPDSR system to be strengthened, but context-specific solutions are necessary for different parts of the country, both within and outside of government-controlled areas. Key informant interview participants working for UN agencies in cross-border hubs that support reproductive health programming in Northeast and Northwest Syria shared very different, but equally promising, foundations for MPDSR.

In Northwest Syria, more than 90% of births occur at health care facilities, and the SRH working group has standardised tools for reporting maternal and newborn deaths, as well as dashboards tracking these cases across all supported facilities. Although there is not a formal review and response mechanism in place, interview participants noted strong coordination amongst health cluster and SRH working group members; these informants were able to share not only the numbers but also the case details and circumstances of the few maternal deaths that occurred in the last year. Participants in Northeast Syria noted similar collaboration amongst UN partners, and offered detailed insights into the newborn deaths that had occurred in UN-supported facilities, but also noted the highly siloed nature of health facility management and programme support, particularly between areas under government control and self-administered regions. All informants expressed an interest in learning how others operating in similarly challenging and resource-constrained settings are addressing identified needs through death reviews, and expressed a need for simple, standardised tools that could be adopted by NGOs, UN agencies, and other supporting health services—even if information is not shared across networks.

ADOLESCENT GIRLS

Adolescents are especially affected and vulnerable to risk in times of crisis, but they are rarely sufficiently prioritised in the humanitarian response. This is true for the Syrian response. There is very little information available on the health needs of adolescent girls. The 4W response data on deliveries has been disaggregated by age, into two categories—under 18 years of age and over 18 years of age—but little other information was found. Information collected through the literature review supports the finding that adolescents have been largely left out of the response.[45] Data collected through SMART surveys by the nutrition working group in 2023 found that one in five teenage girls (aged 15-19) in Syria either has children, is pregnant, or is lactating.[1] This is similar to the data collected from a 2017 study, which found 24% of pregnant women inside Syria were adolescents, largely due to the increases in early marriage post-conflict.[19]

Economic hardship can give rise to negative coping mechanisms for individuals and families. While there is much evidence in the literature of the harm adolescents can experience within early marriage, many Syrian communities view marriage as a mechanism to protect girls, and therefore increasingly practice early marriage during times of uncertainty and violence.[46] A survey assessing the rates of marriage before age 18 among Syrian women found a 34% increase in child marriage after the onset of the crisis, and pointed to displacement, instability, and poverty as the major causes.[47] Child marriage is clearly a product of poverty, but it is also a symptom of gender inequality. Some parents see their daughters as burdens or commodities. In Syria, a groom or a groom's family pays a bride price, and parents in difficult circumstances may choose to marry off their daughters as a source of income. Some families are unable to provide for their adolescent daughters, and therefore may feel that another family may be able to do better.

45 Singh NS, Ataullahjan A, Ndiaye K, Das JK, Wise PH, Altare C, Ahmed Z, Sami S, Akik C, Tappis H, Mirzazada S, Garcés-Palacio IC, Ghattas H, Langer A, Waldman RJ, Spiegel P, Bhutta ZA, Blanchet K; BRANCH Consortium Steering Committee. Delivering health interventions to women, children, and adolescents in conflict settings: what have we learned from ten country case studies? Lancet. 2021 Feb 6;397(10273):533-542.

46 Spencer D. To Protect Her Honour: Child Marriage in Emergencies–the Fatal Confusion Between Protecting Girls and Sexual Violence. Gender and Protection in Humanitarian Contexts: Critical Issues Series. United Kingdom: Care International (2015).

47 Abdulrahim S, DeJong J, Mourtada R, Zurayk H, Sbeity F, Khawaja M. The Prevalence of Early Marriage and its Key Determinants Among Syrian Refugee Girls/Women. Lebanon: American University of Beirut, UNFPA, SAWA for Development and Aid (2016).

However, the fact remains that the risk of death associated with pregnancy in adolescents is about a third higher than that of young women aged 20 to 24 years old.[48] Adolescents are also more likely to experience a greater number of complications, such as obstructed labour, fistulas, and premature delivery, and are more likely to give birth to babies with low birth weights. These inherent risks are compounded by the disruption and destruction of Syria's health system and infrastructure.

In Northwest Syria, a programme grounded in gender transformative approaches was developed and piloted to address the needs of adolescent girls. CARE, UNFPA, and Syria Relief and Development adapted global evidence-based approaches to humanitarian contexts in order to create the Adolescent Mothers Against All Odds (AMAL) Initiative for pregnant girls and first-time mothers aged 10 to 18 years.[49] AMAL includes three components: a Young Mothers Club for first-time mothers and pregnant girls, participatory dialogues with health providers, and reflective dialogues with girls' marital families and community members. The programme encountered challenges in recruiting younger girls, due to community pressure and the demand that young women over the age of 19 be included. In response, the inclusion criteria was increased to 25 years old. The high demand that AMAL created among young women over the age of 18 highlights the need for age-appropriate programming for girls and young women. Adolescents aged 10 to 18 undoubtedly have unique needs that must be included in programme intervention design, and this remains an important gap in programming.

The AMAL initiative is an important step, as it seeks to inform the data and dialogue surrounding nexus approaches to adolescent responsive SRH programming. Building off the lessons of the pilot implementation, the AMAL Initiative is being scaled up across Syria, with implementation by eight local organisations. In order to effectively meet the needs of vulnerable adolescents in Syria and beyond, this kind of continuous learning is vital. Investments in operational research and documented learning must be prioritised.

FAMILY PLANNING

UNFPA currently provides family planning commodities and supplies through static clinics and integrated mobile teams throughout NWS, government-controlled Syria, including areas in NES. One of UNFPA's main strategic goals is to have zero unmet needs for contraception by 2030. The lack of national statistics and the absence of recent large-scale surveys in any part of Syria have inhibited the availability of holistic data on family planning. The unmet needs for family planning in Syria are not currently known as the last survey on this topic was conducted in 2011.

Through HeRAMS reporting, it is known that many health facilities are providing family planning. Throughout the GoS controlled-areas of Syria, HeRAMS mapped out the 981 health facilities that were reportedly providing family planning by the end of 2023. HeRAMS for Gaziantep cross-border also reports on the numbers of facilities, by district, that are providing family planning services. UNFPA-supported facilities report on their programme data, which includes the number of family planning consultations being provided. However, there is no available data on the utilisation rates of family planning overall, or data on the types of contraceptives being used.

