ISIL EROL

A COMPARATIVE STUDY OF TURKEY, LEBANON AND JORDAN: HOST COUNTRY CONDITIONS AND SYRIAN REFUGEE WOMEN'S REPRODUCTIVE HEALTH

UNIVERSIDADE FERNANDO PESSOA

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SIGNATURE

Work submitted to Fernando Pessoa University as a requirement for the attainment of the degree of Master of Art in Humanitarian Action, Cooperation and Development, under the supervising of Cláudia Toriz Ramos.

ABSTRACT:

This work project explores the differences in the reproductive health of Syrian refugee women in Turkey, Lebanon and Jordan based on three independent factors, which are gender in/equality, pre-existing general women's health and the official importance given to national health care services. These countries are chosen because Turkey, Lebanon and Jordan are the countries who host the most crowded Syrian refugee populations. This research investigates whether or not these factors have an impact on the Syrian refugee women's reproductive health in these three host countries. The research includes a quantitative analysis with the help of SPSS statistical program and a general and country-based literature reviews. My data comes from the World Values Survey and the CIA World Factbook. It is important to raise these questions in this field because the refugee influx is one of the most important issues in the world in the last decade, and refugee women are one of the most vulnerable populations whose health status has been affected by.

ÖNSÖZ:

Bu proje, Türkiye, Lübnan ve Ürdün'deki Suriyeli mülteci kadınların üreme sağlığındaki farklılıkları, cinsiyet eşitliği, var olan genel kadın sağlığı ve ulusal sağlık hizmetlerine verilen resmi önem olmak üzere üç bağımsız faktöre dayanarak araştırmaktadır. Bu ülkelerin seçilmesinin sebebi Türkiye, Lübnan ve Ürdün'ün en kalabalık Suriyeli mülteci nüfusuna ev sahipliği yapan ülkeler olmasıdır. Bu araştırma, bu faktörlerin Suriyeli sığınmacı kadınların üreme sağlığı üzerinde bu üç ev sahibi ülkede bir etkisi olup olmadığını araştırmaktadır. Proje, genel ve ülkeye dayalı literatür incelemeleri ile SPSS istatistik programının yardımıyla nicel bir analizi içermektedir. Verilerim World Values Survey ve CIA World Factbook kaynaklarına dayanmaktadır. Bu alandaki çalışmalar düşünüldüğünde bu soruları sormak büyük önem arz etmektedir. Bunun sebebi son 10 yılı göz önünde bulundurduğumuzda mülteci meselesinin toplum ve devletler bazında en önemli sorunlardan biri olmasıdır. Bu mülteci sorunu içerisinde mülteci kadın popülasyonlarının sosyo-ekonomik durumlarının yani sıra, alınan sağlık hizmetleri içerisinde en savunmasız sayılabilecek konumda olması, bu çalışmanın temel sorusunu ortaya çıkarmıştır.

RESUMO:

Este trabalho de projeto explora as diferenças na saúde reprodutiva de mulheres sírias refugiadas na Turquia, Líbano e Jordânia, com base em três fatores independentes: igualdade de género; condições pré-existentes de saúde das mulheres, no país em causa; importância dada aos serviços nacionais de saúde. Estes três países foram escolhidos porque a Turquia, o Líbano e a Jordânia são os Estados que mais refugiados sírios têm recebido. Esta pesquisa procura investigar se esses fatores têm impacto na saúde reprodutiva das mulheres refugiadas sírias, nestes três países. A pesquisa inclui uma análise quantitativa realizada com recurso ao programa de estatística SPSS e uma revisão comparativa da literatura. Os dados quantificáveis têm origem no *World Values Survey* e na CIA *World Factbook*. Considerou-se importante fazer esta abordagem porque os fluxos de refugiados têm sido, na última década, um tema prioritário no mundo; e porque as mulheres refugiadas são uma das populações mais vulneráveis, cuja saúde tem sido profundamente afetada por essas circunstâncias.

ملخص:

هذا العمل يبحث اختلافات الصحة الإنجابية للنساء السوريات اللاجئات في تركيا و لبنان والأردن بناء عل ثلاث عوامل مستقلة وهي: المساواة بين الجنسين و وصحة المرأة العامة الموجودة مسبقًا والأهمية الرسمية الممنوحة لخدمات الرعاية الصحية الوطنية. تم اختيار تركيا و لبنان و الأردن لأنهم أكثر الدول استضافة و ازدحام باللاجئين السوريين. هذا البحث يقوم بدراسة فيما إذا كان لهذه العوامل تأثير على الصحة الإنجابية للنساء السوريات اللاجئات في هذه البلدان المضيفة الثلاثة أم لا.

البرنامج الإحصائي مع مراجعات الأدبيات العامة. البيانات SPSS يتضمن هذا البحث تحليلاً كمياً بمساعدة من .CIA المستخدمة في هذا العمل تأتي من مسح القيم العالمية ووكالة المخابرات المركزية التابعة للبنك الدولي المهم طرح هذه الأسئلة في هذا المجال لأن تدفق اللاجئين هو أحد أهم القضايا في العالم في العقد الماضي، والنساء اللاجئات من أكثر الفئات السكانية ضعفاً التي تأثرت حالتها الصحية.

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LIST OF ABBREVIATIONS

AFAD - Afet ve Acil Durum Yönetimi Baskanligi (Disaster and Emergency Management Presidency)

GEI – Gender Equality Index

MOH – The Ministry of Health

MOU – Memorandum of Understanding

ORSAM- Orta Dogu Arastirmalari Merkezi (Middle East Strategic Research Center)

OIGNHC – The Official Importance Given to National Health Care

PWHI – Pre-existing Women's Health Index

UNDP – United Nations Development Programme

UNHCR – United Nations High Commissioner for Refugees

WHO – World Health Organization

WVS – World Values Survey

I. INTRODUCTION

Rana Dikko is a Syrian woman who fled to Turkey five years ago, after the civil war started in Syria. Her husband was a deaf man who did not hear the warnings of a soldier and was subsequently shot dead. At the time she was pregnant with their third child. She had to give birth amidst war. “I was so traumatized by the constant heavy shelling, my husband’s death and being a pregnant mother alone, that I couldn’t produce milk when my baby was born. I used to give him a mix of tea and bread,” she said in her interview that she gave to NBC News (D’Ignoti, 2019). After four months of her son’s birth, she paid a smuggler to take her, her children and sister-in-law to flee to Turkey. Now she stays in the biggest refugee shelter in Gaziantep, a southern city in Turkey, which borders Syria, with her children. Her son is four years old now but because of a lack of nutrition and health care facilities, he could not grow as much as he normally should have Rana says.

Noha is another Syrian woman who was born and raised in a village called Hama in Syria. She and her family fled to Beirut, Lebanon when the civil war in Syria reached their village in 2012. During her stay in the village, she experienced verbal and sexual harassment from military personnel many times. They had to wait for six months to be allowed to leave Syria and when they left the country, they struggled with access to health care and financial obstacles. When she was pregnant with her eighth child, she wanted to have an abortion. However, Lebanon only allows women to have abortions when they have a signed permission from the husband. Because of this, she could not have the abortion and now uses contraceptives. However, as she says in her interview in Global Fund for Women (“Noha’s Story”, n.d.), it is quite challenging to have public health care for Syrians in Lebanon since only one visit to a doctor costs 75 dollars. Even though some of the health care is covered by the UNHCR, the remaining cost is still too much for her to afford, especially with eight children and a husband who had a stroke.

Mariam is another Syrian woman who had to flee to Jordan in 2012. She has been living in Irbid, in north Jordan, with her six daughters since her husband died four years after flight from Syria. Their biggest challenge is the health problems. One of her daughters was diagnosed with diabetes in 2016 and they received a 3,000JD (£3,200) bill for the treatment. They were shocked and devastated, and did not know how to pay this amount of money for the treatment. The family received food from the UN, but Mariam had to

sell this food to other refugees in order to get money for the treatment. She also worked in some temporary jobs to support her family. She said “Last week I sold two blankets and a heater just to support ourselves. Healthcare prices are really high - when my daughters get sick, I can't afford to go to the doctor." in her interview to BBC News (BBC News, 2018).