In NWS, contraceptives and family planning kits are procured outside of Syria, distributed and made available free of charge in all humanitarian-supported facilities that provide SRH, including mobile clinics. When demand surpasses supply and these facilities are out of stock, people may then need to purchase their contraceptives from local pharmacies. For NWS, the SRH WG dashboard shows that there were 279,000 family planning users in 2023—37% of whom were new users.[50]

In the GoS-controlled areas, the Ministry of Health (MOH) supports the vast majority of the health facilities that are providing family planning services, and the data is collected by the existing health information system (HIS). The HIS remains paper-based and thus the aggregation of data from facilities across the governorates is slow, incomplete, and makes it difficult to compile comprehensive, disaggregated data. UNFPA supports NGOs that provide family planning, in

48 Sedgh G, Finer LB, Bankole A, Eilers MA, Singh S. Adolescent pregnancy, birth, and abortion rates across countries: levels and recent trends. J Adolesc Health. 2015 Feb;56(2):223-30. doi: 10.1016/j.jadohealth.2014.09.007. PMID: 25620306; PMCID: PMC4852976.

49 Elevating Married Adolescents› Voices for Responsive Reproductive Healthcare in Syria, AMAL evaluation, Care International. https://www.frontiersin.org/articles/10.3389/frph.2022.780952/full#B16

50 GXB SRH service mapping, SRH working group,link and Gaziantep Cross border SRH working group dashboard link

addition to supporting some MOH facilities that provide data on a quarterly basis. The NGO data is collected routinely and is reported monthly. Information collected from a site visit to UNFPA-supported health facilities in Aleppo observed that all facilities had some form of modern contraceptives, including oral pills (100%), intrauterine devices (IUDs) (50%), and injectables (30%). Each facility should have at least three family planning choices. Awareness sessions predominantly focused on breast cancer (60%), with 20% addressing pregnancy and 40% discussing family planning and menstrual hygiene.

It has been reported that, in certain areas in NES, family planning is rarely discussed among the humanitarian-led response. Anecdotal reporting highlighted that the health response in the NGO Forum is very male-dominated and not particularly interested in or knowledgeable about SRH or maternal health. It was also stressed that there is both a lack of understanding and a lack of priority-setting for SRH, with more discussion around CEmONC, but little around family planning, STIs, or other preventive interventions.

UNFPA currently provides family planning commodities and supplies in the Hasakah and Raqqa governorates and brings reproductive health medicines and equipment to NES. There are often logistical and financial challenges in getting these essential supplies to certain areas of NES. Importing the supplies from Damascus by road require passing through checkpoints between the GoS and SDF areas in NES.

Studies note that, in Syria, family planning was not prioritised by the stakeholders responsible for implementing the early phases of the humanitarian response, and it took considerable time for these priorities to be reestablished.[12] Unlike ANC, EmONC, and infant and young-child feeding (IYCF), family planning wasn't considered to be a lifesaving service, and thus wasn't immediately prioritised. However, there has been a global shift since the time of the initial response, and when the MISP was revised in 2018, family planning was recognised as being life-saving. The delays in setting up family planning services were reportedly linked to specific donors and governing authorities restricting service delivery in certain areas; in other regions, meanwhile, donors actively promoted family planning programmes. Notably, services that were not strongly institutionalised in the public sector before the conflict, such as family planning and adolescent-specific services, were not prioritised in the emergency humanitarian response.

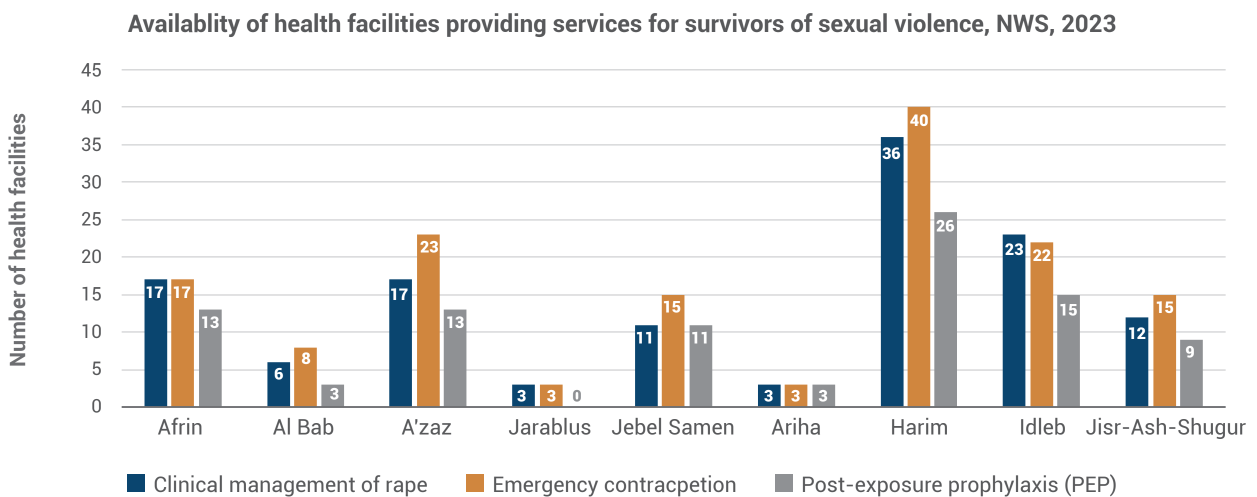
While we do not have a clear view on the unmet need for family planning, or a clear idea of broadly how many women are using family planning throughout Syria, we do know that the provision of family planning is neglected in most countries and humanitarian situations—particularly in countries where religious and cultural practices affect the acceptability of such services.[42] In Syria, broader access challenges related to facility functionality add to other identified challenges, such as the influence of cultural and societal norms on family planning decisions and their impact on women's autonomy in making family planning choices.

PROVISION OF SRH SERVICES TO SURVIVORS OF GBV

The integration of GBV and SRH approaches can help increase women's and girls' access to both GBV and SRH services, expanding the reach and impact of these lifesaving interventions. Objective Two of the MISP is to prevent sexual violence and respond to the needs of survivors. SRH services are often the first, and sometimes only, point of contact for survivors. When health care providers have the knowledge and skills to meet the needs of survivors, health facilities and services can provide a safe and non-judgmental entry point for women and girls to receive information, integrated GBV services, or safe referrals to GBV services. Enhancing the delivery of integrated services is an important mechanism for improving the health and well-being of women and girls in humanitarian settings.

In NWS, the gender-based violence (GBV) sub-cluster, the SRH WG, and the humanitarian health actors in NWS are all actively engaged in promoting and implementing integrated SRH and GBV services. Additionally, in GoS-controlled areas of Syria, including in NES, health workers have been trained on the clinical management of rape (CMR). The supplies and medicines for CMR are procured through Kit 3 of the Inter-Agency Reproductive Health (IARH) Kits. It should be noted that Kit 3 is not available for UNFPA partners in NES.

Figure 11. Availability of Health Facilities Providing Services for Survivors of Sexual Violence, NWS HeRAMS 2023



Box 5. Integrated SRH and GBV Services in Northwest Syria

Through a UNFPA-led programme on GBV/SRH integration, many of the health facilities in NWS have trained staff on the clinical management of rape (CMR). Several of the training sessions were held jointly with both SRH and GBV staff, which resulted in important knowledge exchange. Over the last two years, the Gaziantep cross-border hub has done a substantial amount of work to improve coordination at the inter-agency level and has established a GBV-SRH Taskforce. The taskforce has worked, among other things, on (1) assessing all health facilities to understand their capacity to provide integrated services; (2) a capacity-building plan based on identified needs; (3) awareness-raising messages and information, education, and communication (IEC) materials; and (4) advocating with OCHA and the health cluster for this integration to be a standard requirement in the submission of health proposals.

There are now 117 facilities operating under the initiative, with 50 facilities providing at least in a basic level of integration, compared to only two in the baseline. Seventy-nine (79) facilities now have 100% of their staff trained on GBV basics, safe identification, and referrals, compared to only two facilities in the baseline. Fifty (50) facilities have CMR-trained staff available 24/7, compared to only 13 in the baseline. Nearly 70% of the interviewed medical staff reported a positive attitude towards GBV integration, an increase of 23% compared to the baseline. GBV survivors are more likely to suffer from heightened SRH risks, such as unintended pregnancies, sexually transmitted infections and HIV, and pregnancy or abortion complications. In 2023, medical and health services were consistently the services most-referred to survivors and the second most-commonly received services prior to seeking GBV services by survivors.[51]

Some of the integrated SRH/GBV services also include adolescent SRH and early marriage. For example, the NGO Syria Relief and Development (SRD) has adopted an integrated service model approach that combines health, GBV, child protection, and mental health services, specifically for child survivors of assault, abuse, and rape.[52] This model incorporates health services into mobile service delivery, providing broader geographic coverage for remote, hard-to-reach communities and minimising access barriers by reducing the need for dangerous and expensive transportation.

UNFPA recently developed Stronger Together,[53] a tool to support the integration of GBV and SRH interventions in humanitarian settings throughout the Arab region. Aimed at GBV and SRH service providers and programme managers, Stronger Together facilitates the initiation, strengthening, and scaling of integrated approaches. Rather than prescribing a standardised approach, this tool emphasises the importance of tailoring interventions to specific contexts. It shares promising practices, identifies potential obstacles, and offers practical tips for overcoming challenges associated with integrated GBV and SRH approaches.

OTHER KEY SRH SERVICES

There are a number of key areas along the continuum of care for which little to no information was found, including information on the diagnosis and treatment of STIs, postpartum care, and comprehensive abortion care. The IRC report states that services for the counselling, screening, and management of sexually transmitted infection (STIs) are widely available across Northwest Syria, as complementary services in SRH-providing healthcare facilities. There are no standalone facilities that provide care for STI patients. Basic screening and treatment services are free for patients in NGO-funded medical facilities. Patients seeking more advanced services or specific screenings must go to fee-based private facilities. Northwest Syria is considered a low-risk area for HIV, and HIV counselling, screening, and treatment services are limited, and found in only a small number of facilities.

51 GBVIMs+ 2023, GBV AOR Northwest Syria.

52 International Rescue Committee (IRC). She pays the highest price, the Toll of Conflict on SRH in Northwest Syria. 2023 https://www.rescue.org/sites/default/files/2023-03/The%20Toll%20of%20Conflict%20on%20Sexual%20and%20Reproductive%20Health%20in%20Northwest%20Syria_March%202023.pdf

53 UNFPA, Stronger Together - Integrating Gender-based Violence and Sexual and Reproductive Health Approaches in Humanitarian Settings, March 2024. https://arabstates.unfpa.org/en/publications/stronger-together-integrating-gender-based-violence-and-sexual-and-reproductive-health.

The HeRAMS data for Gaziantep cross-border includes the number of facilities, by district, that are providing postpartum care and comprehensive abortion care. The NWS SRH WG dashboard collects and reports on the number of postnatal care visits, disaggregated by visits 24 hours after delivery and 6-week postpartum visits (42 days), for each month of 2023. No health facilities in NWS perform induced abortion, which is highly restricted in Syria. Medically indicated abortion is available in limited cases, when a doctor believes that a woman's life is in danger. Post-abortion care is available for spontaneous or induced abortion.[49] The NWS HeRAMS data shows that there are 36 facilities providing comprehensive abortion care. This includes uterine evacuation, antibiotic prophylaxis, treatment of abortion complications, counselling for abortion, and post-abortion contraceptives.

There was no specific information reported on the management of STIs, PNC, or abortion care for GoS-controlled areas or by the NES NGO forum. However, a study was conducted in NES that reviewed the case notes for over 1,100 patients across nine healthcare facilities, assessing care for the seven most common reproductive or maternal morbidities (UTIs during pregnancy, anaemia during pregnancy, reproductive tract infections, vaginitis, infections after delivery, miscarriage/abortion, and dysmenorrhoea).[54] The findings highlight an urgent need to improve the quality of women's reproductive health care in NES. Medical histories were inconsistently recorded, and clinical examinations were inadequately performed, especially essential examinations such as abdominal palpations and speculum and/or bimanual pelvic examination when required. Diagnostic investigations, such as blood tests and urine examinations, were often unavailable or underutilised. The prescription of multiple medications, including antibiotics, was common, with limited documentation of follow-up and referral information.