These are just three examples of three Syrian refugee women in three different host countries. There are millions of refugee women around the world who have the same or worse problems and challenges. Being a refugee in a host country is already a troublesome issue, and yet being a refugee woman makes this issue even harder to cope with. This is why the chosen focus is specifically refugee women, since the gender perspective of the refugee topic makes it an even more sensitive issue to tackle.

Since the beginning of the civil war in Syria, the neighboring countries have been hosting a great number of refugees and every host country has different socio-cultural and socio-economic environments which will affect refugees in different ways. These differences include economic problems since most refugees cannot afford the health care services. This eventually affects the health status of refugee people, especially women since they are one of the most vulnerable populations and refugee women’s health status has a significant impact on the whole refugee population.

The reason why Turkey, Lebanon and Jordan are chosen is that these three host countries were affected the most by the refugee influx and have been hosting the most crowded refugee populations within their borders. And, since the half of this population is women, the study is focused more on gender-centered problems which include gender inequality and reproductive health problems of refugee women in these three host countries.

The main concern of the empirical part of this work is to analyze the differences in Syrian refugee women’s pregnancy outcomes who have come to and lived in the three countries that host the most Syrian refugees (Turkey, Lebanon and Jordan), and question the explanatory potentials of three factors: the level of gender inequality, the pre-existing general women’s health outcomes, and the official importance given to national health expenditure. Gender inequality is selected to discuss whether or not the socio-cultural environment of a host country has an impact on the Syrian refugee women’s reproductive health conditions. The pre-existing general women’s health

outcomes is chosen to see whether or not these three host countries' local women's existent health conditions make any impact in refugee women's reproductive health outcomes. Also, the official importance given to national health expenditure is chosen to debate whether or not the allocated budget of health in a host country has any impact on the Syrian refugee women's reproductive health outcomes.

The literature review included in this research is divided into two parts. The first part covers the definitions and conceptual debates about gender in/equality, refugee health, and women's reproductive health. The second part covers the country profiles of Turkey, Lebanon and Jordan, as they relate to refugee health, gender in/equality and women's general reproductive health. The empirical part of this study is an attempt to establish a comparison between the three countries, on the basis of a tentative model of analysis. The explanatory capacity of the model is obviously limited, statistically by the small number of cases compared, and factually by the lack of comprehensive data on each and every aspect to be addressed, in debating refugee women reproductive health, as further explained below.

The data for gender inequality for each country was taken from the sixth wave of the World Values Survey. In this source, several countries have been involved in a universal survey, where participants were asked the same questions related to gender in/equality. Turkey, Lebanon and Jordan, and their relevant questions about gender in/equality are selected in order to make a comparison between these three host countries. The data that was taken from the World Values Survey was bound together in an index with the help of the statistical analysis software SPSS. The data for general women's health and the official importance given to national health care services for each country was taken from World Health Statistics (2018) and adapted in SPSS statistical program in order to measure statistically significance variance.

Having the refugee women as a sample group brings out strong limitations in terms of reaching the relevant data. Since every host country has its own registration system for refugees, it can be hard to collect the necessary data on reproductive health, especially when it comes to thorough research about maternal and infant health of refugees. In refugee camps, it is easier to reach the information of the refugee registration process and their health conditions because they use the health facilities in the camps and it is under greater control. However, when they live in cities, it becomes harder to track the

health conditions of refugee women because countries such as Turkey give primary health care services to unregistered refugees as well. Also, the governments of host countries sometimes do not reveal thorough information about the specific conditions of refugees, which creates another obstacle in order to collect adequate data. In the light of these limitations, this work project focuses on refugee pregnancy rate as an approximation of reproductive health to circumvent these problems. Thus, this project is carried out with the hope that it will start exploring potentially relevant venues which can be further investigated in greater detail by future and more encompassing research. In line with this, the study ends with a reflection on the results achieved and the ways ahead, notably for policy and humanitarian purposes.

II. LITERATURE REVIEW

1. GENERAL CONCEPTS AND DEBATES ON REFUGEE REPRODUCTIVE HEALTH AND GENDER IN/EQUALITY

In this section, the aim is to analyze the general perspective of concepts and debates on women's health status, gender in/equality and the importance of health expenditure in relation to reproductive health of women worldwide. The main goal of this section is to provide an overview of how the literature points out these concepts and interprets the relationships between them. In what follows, we shall compile a constellation of literature that investigates the connection between gender equality, health expenditure of a country, and the reproductive health outcomes of women.

Chirowa et al. (2013), in their article that explores the connections between gender inequality and its relation with health expenditure and maternal mortality in Sub-Saharan Africa specifically point out that gender discrimination widens the gap between men and women which eventually impacts women's health in a negative way. The reason behind this is the socioeconomic discrepancy between men and women. This difference in socio-economic life has affected women's health life because they do not have economic freedom in order to be decision-makers and take control of their reproductive health life without consulting their husbands (Pillai and Gupta, 2011). Since women do not have financial support for themselves, it prevents them from using the modern contraceptive methods in order to avoid unwanted pregnancies. For that not to happen, the governments need to use their health expenditure to women's health's best interest. According to Chirowa et al. (2013), governments usually fail to make reproductive health services accessible for women because their domestic expenditure does not directly focus on women's health but they prioritize other issues.

Some parts of the world such as Europe and America where the most developed countries reside have a significantly high health expenditure compared to developing countries. Generally, with a high expenditure in the health care system, these countries have high gender equality and reproductive health outcomes for women. Chirowa et al.'s (2013) research complicates this equation. The research that the authors did in sub-Saharan African countries show that even though Angola has a higher domestic health expenditure, compared to Mozambique and Zambia, the maternal mortality rate is higher. The reason behind this according to Wagstaff (2002) is that the high expenditure

in the health system gives positive feedback only when this expenditure is well distributed and well associated with more intensive use of both public and private health services.

When governments distribute their domestic health expenditure budgets into public reproductive health care services and maintain reproductive health services organized and efficient, the results of women's health will be satisfying. According to the UN Millennium Project (2005), when governments invest in reproductive and sexual health, it is cost effective. To give an example, every peso that the Mexican government spends for reproductive health and family planning services saves nine pesos for the treatment of possible complications during the pregnancy and labor. Or when we look at Thailand, every one dollar that the social services spend, the Thai government saves sixteen dollars for family planning services (UN, 2005). These numbers may not seem significant; however, all things considered they have a tremendous impact on social services, especially on reproductive health care services because such preventative investments directly lift the burden on these services.

According to the definition of World Health Organization (n.d), reproductive health is "the capability to reproduce and the freedom to decide if, when and how often to do so". The pregnancy period is at the core of reproductive health because the possible complications start during this period for women. According to WHO (2004), every year 210 million women face life-threatening complications during their pregnancy and 99% of these unwanted reproductive health complications happen in developing countries. It is because in these developing countries 1 of 3 pregnant women cannot receive health care during their pregnancy period, out of all the deliveries only %40 take place in a health facility, and only %60 of those deliveries take place with a health professional personnel (WHO, 2005-2006).

On the other hand, in developed countries, even though the contraceptive usage is high, governments are mostly concerned with adolescent pregnancy. This is because, as it is known, teenage pregnancy brings several hardships such as single motherhood, unfinished education, isolation from social life and most probably and unfortunately more unwanted pregnancies (Kane and Wellings, 1999). These hardships do not only affect mothers, but infants also face health problems such as prematurity and low birth

weight, and children face disadvantages like being unwanted, being deprived of education and/or proper nutrition (Conde-Agudelo et al., 2006).

Gender differences affect the health system significantly, because men and women use the health care services differently. Multiple studies have proven that men's and women's experiences of health care services are shaped by gender norms (Payne, 2009). For instance, according to Doyal (1995), gender norms affect access to health services for women and men differently, because women have caring responsibilities at home which may prevent them from accessing health care services at certain hours. This shows that the difference in availability of people to health care services would directly influence the access of women and men.

Sorlin et al. (2011), in their study on the health impacts of gender equality, show that the inequality between men and women is a challenge to public health and women use health care services more because they experience more health problems compared to men even though women live longer than men. However, according to the Pan American Health Organization (2005), men contribute health financing more and receive health care services more compared to women, because they have more economic capacity. This means, men and women receive health care services according to their financial status, but not according to their needs.