> A study was conducted in NES assessing care for the seven most common reproductive or maternal morbidities. The findings highlight an urgent need to improve the quality of women's reproductive health care in NES.

54 Diagnosis and Management of Reproductive and Maternal Health Morbidities in Northeast Syria (NES), Expertise France, 2024

ANALYSIS

Gaps and Barriers to Ensuring Reproductive Health Services in Syria

The lack of available comprehensive data in Syria makes it difficult to assess the extent of inadequacies and disparities in women's access to health care. Without this data, it is challenging to identify where, and to what extent, health services for women are lacking or unevenly distributed. Despite this limitation, existing knowledge and data can be organised to provide a structured framework for discussing the reasons behind these gaps and their potential solutions. This analysis of the findings of the review offers insights into these service barriers and gaps, in order to support discussions and actions at the hub and Whole of Syria level. Additionally, this analysis can be used to highlight greater evidence-based needs for resource mobilisation and advocacy. Ultimately, understanding key barriers that reduce the availability and access to quality SRH for millions of women and girls is vital to protecting the rights of women and girls and their right to health.

Figure 12 outlines the model employed to identify and describe barriers to SRH service delivery throughout Syria. Certain barriers are specific to particular locations in Syria, while others are prevalent across the entire region.

This analysis integrates two models: first, the "Three Delays" model, which asserts that pregnancy-related morbidity and mortality are primarily attributable to delays in (1) deciding to seek appropriate medical help for an obstetric emergency, (2) reaching or accessing an appropriate obstetric facility, and (3) receiving adequate or quality care when a facility is accessed.[55] While most women in Syria are currently giving birth in health facilities, these delays or barriers can be applied more broadly to encompass access to other services as well. What are the delays in seeking ANC or family planning, the barriers to accessing such services, and the barriers to receiving quality or sufficient services?

Additionally, this analysis incorporates a framework for health system strengthening based on the Tanahashi model, examining four key domains that influence effective SRH services for women: (1) the **demand**, or whether women are wanting or seeking health services; (2) the **supply**, or whether the health services, medicines, equipment, or human resources needed for those services are available and reachable; (3) the **quality**, or whether the existing and accessible services are sufficient, and of sufficient quality to treat and care for those arriving at the health services; and (4) whether there are barriers within the **enabling environment**—in this case, with a focus on the policy- and/or system-related mechanisms that help to ensure that women seek, access, and receive quality SRH services. Despite some overlaps in categories, this approach offers a comprehensive understanding of the multifaceted challenges being faced.

"The lack of available comprehensive data in Syria makes it difficult to assess the extent of inadequacies and disparities in women's access to health care. Without this data, it is challenging to identify where, and to what extent, health services for women are lacking or unevenly distributed.

55 Thaddeus S, Maine D. Too far to walk: maternal mortality in context. Soc Sci Med. 1994;1982(38):1091–110.

Figure 12. ACCESS+: A Model for Analysing Reproductive and Maternal Health Service Delays: Bridging Gaps and Overcoming Barriers

DEMAND BARRIERS	SUPPLY BARRIERS	QUALITY BARRIERS	ENABLING ENVIRONMENT
Insecurity and fear of violence	Geographic access: • Limited facilities • Long distances • Insecurity and access issues	Stock out of medicines and equipment	Data gaps, insufficient health surveillance, limited HIS
1ST DELAY: SEEKING			
Agency and decision-making ability Cost	Availability: Insufficient: • Human Resources • Medicines and equipment	Inadequately trained or motivated staff	Coordination
	2ND DELAY: ACCESSING		
Stigma, cultural expectations	Affordability: • Cost of transport • Private sector	Inadequate referral systems	Policies and guidelines SRH within: • Primary Health Care (PHC) Strategies • Essential Health Care Service Packages (EHSP)
		3RD DELAY: RECEIVING	
Lack of awareness		Overcrowding	Standardised tools for service delivery, e.g. ANC cards, facility monitoring checklists, etc.

DEMAND-SIDE BARRIERS (FIRST DELAY)

Insecurity and Fear

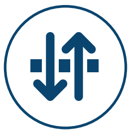
Escalating violence was witnessed throughout 2023, and fear continues to be a significant hurdle in seeking or prioritising health services across certain locations and regions. Women in NWS have reported that the fear or experience of bombings and attacks on health facilities deters them from accessing health clinics. The earthquakes in February 2023 also created a fear of spending time in buildings perceived to be unstable.[56] Some women reported foregoing care or relying on informal health service providers. Frequent attacks on health care facilities have reportedly led a high number of pregnant women in Northwest Syria who prefer caesarean sections over vaginal births, as women do not want to spend prolonged hours in a potentially insecure area. Women reported avoiding ANC visits for the same reason.[49]

Agency and Decision-making

In UNFPA's 2023 Impact Assessment, family restrictions—especially the need for a chaperone or family approval to visit UNFPA sites—were identified as major barriers. Cultural expectations and lack of awareness of their rights can also be barriers to women seeking services. The impact assessment reported that, in some areas of the country, this is gradually improving. However, in others, cultural expectations are moving the opposite direction. In the Idleb province of NWS, a strict social framework has been developed and may be controlled through a new public morality law. These shifts foretells a dire situation for women and girls. Under such regulations, their individual choices and freedoms will be further jeopardised.

Stigma and Lack of Awareness

Stigma and lack of awareness of service availability can make it difficult for women and girls to seek key services. According to those interviewed, the services that are often most stigmatised, including diagnosis and treatment of STIs and health services for survivors of GBV, are also the least accessible. A study reporting very low rates of ANC and PNC visits investigated the reasons behind the low uptake, and found that more than half of the pregnant women surveyed did not know how many times, or when, they should come for ANC. However, the majority (92%) of the women surveyed reported acknowledging that ANC is important.[19]



SUPPLY SIDE BARRIERS (SECOND DELAY)

Geographic Access

Limited Facilities

Throughout the 13 years that have passed since the crisis began, one of the myriad challenges facing the country is the widespread destruction of medical services.[57] Basic health service providers continue to grapple with functionality issues, as discussed in the findings section. This situation significantly reduces the availability of facilities that provide SRH, contributing to a persistent barrier in efforts to reduce the Maternal Mortality Rate (MMR).[56]

Furthermore, the availability of health facilities that are providing basic EmONC care and/or uncomplicated vaginal deliveries is either not fully understood or there are limited facilities providing these essential services—likely far below the internationally accepted standard of five EmONC facilities for a population of 500,000 (with at least one providing CEmONC). Furthermore, information on catchment areas—mapped areas within a specific distance that would be considered geographically accessible for pregnant women—was not available for facilities providing BEmONC.

56 Direct Relief, Mothers & Midwives Hope for New Life in Northwest Syria, Nov. 2023

57 Bashour H, Kharouf M, DeJong J. *Childbirth Experiences and Delivery Care During Times of War: Testimonies of Syrian Women and Doctors.* Front Glob Womens Health. 2021 Jun 30;2:605634. doi: 10.3389/fgwh.2021.605634. PMID: 34816179; PMCID: PMC8593930.

Long Distances and Lack of Affordable Transportation

Pregnant women encounter significant challenges in accessing medical care due to the necessity of travelling long distances, which exposes them to heightened risks. The reduction in the number of SRH facilities has exacerbated this issue, further elongating the distances that women must travel. Some women from Deir Ez-Zor visited ANC facilities only in the last month before delivery. The primary reason cited for delayed facility visits was a lack of available transportation. Some women had to resort to taking multiple taxis, and one even mentioned using a motorbike, with transportation costs posing a significant challenge for all. UNFPA's report "One Step Closer: The essential role of transportation when accessing GBV and SRH services in humanitarian settings" provides additional information.[58]

The study that reported very low ANC and PNC visits also investigated the reasons underlying the low uptake and found that transportation to facilities was the greatest barrier, and included issues like lack of transportation, lack of money to access transportation, and road safety.[19]

Insecurity and Access Issues

The impact of the violence in Syria specifically on the provision of SRH care is scant. A recent IRC report on NWS contributes to a greater understanding of this under-examined crisis. The continued and escalating violence affects access to health facilities, as travel is often prohibited in unsecure areas, and unsafe roadblocks and checkpoints continue to be barriers to women seeking to access SRH services. Health workers surveyed by the IRC identified attacks on health care facilities as a primary challenge, second only to a persistent lack of medicines.[49]

Availability

Insufficient Human Resources for Health (HRH)

The prolonged crisis has taken a significant toll on Syrian health care providers. An estimated 50-70% of health care workers have left the country.[59,60] Attacks on health care professionals and health care facilities have become a haunting feature of their professional lives. A staggering eight out of 10 health care workers surveyed by the IRC have witnessed attacks on health care workers and facilities: the average number of attacks witnessed by health care workers was four, although some had witnessed or experienced as many as 20. Physicians for Human Rights estimates that some 923 medical personnel were killed in Syria between the start of the conflict, in March 2011, and March 2020.[49]

There continue to be attacks on health facilities and medical personnel, and more than 50 percent of health workers are estimated to have left the country in the last decade.[56] Furthermore, the value of salaries is dropping rapidly due to currency deflation and global inflation. Such fast-paced changes affect the degree to which salaries are perceived to be sufficient. Staff motivation is affected by the adequacy of salaries.

There is a study being finalised around the current scope of practice for midwives working in NES, with a view to identify opportunities and mechanisms for task-shifting for midwives. (See Box 1 for the findings and recommendations.)

Delays in Moving Equipment, Supplies, and Medication

UNFPA currently procures family planning commodities and supplies centrally and provides them to the MOH in Damascus. From there, these commodities are distributed to various DOHs across various areas of the country, including parts of Southeast Syria. Transporting the supplies from Damascus by road requires passing through tedious and often dangerous checkpoints. This crossline distribution is facing political and administrative challenges that often result in delays or refusals, due to varying regulations and requirements.

There are also serious communication and coordination challenges that hinder the timely and effective coordination needed among stakeholders across different regions of Northeast Syria. Effective coordination is necessary for the movement of supplies, the coordination of humanitarian support, and the ability to share knowledge and evidence that can enhance the quality of programmes and responses for women.

58 UNFPA One Step Closer - One Step Closer The essential role of transportation when accessing GBV and SRH services in humanitarian settings, January 2023.

59 Devi, Sharmila (2021-03-13). «Health in Syria: a decade of conflict». *The Lancet.* 397 (10278): 955–956. doi:10.1016/S0140-6736(21)00618-8. ISSN 0140-6736. PMID 33714377. S2CID 232201250.

60 OCHA, Humanitarian Needs Overview 2023

Affordability

Cost Barriers

The spread of poverty in Syria has had a significant impact on its population's ability to secure their daily needs for food and basic commodities, particularly given the sharp and unprecedented rise in prices. This also impacts the population's access to health care, as the rising costs of medicine, transportation, and private health care services pose a significant barrier to individuals seeking essential and potentially life-saving medical care.

Ninety per cent (90%) of the population of Syria now lives below the poverty line.[61,62] For most people, the current socioeconomic challenges represent some of the most challenging times they have faced since the beginning of the crisis. These structural and economic realities reduce women's access to SRH services.

Private-sector Costs

While private health services may exist and may be closer in distance, they are not accessible to most women, who are unable afford the high costs of services. The numbers of private hospitals and doctors have been increasing in both large urban areas and rural areas. It is unknown what proportion of health services the private sector currently covers; however, it is largely unregulated and the quality is uneven. In NWS, WHO is leading a study on the composition of health structures, and will assess the capacities of the private sector. There is a growing number of private facilities in parts of NES where there are shortages of public facilities due to staff and funding; these private facilities also lack regulation and quality standards.

QUALITY (THIRD DELAY)

There was very little specific information found on the quality of health services being provided, and little attention seems to be given to the quality of care provided or to improving the quality of care provided. Many reports and studies mention that, although SRH services are being provided, the availability of good-quality SRH services is inconsistent across settings. Quality is an important component for providing services both effectively and efficiently.