This is another challenge for the health policies of governments: to provide gender-sensitive and accessible health care services for the people in need. The health system in a country can make a major contribution to gender equality by improving the experiences and health outcomes of both sexes. Diniz et al. (2012), in their study on the role of health care equity in Brazilian women's access to contraception, abortion and childbirth services, point out that in order to achieve equity in women's health, the government and the health system need to go beyond universal and unregulated access to health care, and move towards effective, safe and transparent care to respect the rights of women.

Gender inequality has always been a serious problem for most of the women in the world, but it gets even more serious when that inequality is experienced by a refugee woman. It is because they do not only face problems for being women, but they are also facing the problems of being refugees in a different country. They are under the pressure of giving care to their children and supplying food or other necessary needs for

them. This burden will not be lifted even though women migrate to another country. The conditions under which the refugee women are affect the health status of these women in the host country they live in.

There is a socio-economic challenge which refugee women face when they migrate from a low-income country to a high-income country. Their financial status cannot keep up with the host country's economic structure. Officially, a person who is registered as refugee automatically has the right to work in that host country. Even though women who have de facto refugee status cannot have de jure refugee status and because of that, they cannot find a work opportunity in the host country. There are multiple factors behind this and one of the most important factors is the language struggle. When they do not speak the same language of the host country, it is almost impossible for them to be employed and Turkey is an accurate example for this situation. Because of this, most of these refugees cannot be fully integrated into Turkish society. As Amara and Aljunid said, "Inability to communicate with local people subjects refugees to discrimination and xenophobia." (2014, n.p). Not speaking the same language of the host country not only brings difficulties in job opportunities, but also in obtaining health care and access to it. Most of the time, refugee women are dependent on men and this disables them to access the health care system since male dominance does not create the adequate conditions for them to receive independent health insurance (Carballo et al., 1996). Eventually, it turns out that, as Bollini et al. Said, "Women who do not speak the language and do not have jobs are less likely to benefit from the health system of the host nation." (2007, n.p).

This situation becomes more vulnerable when these refugee women are pregnant or get pregnant after their arrival to the host country. The registered refugee women inside and outside of the camps are technically able to receive health care in the host country. However, the registration process takes too long. In most cases, refugees wait for months or even years for paperwork, which would ensure them access to health care (Norredam et al. 2005). Most of the studies have shown that adverse pregnancy outcomes of refugees increased (Gibson-Helm et al., 2014) and especially in the Turkish case, it is reported that %47.7 of Syrian refugee women faced pregnancy losses during their stay in Turkey (Simsek et al., 2017).

It is obvious that pregnant refugee women are in a great need of getting reproductive health care in order to avoid pregnancy losses or any kind of sexually transmitted diseases, because the transmission risks of these diseases are higher among refugees compared to the general population (Eiset and Wejse, 2017). This is why the health care provision in the host country is quite important in order to create a healthy environment for refugees. The Syrian refugee women in Jordan, for example, experience higher rates of perinatal and delivery complications compared to Jordanian women (Alnuaimi et al., 2017).

Thus, as relevant studies have shown, refugee women experience various economic and social obstacles which affect their health status within their stay in a host country. They are clearly more open and vulnerable to unwanted pregnancies, delivery complications, and many more diseases which would possibly follow these complications. The conditions of the act of migration and seeking refuge for these women create such an environment for them that eventually influences their health outcomes in various ways, because it is contingent on the socio-economic situations and health conditions of the host country they live in. We now turn to the identification and analysis of these conditions specifically held in Turkey, Lebanon and Jordan in the next section.

2. COUNTRY PROFILES

As the official Syrian refugee crisis has started in 2015, there has been a massive influx of Syrian people to neighboring countries. According to the UNHCR statistics, there are 25.9 million refugees worldwide (UNHCR, 2019) and 11.7 million of them are Syrian refugees (OCHA, 2019). Turkey, Lebanon and Jordan have been hosting the largest numbers of Syrian refugees. To be more specific, Turkey is hosting 3,676,288 registered Syrian refugees (UNHCR, Syrian Regional Refugee Response, 2019), Lebanon is hosting 919,578 registered Syrian refugees (UNHCR, Syrian Regional Refugee Response, 2019) and lastly Jordan is hosting 654,955 registered Syrian refugees recently (UNHCR, Syrian Regional Refugee Response, 2019). Below, a review of the literature will be provided which identifies the most important aspects of refugee reception in these three countries.

2.1. COUNTRY PROFILE: LEBANON

Lebanon, as its geographical location is considered, is a country where Mediterranean and Arabic culture unite and combine together, and create a rich multi-cultural and multi-ethnic country where Christian and Muslim communities live together. These ethnic and cultural differences have made the flight of Palestinian and Syrian refugees possible to Lebanon after the conflicts in both Israel and Syria. Lebanon is one of the most crowded host countries in terms of welcoming Syrian refugees worldwide. The country's population is about 6 million and it has the highest number of refugees per capita which means that almost 1 in 6 people in contemporary Lebanon is a Syrian refugee. Lebanon is not a state party to the 1951 Refugee Convention or its 1967 additional protocol (UNHCR, States Parties to the 1951 Convention). This means that Lebanon has no commitment to obey the rules of the Convention or its protocol. There is only a Memorandum of Understanding (MOU) signed between Lebanon and UNHCR addressing the status of Syrian refugees (UNHCR, 2004).

After the influx of Syrian and Palestinian refugees to Lebanon, the country has been exposed to several difficulties in its political, economic and social structure. These difficulties have put a burden and worsened the public health care system in Lebanon.

The government of Lebanon has decided not to build any refugee camps for Syrian people within the country. This means that all of the Syrian refugees that are in Lebanon are located in local communities (Blanchet et al., 2016, p.2). The majority of the Syrian refugee population has been living in the poorest regions of Lebanon which causes a significant financial problem in terms of obtaining and accessing health care services. The public healthcare services are extremely overcrowded with the influx of refugees and that is why the health system in Lebanon is quite disorganized and uncoordinated (ibid). UNHCR is responsible with the registration and resettlement of the refugees, and covers %75 of the medical costs of refugees in general, and %85 of the medical costs for pregnant women and nursing mothers (OCHA, Lebanon Crisis Response Plan, 2015-16). However, even though %75 of the medical costs is covered by UNHCR, the remaining %25 is not affordable for the majority of Syrian refugees and this puts more pressure on the public health care system.

Since the Syrian civil war caused an inordinate amount of people to flee to Lebanon, the social services have encountered many difficulties in order to give adequate care to not

only the Lebanese people but also to the Syrian refugees in the country. The economic balance in the country has been shaken and it directly has influenced the Lebanese people and Syrian refugees badly. These economic imbalances affect the health system badly within Lebanon and that is why the public health care system has started to turn into a private system. The most obvious reasons behind this change are considered to be the unclear policy in healthcare, irregularity in financial distribution and provision of healthcare in the system (Ammar, 2009). What Ammar meant by this claim is that public health care services are more equitably distributed and more affordable but inefficient in terms of its quality, while private health care services are unequally distributed but have more quality compared to public health care services. According to Blanchet et al. (2016, 3), there is a failure of humanitarian action in Lebanon and the reason behind it is the lack of international funding, and there is a big discrepancy between the population’s needs and service coverage because of the inequitable structure of the health system.

Having a fragmented health care system in Lebanon leads the majority of the population to receive private health care services from private providers which are dependent on public financing (Country Report Lebanon, 2014). Since the health system has been suffering from unqualified reproductive and primary health care, the Ministry of Public Health has decided to constitute a restoration in health care and has achieved its targets of Millennium Development Goals 4 and 5 to reduce infant and maternal mortality. This package includes the improvement of primary and reproductive health care as providing 80 primary health care centers and adapting a comprehensive maternal, infant and child care in order to improve the quality of the health system in Lebanon (WHO, Lebanon Health Profile, 2015). The Ministry of Public Health has created a project called ‘The Lebanon Emergency Primary Healthcare Restoration towards Universal Health Coverage’ in 2016. The aim is to give free primal health care services to 150,000 underprivileged citizens (WHO, 2017). However, the number of people who are in need of health care services is extremely high and health care coverage packages such as this one are not enough for the population yet. Besides, the influx of refugees to Lebanon has brought too much pressure on the public health system to bear and it directly has a bad impact on medical resources and medical staff (Hampton, 2013; Kasturi, Al-Faisal, & AlSaleh, 2013).