Box 6: Improving Quality of Maternity Care through Clinical Audits in NES

The HERNES III Programme worked to enhance the quality of care across health care facilities in Northeast Syria in 2023.[63] All partners providing reproductive, maternal, newborn, and child health (RMNCH) in NES collaborated on this initiative, and work was conducted across 10 healthcare facilities (including four Hospitals and six cPHCs). Comprehensive assessments of maternity care at these facilities was carried out, working together with healthcare managers and providers. An agreed-upon, comprehensive list of 20 standards, with Structure, Process, and Outcome (SPO) criteria, was developed, and a standards-based audit was successfully introduced as a quality improvement approach.

Key activities included conducting workshops wherever gap analyses were conducted and introducing concepts of supportive supervision and quality improvement. Several priority areas for audit and support were identified: neonatal resuscitation (basic and advanced), partograph use during labour, and breastfeeding support (after vaginal birth and caesarean section). Following the baseline measurement of compliance, action plans were developed to address deficiencies, including ensuring equipment availability, conducting staff training, and implementing motivational initiatives. Subsequently, repeat measurement showed improvements in compliance with standards, including increased use of partographs and enhanced availability of equipment for neonatal resuscitation. However, challenges remained, particularly in advanced neonatal resuscitation and breastfeeding support after C-sections.

Key outcomes include:

- Partograph Use: Compliance increased from 66% to 73%, with completeness scores rising from 7/10 to 8/10.
- Basic Neonatal Resuscitation: Compliance in labour rooms and operating theatres increased by 14.7% and 28.5%, respectively.

61 Euro-Mediterranean Human Rights Monitor, "Syria: Unprecedented rise in poverty rate, significant shortfall in humanitarian aid funding" Oct. 17, 2022. https://euromedmonitor.org/en/article/5382/Syria:-Unprecedented-rise-inpoverty-rate,-significant-shortfall-in-humanitarian-aid-funding

62 UNICEF, Every Day Counts, Children of Syria cannot wait any longer, 2023

63 Al Daher, H.,van den Broek, N. Technical report: Supportive Supervision and Quality Improvement for Maternal and Newborn Health - Development of Standards and Clinical Audit. HERNES III Programme February-December 2023, Expertise France, 2024.

- Advanced Neonatal Resuscitation: Compliance improved for 80% of structure criteria. However, availability of life-saving drugs remained low.
- Staff Confidence in Neonatal Resuscitation: While 93.5% of health care providers felt confident in basic neonatal resuscitation, only 37.6% of staff capable of providing advanced neonatal resuscitation expressed confidence, with 47.2% having received no training for it.
- Breastfeeding Support: While, initially, 100% of women reported receiving support for breastfeeding after vaginal birth at four out of 10 facilities, overall, no significant change in breastfeeding rates was observed. Support for breastfeeding after caesarean section varied, with 77.2% of women receiving support, and only one facility showing increased compliance.

The full report will soon be available on Relief Web and Expertise France's website

Inadequately Trained or Motivated HRH

The issue of HRH was discussed earlier, as it impacts both access and quality. The fact that many obstetricians and gynaecologists have left the country, and surgeons without sufficient training in obstetrics are left to attend to births for many women in Syria, may play a role in the increased numbers of C-sections, which then often leads to subsequent births being delivered by C-sections.

Regulations are also a barrier, as midwives in Syria are only authorised to perform three of the seven BEmONC signal functions (parenteral administration of antibiotics, administration of anticonvulsants, and assisted delivery by vacuum extraction).[64]

Furthermore, low salaries and the declining worth of such salaries, in line with the decline in value of the Syrian lira, are affecting the motivations of doctors and nurses across the country. Work is ongoing in NSW and NES to harmonise salary scales for health care workers across public institutions, NGOs, and UN agencies.

Referral Networks and Pathways

Referral networks and pathways for EmONC are a key component in reducing maternal mortality and morbidity in many countries. A functioning referral network and pathway must have an ability to communicate between different levels of health care facilities, and must have transportation networks to a facility capable of providing lifesaving BEmONC and/or CEmONC.

The need for EmONC services is normally established according to size of population and the possibility for referral, whereas a group of health care facilities able to provide BEmONC and CEmONC can operate as a 'hub' with established referral pathways and processes navigating between them. This serves to ensure women and/or babies who require referral to a higher level of care are referred and managed in a timely manner (reducing the 'second' and 'third' delays).

No information was found on referral networks for pregnant women, with the exception of clear pathways spelled out for women needing to leave Al-Hol and Areesha camps for specific medical care, including CEmONC.

In many areas in Syria, there seem to be insufficient BEmONC facilities, and many women are skipping lower-level health facilities and delivering at hospitals. This is a potential driver of higher levels of C-sections in many parts of Syria. However, in areas where women are unable or not choosing to give birth in hospitals and facilities that provide CEmONC, referral networks or pathways are vital. Northeast Syria currently faces significant and crucial gaps in secondary health services and inadequate referral capacities. Only one public hospital out of the 16 located in the NES area is fully operational, and private hospitals are financially out of reach for many. The WHO has repeatedly underscored the unsustainable nature of the current referral system in the northeast, however decreased funding has made the situation urgent. (See Box 4.)

64 UNFPA. The State of the Midwifery Workforce in the Arab Region, May 2022.

Overcrowding

Even with the increasing number of private facilities popping up, the vast majority of the population can only afford public facilities, and thus there is a high demand on the public health care system, resulting in patient overcrowding in many regions of Syria—especially in the northwest and northeast. Furthermore, many facilities in NWS that are located away from conflict zones have reported overcrowding, adversely affecting the quality of services and women's experiences at these facilities.[49]

Box 7. Critical Situation with Disruption of Health Referrals in Northeast Syria

Al-Hol camp, situated in Hassakeh District, approximately 40 kilometres southeast of Hassakeh city, is the largest refugee camp in Northeast Syria (NES). As of the end of December 2023, it sheltered just under 44,000 internally displaced persons (IDPs) and refugees from Iraq and Syria, as well as 60 different nationalities from other countries (TCNs).[65] Ninety percent of the camp residents are women and children who fled their homes in late 2018 and early 2019 as the Islamic State terrorist group lost the last of its territory in Syria. They are distributed across nine phases, with restricted mobility outside the camp.

As of March 2024, the SRH health services within the camp were being delivered through one maternity clinic, two static clinics, two CEmONC facilities and three mobile teams. An external referral system remains operational to transfer patients with critical cases that cannot be managed within the camp to hospitals in Hassakeh city.

In Al-Hol camp, an internal referral pathway exists within the camp-based health facilities. From the beginning of the year, life-saving C-sections have become unavailable inside the camp, as a result of the suspension of activities by health partners. Lifesaving obstetric and surgical cases that cannot be managed in the camp are transferred to Nijma Private Hospital through the assistance of the Syrian Arab Red Crescent (SARC), ICRC, Monastery Saint James the Mutilated (MSJM) field hospitals, and UNFPA.

Since the beginning of 2024, the current system of support for health referrals from Al-Hol camp has moved from very challenging to critical, for various reasons. Since 2017, there has been an exclusive reliance on a WHO Syria contract with Al Hikma Private Hospital to provide support for life-saving and life-sustaining referrals from the camps. This arrangement was known to be far from sufficient to cover the existing and increasing needs, but it was nonetheless an important contribution. The WHO contract was suspended at the end of March 2024. The MSJM field hospital is under restoration due to a fire in December 2023 and has not yet resumed services. The latest suspension of SARC activities has had a direct and indirect impact on the work of the field hospital, mobile team, and polyclinic. If a solution is not identified to re-establish regular activities at the field hospital, the situation of referrals within and outside the camp will become unmanageable.

Health-sector partners have been asked to provide comprehensive support to help make Al Loula Hospital fully functional under DoH Hassakeh, which is ready to accept and provide medical care to all patients in need. It should be noted that Al Loula is in a GoS-controlled area and may not be accessible by all Al-Hol residents, although it is accessible for the rest of the city's population. Since 2020, UNFPA has been supporting referrals of life-saving gynaecological cases from Areesha camp, based on specific medical criteria. These referrals are directed to Dar Al-Shifaa; however, this hospital lacks incubators.

65 OCHA. Humanitarian Update Syrian Arab Republic - Issue 19 / December 2023, posted 7 Feb 2024.https://reliefweb.int/report/syrian-arab-republic/humanitarian-update-syrian-arab-republic-issue-19-december-2023

ENABLING ENVIRONMENT

In this context, the enabling environment will examine the existence of data and surveillance systems, guidelines, protocols, standard services packages or packages of care, etc.

Data Gaps

The limited availability of robust monitoring mechanisms hinders the assessment of the completeness and quality of the interventions being delivered, as well as the assessment of the validity of the collected data. This is consistent with findings from all studies conducted.[11, 13]

This includes a lack of coverage rates, clear denominators of women and girls in need, maternal mortality estimates, recent population-based surveys, such as MICS, and family planning surveys.

Coordination

There are SRH WGs operating at all three hubs; however, there a fluid communication pathway on SRH between these WGs and across the Whole of Syria in lacking. UNFPA could bridge that gap, but there needs to be an identified mechanism of partnership at the WoS hub level.

There are also significant challenges related to the variation in response models. In Syria, there are largely two different models which coexist: a humanitarian actor-led model in non-government-controlled areas and a collaborative model in government-controlled areas. Syria has had, and continues to have, different decision-making systems in place that influence the humanitarian response and determine which interventions are prioritised. The differences between the humanitarian modes of delivery and national health systems are not without tension, and add to existing political and coordination challenges.

Policies and guidelines

Primary Health Care Strategy

Late in 2023, the Syrian MoH launched the National Primary Health Care Strategy 2023-2027 for the GoS-led areas, developed with technical support from WHO. This strategy outlines the ministry's priorities in achieving Universal Health Coverage, and serves as a roadmap for the recovery of the health care system.[66] It will be important to ensure that all key areas of RMH are sufficiently included in the strategy, and that UNFPA and its partners are at the centre of integrated PHC implementation.

Essential Health Care Service Packages (EHSP)

An Essential Healthcare Service Package (EHSP) for the Government of Syria-led areas was developed by the MoH team, in consultation with stakeholders. The finalised package will be costed with the One Health tool. It will be important to ensure that all key areas of reproductive and maternal health are sufficiently included in the strategy, supported with the costing and in its implementation. The costing exercises provide an important opportunity to identify clear baseline coverage for SRH. In 2016, an EHSP was developed in NWS with SRH interventions integrated, and it was revised in 2020. A reproductive health EHSP has been developed in NES with the Forum's SHR WG; however, its finalisation, rollout, and implementation are nascent. Once finalised, this can provide guidance for the Whole of Syria and can be shared with all hubs.

66 Whole of Syria (WoS) Monthly Situation Report October 2023
https://www.emro.who.int/images/stories/syria/WOS_Monthly_report_October2023.pdf

RECOMMENDATIONS

The scope of the recommendations below is largely focused on the generation of data and evidence, as well as the coordination and sharing of information across the Whole of Syria. Additional recommendations can be added by the SRH WGs and other stakeholders in order to look more specifically at programmatic and policy shifts.

Improve Data and Evidence Generation across All Hubs

1. Prioritise more comprehensive data collection and analysis for SRH across the continuum of care, and ensure accurate, timely, and actionable information.
    a. Consider GoS-led SRG WG dashboards where feasible.
2. Working with WHO and the Health Cluster, develop common indicator sets for monitoring and evaluating the effectiveness of the response, including coverage rates and/or trend data that shows progress.
3. Prioritise operational research and documented learning for SRH wherever evidence and guidance are lacking.
    a. Increase collaboration among humanitarian agencies and academic institutions for operational research, evidence collection, and implementation.
    b. Develop a WoS operational research plan for increasing implementation effectiveness. The NES Forum SRH WG has carried out a series of key operational research on reproductive and maternal health: ensure these studies are widely shared with other implementers.
    c. Prioritise documentation and sharing of goof practices and lessons learned.
4. Standardise and share methodologies, estimates, and indicators for assessing SRH and larger health needs in order to enhance evidence-based decision-making.
    a. Establishing a better understanding and agreement on how each of the estimates are calculated and used may improve the transparency, availability, and coordination of SRH estimates across all of Syria.
5. Invest in technological innovations for data collection and analysis, such as expanding usage DHIS2, mobile phones, and beyond. Technological innovations are a growing tool in humanitarian aid responses, and investing in new and advanced methods of data collection and analysis is necessary. Developing or adapting tools to the Syrian context with the use of mobile phones, drones, or other tools can help fill the data gaps.