In conflicts and wars, women and children are always the most vulnerable ones. Especially pregnant and breastfeeding mothers and newborn babies are at great risk (Benage et al., 2015). Also, it is harder for women to obtain legal status and resettlements and to find protection from violence during conflicts (Akram, 2013). The health of Syrian mothers and babies put more pressure on the Lebanese health system. According to the Regional Refugee Resilience Plan of United Nations, 1 in 5 women in a Syrian family is either pregnant or a breastfeeding mother (OCHA, Lebanon Crisis Response Plan, 2015-16). However, 1 in 3 Syrian women cannot receive antenatal care because of the financial burden it causes, and those who could receive antenatal care mostly complain about the high costs of reproductive health care services and the difficulties of transportation to these services (UNHCR, 2014). In fact, according to the study done by Masterson et al. (2014), half of the Syrian refugee women claimed that the medical costs are the primary barrier to accessing reproductive health care services.

Moreover, as the study done by Benage et al. (2015) shows the pregnancy rate among Syrian refugee women is quite high, and more than %70 of the pregnancies are unwanted or unplanned. This information highlights that the lack of access to contraceptive usage for refugee women is a crucial issue. The majority of refugee women have been exposed to unwanted pregnancies during their stay. Especially when they are not registered as refugees, UNHCR does neither give any free medical support to them, nor any access to contraceptives. This puts these women's health in jeopardy, since they do not have any financial support to receive proper health care in Lebanon's mostly private health system.

2.2. COUNTRY PROFILE: TURKEY

Turkey, because of its geographical location and connection with three different continents, was suitable for a refugee influx; especially, since 2012, the country has been hosting a great number of Syrian refugees. The population of Syrian refugees is 3, 676,288 in Turkey by 2019 (UNHCR, Syrian Regional Refugee Response, 2019), and this number shows that Turkey has the highest refugee population in the world. More than 3 million of this population have been living in local communities, mostly in the Southeastern cities and in the biggest cities such as Istanbul and Ankara, and only around 300,000 of them have been staying in the refugee camps at the border (WHO in

Turkey, 2017). As a result, Turkey has been exposed to economic, political and social changes as the other host countries have. After the official refugee crisis from Syria to Turkey, refugees used Turkey as a bridge to pass through to the European countries.

Europe has witnessed the biggest refugee influx after the World War II and this influx strained Europe deeply both politically and economically (Prothero, 2019). With the fear of the refugee influx, the European Union decided to interfere with this migration and made an agreement with the Turkish government in 2016 to prevent the Syrian refugee movement to Europe. For the exchange, the European Union committed to establish a high-level dialogue with Turkey, speed up the visa requirements for Turkish citizens and also support Turkey financially by giving 3 billion euros for the Syrian refugees as an initial humanitarian aid (Adam, 2016). However, the international relations between Turkey and the European Union have not gotten better since the agreement. There is a mutual distrust between Turkey and the EU, and this agreement has jeopardized their relation as a whole (Senyuva and Ustun, 2016).

Considering the political status of Turkey and its behavior in the refugee influx, points out an important issue. Even though Turkey is a state party to the 1951 Refugee Convention and its protocol, Turkey’s existence as a signatory in the convention has a difference. The 1951 Refugee Convention itself had a geographical limitation, which implies that refugees and asylum seekers from only Europe are accepted and given the refugee status. Then the protocol in 1967 has lifted this geographical limitation and covered asylum seekers and refugees all around the world. However, Turkey has signed this protocol of 1967 but later has added an annotation which means that Turkey decided to follow the previous rules of the Refugee Convention of 1951, which still has the geographical limitation. This brings to the conclusion that Syrian people in Turkey are not considered as refugees, but ‘guests’. According to Ozden (2013), the most plausible reason behind this consideration is that the Turkish government aimed to prevent any kind of interference from UNHCR or any other international bodies to control the Syrian refugee influx in Turkey. This is why UNHCR is connected to the Turkish government which means that it gives its services through the Turkish government for refugees. This is very unlike the direct services of UNHCR in Jordan and Lebanon.

These political issues have brought several economic problems for Syrian refugees, especially since the Turkish government is not open to receive international support from foreign organizations, which resulted in obstacles specifically in health services. AFAD (Disaster and Emergency Management Presidency), a Turkish organization, is mostly responsible for the basic health needs of Syrian refugees in the camps, and the refugees who are registered with AFAD can receive free health care services. The ones, who are not registered and cannot receive free health care services from AFAD, have been living in local cities with limited access to health services (Bidinger et al., p. 113). In the refugee camps, Syrian women have concerns for the lack of feminine and basic hygiene products which make their health status even more unfavorable (Masterson et al., 2015).

There are several factors affecting the reproductive health of refugee women. One of the most important problems with healthcare services is the language barrier. Most Syrian refugees cannot speak Turkish and most Turkish health professionals cannot speak Arabic. Thus, the lack of communication affects the quality of health care provided by health professionals. This is why this social barrier has put a burden on the delivery of health care system and this burden is quite hard to lift. These women are in a vulnerable position and have been forced to fight against gender inequality both in their family and in the host society that they fled to. The majority of the refugee women struggle with low socio-economic status, cultural differences and lack of language. These challenges prevent them to access health care services, also to provide and maintain legal restrictions. The study done by Deger et al. (2018), which is about the maternal health of Syrian refugee women in the Southeast region of Turkey, shows that almost %58 of refugee women have limited access to the health services, and more than %50 of refugee women claimed that they have a language barrier in order to communicate with the health professionals.

When these problems are taken into account, Syrian refugee women's reproductive health is in worse condition compared to Turkish women's reproductive health, because this vulnerable position paves the way for Syrian refugees to have unwanted pregnancies, to receive inadequate ante-natal and post-natal care, and also be at a high risk of labor complications. Another study done by Buyuktiryaki et al. (2015), which is about pregnant Syrian refugee women in Turkey, shows that 1 of 4 babies are born pre-term and the neo-natal mortality is %1.8 which is four times more than for Turkish

pregnant women. This result shows once more that the Syrian refugee women's health status is in worse condition than the Turkish women's health status.

Turkey has implemented a 'Healthcare Services Reform' more than a decade ago, which was aimed to improve maternal and infant mortality, life expectancy and accessibility of health care. This reform was implemented and used to reduce the financial burden on the citizens, to change the healthcare performance, and to boost the quality of Turkey's health system (Akdag, 2011). According to the scholarly consensus on the evaluation of this new health care reform, the interventions for health care services have made effective and significant contributions to the Turkish health system (Akinci et al., 2012). However, the economic status of Turkey, considering the Syrian refugees' needs, is on shaky ground. Especially the cities which are overcrowded with refugees have been suffering from lack of infrastructure and manpower for the provision of health care services. Moreover, the lack of health policies to cover the medical costs causes increasing health problems for refugee women. This failure prevents Syrian refugee women from accessing and receiving adequate quality health services. To give an example, according to the report of ORSAM (Middle East Strategic Research Center) in 2015, there were only 35,000 Syrian refugee women who live in camps could give birth in hospitals, which gives a sign that there are serious problems regarding to fertility concerns (Orhan and Gundogar, 2015). Considering the fact that most of the population lives out of refugee camps, the pregnant refugee women who do not live in the camps have to give birth at home because of inadequate transportation to the health services and lack of money to provide this health care. This also puts these women's health at high risk which eventually may result in labor complications and neo-natal mortality. A study done with Syrian refugee women who gave birth at least once in Turkey shows that %47.7 of refugee women either lost their babies during the labor or had a miscarriage during their pregnancy period (Simsek et al., 2015). Thus, all these disheartening results once again show that Turkey lacks an adequate and qualified health care system for Syrian refugee women.

2.3. COUNTRY PROFILE: JORDAN

Jordan is a Middle Eastern country where Muslims are the vast majority of the country which is similar with Turkey but contrary to Lebanon. Jordan shares the same cultural

and religious norms with Syria which has enabled Syrian refugees to flee to Jordan easily. The country's population is around 10 million estimated in 2019 (Department of Statistics Jordan, 2019), but more than 2 million of it is Palestinian refugees and more than 1 million is Syrian refugees since they have fled to Jordan. The recent number of Syrian refugees is around 650,000 estimated in 2019 (UNHCR, Syrian Regional Refugee Response, 2019).

Jordan is one of the most crowded host countries in the world in terms of welcoming Syrian refugees. In the beginning of the refugee crisis, most of the Syrian refugees were staying in Za'atari and Irbid refugee camps, but recently more than %70 of Syrians live in urban communities (Murshidi, et al., 2013). This kind of huge influx of refugees has been affecting the social and economic dynamics in the country, especially the health system. Jordan is known by its advanced and qualified health system. According to the World Bank's ranking in health system quality, Jordan was the number one medical tourism provider in the Arab region and it was in the top 5 of world health list in 2008 (Hazaimeh, 2008).

After both Palestinian and Syrian refugee influxes, the general health system in Jordan has been weakened. The Ministry of Health (MOH) has been trying to provide free primal health care with additional maternal and infant care (Doedens et al., 2015). The MOH also cooperates with UNHCR and several NGOs both in refugee camps and local communities. Even though UNHCR and several multilateral organizations fund and support public health in Jordan, the burden is still heavy. The public health services cannot operate adequately because of financial reasons. This has led the country into a more private system, which results in two subdivided sectors: public/semi public and private health care (Nazer and Tuffaha, 2017).

Even though the general health system is divided in public and private health care systems, the Ministry of Health has been giving a considerable effort to improve primary health and reproductive health in the country. According to the 2012 Population and Family Health Survey in Jordan, %99 of women received ante-natal care, %78 of women had more than seven ante-natal visits to a medical professional and %82 of women received post-natal care in a healthcare facility after the delivery (Department of Statistics, 2013). However, the reproductive health outcomes of Syrian refugees in Jordan are not the same. Especially, in Za'atari refugee camp, which is one of the most

crowded refugee camps in the Middle East, the number of women who received ante-natal care during the pregnancy period is only %29 (UNHCR, 2013). Considering the fact that UNHCR covers all the medical and reproductive health care costs, and gives free primary health care services, the number of women who benefit from ante-natal care is very low. However, a study done by Tappis et al. (2017) shows that almost %82 of women received ante-natal care and completed delivery in a health facility. In fact, these different outcomes contradict each other.

Considering all this information, what could be the reason behind this difference? Why is there a huge contradiction between these outcomes? The reason is most likely because these studies are done in different local communities in Jordan. The cities such as Amman, Irbid and Zarqa are the most developed and organized cities in terms of health system. In these places, the public and private health care services are well-organized and the quality of health care is better than the other parts of Jordan. The south of Jordan, on the other hand, is considered to be a poor area and is more disorganized in terms of the health care system and the costs of medical care are not funded by UNHCR in local communities. This means that Syrian refugees who live outside the camps are obliged to pay the full rate, while the ones who live in the camps can have free health care services (Saleh et al., 2018).

When comparing the received ante-natal care of Syrian women in refugee camps and in local communities, the results do not show such a difference. According to the Department of Statistics, there is %92 of women in the camps who received ante-natal care from a doctor, while in local communities this number is %96 (Department of Statistics and ICF International, 2013). The small difference in the percentage of ante-natal care providers does not seem significant, but it seems like there is a significant difference not in the number of received ante-natal care, but in the quality of given reproductive health care. Also, most of the Syrian refugee families are not aware of free services that the Jordanian government provides such as vaccination for children, and families do not want to receive the care if they need to pay for it (Dator et al.,2018).

Considering these serious problems in Jordanian general health system, women's reproductive health, especially Syrian refugee women's reproductive health, brings too many concerns to the surface. Even though Jordan has the most developed humanitarian aid in reproductive health care compared to Turkey and Lebanon, the quality of these

health services shows the lack of efficiency in Jordan. For instance, regarding the menstrual hygiene products, there has been a great lack of services in terms of providing these materials to the Syrian refugee women and girls. Also, there is an inadequate availability of STI and HIV tests, supplies and health care services (Krause et al., 2015). These inadequate health care services sometimes cause HIV positive refugee women to be deported, because their deportation enables to reduce HIV testing, and eventually the rights of receiving treatment of these refugee women will be taken away (Doedens et al., 2015). Thus, all these inefficient health care activities cause refugee women to be displeased with the quality of health care provision. The reasons behind this are the limited numbers of reproductive health care services and also the limited numbers of female health professionals (Doocy et al., 2016).

III. METHODOLOGY

1. STUDY DESIGN

This study takes Turkey, Lebanon, and Jordan as its three cases for multiple reasons. These three Middle Eastern countries, are collectively hosting an overwhelming majority of the entire population of Syrian refugees. All three of these countries have some qualities that should make integration of Syrian refugees easier, while all three have some qualities that should create added complications. For example, both Lebanon and Jordan are ethno-linguistically Arab majority countries, which might make the integration of Syrian refugees easier there, whereas ethnic Arabs were a very small minority in Turkey, and the Turkish language was entirely foreign to the Syrian refugees. However, mostly Sunni Syrian refugees could be expected to have the easiest integration in Sunni-majority Turkey and Jordan, whereas the multi-religious Lebanese society that consists of a delicate balance between Sunnis, Shiites, and Christians has added complications in relation to integrating such a big Sunni population. Similarly, Turkey and Lebanon could be expected to have the easier time with the economic undertaking of hosting millions of refugees, whereas Jordan, which was already home to millions of Palestinian refugees before Syrian refugees arrived, could be expected to be the most economically overburden. In a way this triangular balance between the cases of Turkey, Lebanon, and Jordan equalizes the field and allows for meaningful comparisons between them.

Syrian women who are refugees in these three countries are having disparate reproductive health outcomes, as measured in this study by Syrian women's pregnancy outcomes because pregnancy is one of the most important factors in reproductive health. Being a refugee, fleeing from civil war, trying to survive in a new country, is one of the hardest experiences one can go through in life. In such situation, refugee women are unlikely to have more planned pregnancies than they would have under peaceful conditions. If these Syrian women are having more children than the Syrian women in the other host country, this means that there may be a reason or more related with the host country.

The existing data related to the reproductive health of the Syrian refugee women scattered among Turkey, Lebanon, and Jordan can be incongruent. This is to say that often there is data about some aspect of reproductive health (for instance refugee infant

mortality rate) about two of these countries and not for the third. Other times there is data relating to the same aspect of reproductive health (for instance, refugee contraceptive use) from all three countries, but measured in different years during the ongoing crisis, the dynamics of which rapidly change. There is data about Syrian refugee women's pregnancy rates (in percentage) in all three countries measured within the same time period of 2015 and between the reproductive age of 15 to 49 (UNFPA, 2015) which makes the comparison reliable. The complexities of reproductive health certainly cannot be reduced to pregnancy rate, but pregnancy rate can be taken as an approximation to start exploring this research venue with the assumption that refugee women who came from the same population (Syria) and are unanimously going through a dramatically difficult time of their lives should make similar choices about their pregnancies in the host countries they fled to. The assumption is that if the observed pregnancy outcome is different, there may be at least some relation with factors in these host countries that affect refugee women's ability to make and follow through reproductive choices in the first place.