Improve Knowledge of Geographic Access and Functional Referral Systems for EmONC

1. Carry out EmONC service mapping across priority governorates in GoS-controlled areas, detailing both the distance and travel time needed for communities to reach the health facility. This can help identify the need for and develop transportation schemes or subsidies to assist pregnant women in accessing healthcare facilities, especially in remote regions. If this is already known for NWS, clear documentation should be done to highlight key areas where distance and travel time causes accessibility issues for women, in addition to developing plans to address them.

Ensure Quality of SRH, including Delivery Care

1. Carry out EmONC assessments in NWS and GoS-controlled areas to understand how many facilities are able to perform the signal functions of BEmONC and CEmONC and can meet the standards of EmONC facilities and ensure quality of care.

Note: Skilled birth attendants also must have an enabling environment to operate in, which includes access to drugs, supplies, appropriate policies, and a functional referral system.[67] The proportion of births attended by skilled personnel remains a key international indicator of universal health care coverage and a measure of a health system's ability to provide adequate care during birth.[68] Skilled Birth Attendance is only considered available when both a skilled birth attendant and the necessary enabling environment are in place.

67 Adegoke AA, Hofman JJ, Kongnyuy EJ, van den Broek N. Monitoring and evaluation of skilled birth attendance: A proposed new framework. Midwifery 2011;27(3):350-9. doi: 10.1016/j.midw.2011.03.006

68 WHO World Health Statistics Monitoring Health for the SDGs Reports 2016 -2020

2. Overall, there is a need for systematic improvements in health care infrastructure, provider training, and guideline adherence in order to enhance the quality of women's reproductive and maternal health care. This gap is particularly prevalent in Northeast Syria. These necessary improvements include enhancing patient documentation processes, disseminating clinical guidelines widely, emphasising the importance of comprehensive clinical examinations, reviewing diagnostic capacities, and promoting rational medication use based on clinical guidelines.

3. Raise awareness on the benefits of vaginal birth as a positive alternative to C-sections. Strategies should be developed to promote and improve experiences of vaginal births.

Identify the Unmet Need for Family Planning

Plan and implement an 'unmet needs for family planning' survey in GoS-controlled areas, ensuring that all vulnerable areas of Syria are included.

Improve Data Collection on and Programming for Adolescent Girls

1. Collect more age-disaggregated SRH data across all the hubs, to capture the needs and services for women and girls aged 10-14, 15-19, and 20–24. The recent data collected through the SMART surveys highlight the vital need to have sex- and age-disaggregated health data.

2. Integrate the unique needs of adolescent girls, including younger adolescent girls, into programme intervention design, filling an important gap in service provision and programming. Develop specific standardised (Whole of Syria) guidance for adolescent mothers, considering their increased risk of death and pregnancy complications.

3. Integrate nutrition and anaemia monitoring and surveillance into programmes reaching adolescent girls, taking into account the recent data showing that half of all adolescent girls are anaemic. In areas where this is happening, highlighting successful programmes that can be shared and scaled up in other areas.

Strengthen Capacity-building of HRH for SRH and Expand Midwifery Care

1. A comprehensive training package to ensure a skilled workforce for reproductive and maternal health services has been developed—including a cascade training initiative—and is being successfully implemented by key partners in areas of Northeast Syria. This can be shared throughout the Whole of Syria for adaptation and use across other hubs.

2. Document work being done on community health, mobile health, and midwives to learn what is working well and what can be expanded or scaled up to help better reach remote areas. In areas of the country where the health system is weak and there are large shortages of skilled health workers, mobile clinics are delivering services to remote areas, and midwives are being trained and deployed to bring services closer to the women. Examine where and how these interventions can be effective and efficient, for example, by creating an integrated package of services for these midwives (i.e. determine whether they are able to provide BEmONC signal functions, ANC with nutritional support, PNC with ICYF, family planning with anaemia prevention). This can be linked to a community-based surveillance programme.

3. A study has been done by the NES Forum's SRH WG on task-shifting for midwives; this study and report should be shared widely with other hubs through the Whole of Syria Health Cluster.

Implement and Scale-Up Antenatal Care Tools and Community-level Outreach and Surveillance

1. Strengthen community outreach (see above) in order to improve access to and utilisation of reproductive health services, and link with stronger community-based surveillance to track key indicators and address health needs, including the identification of high-risk pregnancies through ANC, the development of birth plans during ANC, and the linking of women to appropriate facilities for delivery.

2. Standardise and implement mechanisms to measure and track an integrated package of services for ANC visits, linked with stronger community outreach and community-based surveillance. This could include introducing standardised ANC cards and other home-based records for women and children, including anaemia and malnutrition monitoring in pregnancy and the postpartum period, as well as the introduction of more advanced eHIS tools.

Improve Prioritisation of SRH within Whole of Syria Coordination

3. Ensure that the Whole of Syria SRH coordination is adequately resourced and supported within the Syria regional response. The current Whole of Syria SRH coordination functions are not aligned with the mandate and responsibilities of UNFPA, which represents a missed opportunity for UNFPA.

ANNEX 1.

METHODOLOGY

ANNEX 2.

PRIMARY DATA CURRENTLY COLLECTED ON SRH

ANNEX 3.

ALIGNING SRMNH ESTIMATES FOR THE WHOLE OF SYRIA

ANNEX 4.

LIST OF LITERATURE AND PUBLICATIONS

ANNEX 5.

WOS HEALTH CLUSTER INFORMATION MATERIALS PRODUCED AND AVAILABLE ONLINE

> “In 2023 alone, UNFPA delivered SRH services to over 1.1 million women and girls across the country, underscoring the prioritisation of SRH within the humanitarian response.

NAVIGATING CHALLENGES & BRIDGING GAPS:
A REPORT ON SEXUAL AND REPRODUCTIVE HEALTH DATA AND INFORMATION IN SYRIA