For the purposes of the research and although other variables may be at stake, it is assumed that all Syrian refugees come from the same original sample of Syrian nationals, and if their pregnancy rates diverge in the countries where they are hosted as refugees, this must be, at least partially, caused by the conditions they face in these host countries. Refugee women, during a dramatically vulnerable time in their lives, are able to access contraceptives in the countries where they now live at different rates. This can be affected by multiple factors. Three distinct factors are chosen. First, if a country's general level of gender equality is higher, this might mean better contraceptive access for a combination of reasons like less reproductive health stigma, better education and economic opportunities for women, among others. Second, if a host country's quality of general healthcare is better, it might mean better contraceptive access for reasons such as free clinics and free healthcare. And third, if a host country's quality of general women's health outcomes is better, this might also mean better contraceptive access because it would mean that most pregnancies are by choice. It is important to note here, that these are distinct factors that do not necessarily coexist. For instance, a country can have a great healthcare services with free clinics or comprehensive insurance programs, but poor women's health outcomes perhaps because of cultural stigma. Similarly, a country can have relatively subpar healthcare services with expensive and limited care,

but a high level of gender equality might mitigate the damage this would have done to women's health outcomes, perhaps because women have better access to education and employment resources. Since this research is a comparative one, multiple hypotheses are created in order to structure the comparison. Within this framework, the research question we ask in this study is the following:

2. RESEARCH QUESTION AND HYPOTHESES

RESEARCH QUESTION: How do the differences in Syrian refugee women's health outcomes in Turkey, Lebanon, and Jordan relate to pre-existing levels of gender equality, pre-existing levels of women's health outcomes and official importance given to national health care in these countries?

In relation to the research question, we forward the following twelve hypotheses, which we seek to confirm or deny in this study:

Hypothesis 1A: The pre-existing levels of gender equality suggests a relation to Syrian refugee women's health outcomes in Turkey, Lebanon, and Jordan.

Hypothesis 1B: The pre-existing levels of gender equality does not suggest a relation to Syrian refugee women's health outcomes in Turkey, Lebanon, and Jordan.

Hypothesis 1AA: The higher the gender equality level is in a host country, the lower will be the Syrian refugee women's pregnancy rate.

Hypothesis 1BB: The higher the gender equality level is in a host country, the higher will be the Syrian refugee women's pregnancy rate.

Hypothesis 2A: The host countries' pre-existing levels of women's health outcomes suggests a relation to Syrian refugee women's health outcomes in Turkey, Lebanon, and Jordan.

Hypothesis 2B: The host countries' pre-existing levels of women's health outcomes does not suggest a relation to Syrian refugee women's health outcomes in Turkey, Lebanon, and Jordan.

Hypothesis 2AA: The higher the pre-existing women's health outcomes are in a host country, the lower will be the Syrian refugee women's pregnancy rate.

Hypothesis 2BB: The higher the pre-existing women's health outcomes are in a host country, the higher will be the Syrian refugee women's pregnancy rate.

Hypothesis 3A: The host countries' official importance given to national health care seems to relate with Syrian refugee women's health outcomes in Turkey, Lebanon, and Jordan.

Hypothesis 3B: The host countries' official importance given to national health care does not seem to relate with Syrian refugee women's health outcomes in Turkey, Lebanon, and Jordan.

Hypothesis 3AA: The higher the official importance given to national health care is in a host country, the lower will be the Syrian refugee women's pregnancy rate.

Hypothesis 3BB: The higher the official importance given to national health care is in a host country, the higher will be the Syrian refugee women's pregnancy rate.

2.1. GENDER EQUALITY INDEX

The UNDP's gender inequality index is not used for this research because the latter has been created with a collection of statistical data that come from institutional factors such as the percentage of female participants in parliament in each country. However, this does not show the cultural and sociological aspects of the gender equality. To be more specific, Turkey had %4.4 female seats in its parliament in 2005, while in 2010, it increased to %9.1 female seats, and then in 2013, it jumped to %14.4 female seats in the parliament (The World Bank, n.d). Since the UNDP uses female participation in the parliament as one of the factors to measure gender inequality, according to its results, Turkey has three very different rankings. In 2005, Turkey ranks 0.518, while in 2010, it ranks 0.420, then in 2013 it ranks 0.360 (the more the ranking is closer to 1, the more the gender inequality level is higher). These three different gender inequality results change in such a short time but quite drastically.

Additionally, the UNDP gender inequality score of a country would fluctuate rather rapidly in a few years' time, as the base data that measures those institutional factors might dramatically change (for instance a new parliamentary election might cause the female representation to drop from %40 to %10 overnight). Following such changes, the UNDP gender inequality index would measure very different scores for a given

country, whereas it is unlikely that the culture of gender equality would change that rapidly in the same country. This is why the survey questions of the World Values Survey are chosen to create an original and alternative socio-cultural gender equality index, because the World Values Survey asks people about their personal thoughts in gender in/equality related issues.

In the following, it is aimed to establish a quantifiable and comparable measure of existing gender equality in Turkey, Jordan and Lebanon before the Syrian refugees arrived. This research seeks to establish an articulation of gender equality at the most comprehensive level, and one that is comparable across these three countries. A comparable articulation of the state of gender equality in these host countries will serve as one of the independent variables with which to test health outcomes for Syrian refugee women who arrived in these countries. This is important because the gender equality in a society is a known factor that makes a difference in women's health outcomes independent of the quality of existing health services and women's health access. A comprehensive view of gender equality encompasses gendered differentials in access to educational, political, economic, and public goods. To achieve such a measure, we use the publicly available sixth wave of the World Values Survey data set which was carried out in all three countries between 2012 and 2014: Turkey 2012, Lebanon 2013, Jordan 2014. The World Values Survey is a large-N study conducted with 1605 participants in Turkey, 1200 participants in Jordan, and 1200 participants in Lebanon.

In order to construct a comprehensive snapshot of the level of gender equality in these countries, we identified the questions from World Value Survey to create a Gender Equality Index (GEI). There are nine such questions. Respondents are given the statements as listed below, then asked whether or not they agree with them:

V45: “When jobs are scarce, men should have more right to a job than women.”

V47: “If a woman earns more money than her husband, it's almost certain to cause problems.”

V48: “Having a job is the best way for a woman to be an independent person.”

V50: “When a mother works for pay, the children suffer.”

V51: “On the whole, men make better political leaders than women do.”

V52: “A university education is more important for a boy than for a girl.”

V53: “On the whole, men make better business executives than women do.”

V54: “Being a housewife is just as fulfilling as working for pay.”

V139: “Please tell me for each of the following things how essential you think it is as a characteristic of democracy. Women have the same rights as men.”

The original response scales and directions of these survey questions were not statistically compatible. Respondents could answer the questions V45, V47 and V48 with three options (Agree, Neither, Disagree); questions V50, V51, V52, V53 and V54 with four options (Strongly Agree, Agree, Disagree, Strongly Disagree); and question V139 with ten options (numerically answered between 0=Not an essential characteristic of democracy and 10=An essential characteristic of democracy). In order to quantify the response scales in a comparable manner, we chose 60 as the highest maximum point in my GEI, which is divisible by three, four, and ten.

However, for some of the questions the highest level of agreement would mean the highest possible subscription to an aspect of gender equality, whereas for others, this direction is reversed. For example, a respondent who answers question V45 "When jobs are scarce, men should have more right to a job than women" with "Disagree" is assigned 60 points. Whereas a respondent who answers question V48 “Having a job is the best way for a woman to be an independent person.” with "Disagree" is assigned 0 points.

In this way, we recoded these nine statements in SPSS into new ones with the same direction and the same scale. We then bound the newly recoded statements to get a cumulative measure, which is my GEI. The GEI has a range of 0 to 60, with 0 indicating the lowest level of gender equality, while 60 indicating the highest level of gender equality. After eliminating the individuals with invalid responses who have missing values for any of these nine questions, the final valid sample size for each country is as follows: Lebanon 983 valid cases (with 217 invalid cases), Jordan 1146 valid cases (with 54 invalid cases) and Turkey 1431 valid cases (with 174 invalid cases).

Meanwhile if we compare these results with the gender inequality results of UNDP, it gives us a different scenario. According to the 2013 gender inequality results of UNDP,

within a scale from 0 to 1 (the more it is close to 1, the more the country has a higher gender inequality), Turkey has 0.360 point, Lebanon has 0.413 point, and Jordan has 0.488 point. However, this data cannot be used since this research is searching for the pre-existing gender equality outcomes in those three countries before the refugee influx and by 2013 a significant amount of refugees had already arrived in these countries. The previous UNDP data that can be looked at is 2010. According to the 2010 results of UNDP, Turkey has 0.420 points and Jordan has 0.502, (UNDP, n.d.) but Lebanon does not have any data of gender inequality which is one of the reasons why we needed to construct our own scale. As such, a new Gender Equality Index was constructed that measures more permanent socio-cultural factors for all three of these countries, and from a pre-refugee influx time period that can be replicated among all three cases.

Table 1: UNDP Gender Inequality Index for Host Countries

UNDP GII	TURKEY	LEBANON	JORDAN
2010	0.420	N/A	0.502
2013	0.360	0.413	0.488

Source: UNDP Human Development, n.d.

As a result, it can be seen in Figures 1, 2 and 3 that the GEI mean is different for these three countries. To be more specific, Jordan’s GEI mean is 22.77 in the total range of 0 to 60, which signifies the lowest level of gender equality out of the three cases. Turkey’s GEI mean is 29.31, which shows that the level of gender equality in the country ranks in the middle out of the three cases. And finally, Lebanon’s GEI mean is 31.20, which takes the highest place among the three cases. It should be noted, however, that even the highest score of 31.20 is only slightly above the arithmetic median of 30, when the highest possible level of gender equality would have scored a perfect 60.

Figure 1- *JORDAN GENDER EQUALITY INDEX*

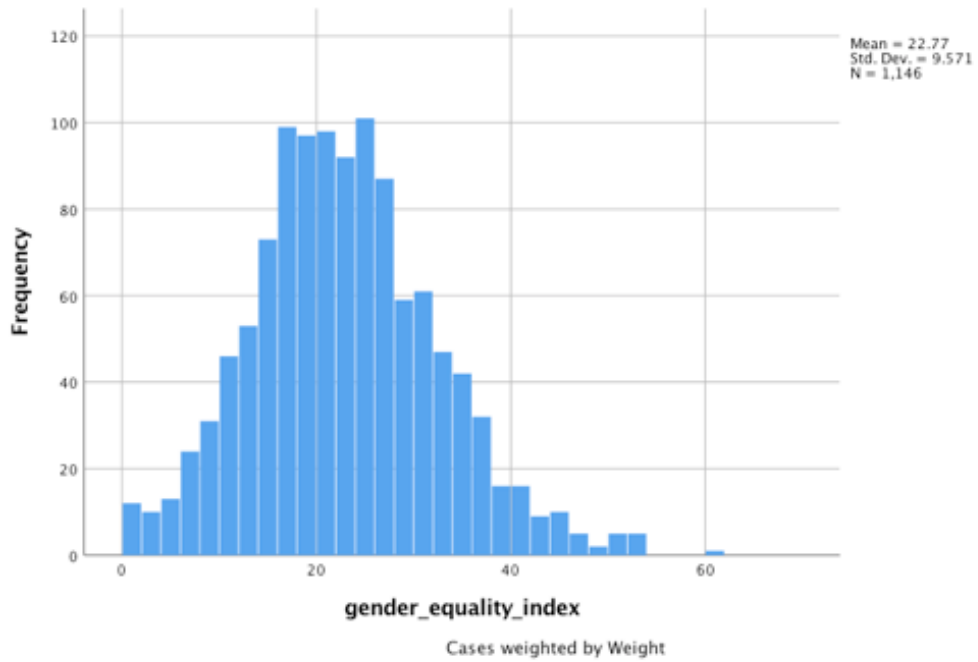


Figure 2- *TURKEY GENDER EQUALITY INDEX*

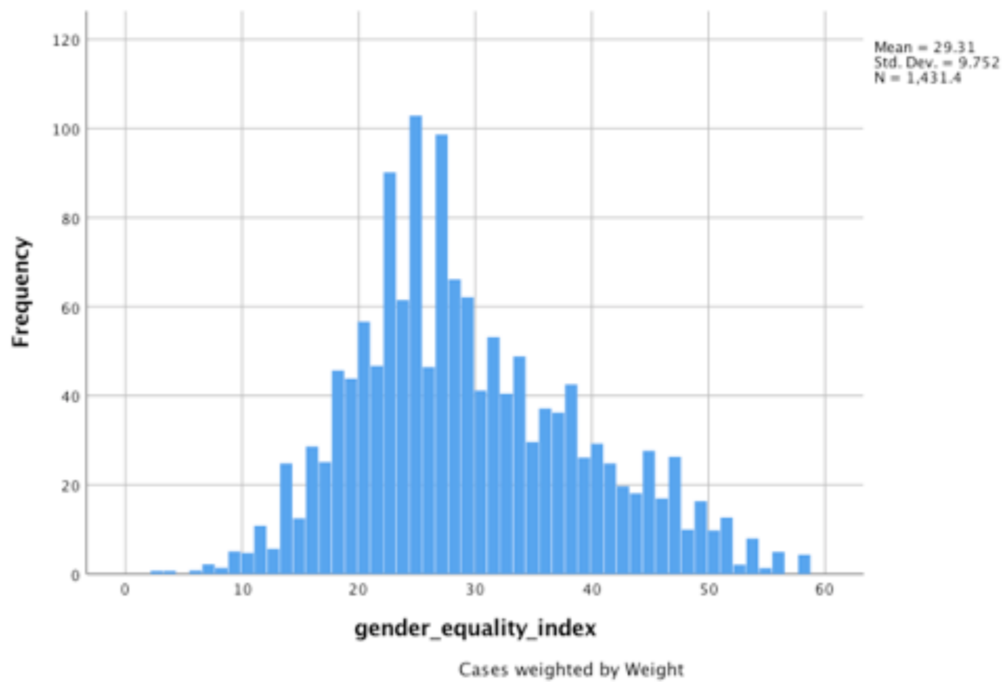
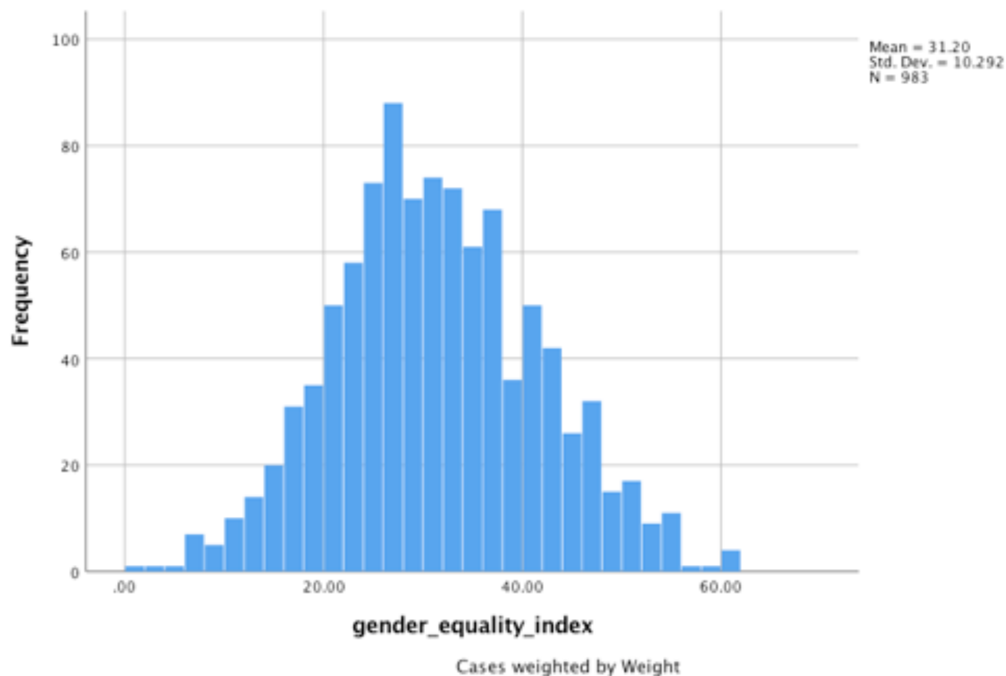


Figure 3- *LEBANON GENDER EQUALITY INDEX*



2.1.1. CROSSTABULATIONS WITH GENDER EQUALITY MARKERS

We created multiple crosstabulations in between the nine variables that measure the individual aspects of gender equality in Turkey, Lebanon and Jordan that we have collected from World Values Survey. We used SPSS to create all crosstabulations and holograms. With the comparison of these variables, the gender equality level will be seen clearly among these three host countries. As it is mentioned above, 0 describes the lowest level of gender equality and 60 describes the highest level of gender equality.

As shown in table 2, we compared the statements V45 “When jobs are scarce, men should have more right to a job than women” and V47 “If a woman earns more money than her husband, it’s almost certain to cause problems”. The total valid population is 1163 Lebanese people out of 1200. According to the table, the results show that 184 people responded these two statements with the direction of gender equality which means that %15.8 of the total population has a high level of gender equality in Lebanon.

***Table 2**: V45- When jobs are scarce, men should have more right to a job than women * V47- If a woman earns more money than her husband, it's almost certain to cause problems Crosstabulation - LEBANON*

Count					
		V47			Total
		0 (Agree)	30 (Neither)	60 (Disagree)	
V45	0 (Agree)	256	131	99	486
	30 (Neither)	77	118	64	259
	60 (Disagree)	131	103	184	418
Total		464	352	347	1163

As it can be seen in table 3, the total valid population is 1189 Jordanian people out of 1200. The results show that 68 people responded these two statements with the direction of gender equality which means that %5.7 of the total population has a high level of gender equality in Jordan.

***Table 3**: V45- When jobs are scarce, men should have more right to a job than women * V47- If a woman earns more money than her husband, it's almost certain to cause problems Crosstabulation - JORDAN*

Count					
		V47			Total
		0 (Agree)	30 (Neither)	60 (Disagree)	
V45	0 (Agree)	520	205	232	957
	30 (Neither)	26	40	10	76
	60 (Disagree)	56	32	68	156
Total		602	277	310	1189

As it is shown in table 4, the total valid population is 1570 Turkish people out of 1605. The results show that 204 people responded these two statements with the direction of gender equality which means that %12.9 of the total population has a high level of gender equality in Turkey.

Table 4*: V45- When jobs are scarce, men should have more right to a job than women * V47- If a woman earns more money than her husband, it's almost certain to cause problems Crosstabulation - TURKEY*

Count					
		V47			Total
		0 (Agree)	30 (Neither)	60 (Disagree)	
V45	0 (Agree)	589	196	160	945
	30 (Neither)	71	119	69	259
	60 (Disagree)	92	70	204	366
Total		752	385	433	1570

With the comparison of the statements V45 and V47 of these three host countries, the analysis shows that Lebanon has the highest gender equality level as %15.8, while Jordan has the lowest as %5.7.

Another crosstabulation can be seen in table 5, where we compared two statements related with gender equality which are V48 “Having a job is the best way for a woman to be an independent person” and V50 “When a mother works for pay, the children suffer”. V48 includes three answers and V50 includes four answers, which means for V48 statement, 60 describes the highest level of gender equality, while for V50 statement, 40 and 60 describe respectively high and the highest level of gender equality. The total valid population for these two statements is 1135 Lebanese people out of total 1200 people. With the light of this information, the results show that the intersection of 60 and 40 which shows the high level of gender equality includes 172 people, which means that %15.1 of this population has a high level of gender equality in Lebanon.

***Table 5**: V48-Having a job is the best way for a woman to be an independent person * V50-When a mother works for pay, the children suffer Crosstabulation - LEBANON*

Count						
		V50				Total
		0 (Strongly Agree)	20 (Agree)	40 (Disagree)	60 (Strongly Disagree)	
V48	0 (Disagree)	54	97	52	16	219
	30 (Neither)	72	128	74	15	289
	60 (Agree)	169	286	146	26	627
Total		295	511	272	57	1135

As it can be seen in Table 6, the comparison of V48 and V50 shows that the total valid population of Jordanian people is 1188 people out of total 1200 people. The number of people who answered these statements in the direction of gender equality is 71 people, which means that %5.9 of the total population has a high level of gender equality in Jordan.

***Table 6**: V48-Having a job is the best way for a woman to be an independent person * V50-When a mother works for pay, the children suffer Crosstabulation - JORDAN*

Count						
		V50				Total
		0 (Strongly Agree)	20 (Agree)	40 (Disagree)	60 (Strongly Disagree)	
V48	0 (Disagree)	220	56	21	9	306
	30 (Neither)	119	109	25	2	255
	60 (Agree)	338	218	54	17	627
Total		677	383	100	28	1188

As it can be seen in Table 7, the total valid population of these two statements is 1519 Turkish people out of total 1605 people. The number of people who answered these statements in the direction of gender equality is 339 people, which means that %22.3 of the total population has a high level of gender equality in Turkey.

***Table** 7: V48-Having a job is the best way for a woman to be an independent person * V50-When a mother works for pay, the children suffer Crosstabulation - TURKEY*

Count						
		V50				Total
		0 (Strongly Agree)	20 (Agree)	40 (Disagree)	60 (Strongly Disagree)	
V48	0 (Disagree)	51	92	39	14	196
	30 (Neither)	52	227	89	8	376
	60 (Agree)	176	432	234	105	947
Total		279	751	362	127	1519

These three crosstabulations of V48 and V50 show that within these two statements, Turkey has the highest gender equality level as %22.3, while Jordan has the lowest as %5.9.

The third comparison is between the statements V51 “On the whole, men make better political leaders than women do” and V53 “On the whole, men make better business executives than women do” as it is shown in table 8. Both of these statements have four answers as 0 and 20 describe respectively the lowest and low level of gender equality, while 40 and 60 describe respectively high and the highest level of gender equality. The total valid population is 1137 people out of 1200. With this information, the results show that 345 Lebanese people answered these two statements with the direction of gender equality which makes %30.3 of the total population in Lebanon.

***Table 8**: V51-On the whole, men make better political leaders than women do * V53-On the whole, men make better business executives than women do Crosstabulation - LEBANON*

Count						
		V53				Total
		0 (Strongly Agree)	20 (Agree)	40 (Disagree)	60 (Strongly Disagree)	
V51	0 (Strongly Agree)	89	70	75	27	261
	20 (Agree)	55	142	154	51	402
	40 (Disagree)	40	61	179	57	337
	60 (Strongly Disagree)	13	15	22	87	137
Total		197	288	430	222	1137

As table 9 shows, the total valid population is 1179 Jordanian people out of 1200. According to the table, the results show that 153 people answered these two statements with the direction of gender equality which makes %12.9 of the total population in Jordan.

***Table 9**: V51-On the whole, men make better political leaders than women do * V53-On the whole, men make better business executives than women do Crosstabulation - JORDAN*

Count						
		V53				Total
		0 (Strongly Agree)	20 (Agree)	40 (Disagree)	60 (Strongly Disagree)	
V51	0 (Strongly Agree)	424	132	97	16	669
	20 (Agree)	52	172	62	9	295
	40 (Disagree)	21	32	106	14	173
	60 (Strongly Disagree)	3	6	6	27	42
Total		500	342	271	66	1179

As Table 10 shows, the total valid population is 1524 Turkish people out of 1605. According to the table, the results show that 315 people answered these two statements

with the direction of gender equality which makes %20.6 of the total population in Turkey.

*Table 10: V51-On the whole, men make better political leaders than women do * V53-On the whole, men make better business executives than women do Crosstabulation - TURKEY*

Count						
		V53				Total
		0 (Strongly Agree)	20 (Agree)	40 (Disagree)	60 (Strongly Disagree)	
V51	0 (Strongly Agree)	230	186	62	25	503
	20 (Agree)	98	366	81	27	572
	40 (Disagree)	33	74	186	47	340
	60 (Strongly Disagree)	13	14	21	61	109
Total		374	640	350	160	1524

The comparison of V51 and V53 statements showed that Lebanon has the highest level of gender equality as %30.3, while Jordan has the lowest as %12.9.

And lastly, we created a hologram for the statement V54 “Being a housewife is just as fulfilling as working for pay” for all three host countries to see the gender equality level in their local population. Figure 4, 5 and 6 obtain the holograms of V54 statement where it shows that Lebanon’s mean is 25.45, while Jordan’s mean is 14.98 and finally Turkey’s mean is 21.02. This result points once more that Lebanon has the highest gender equality level comparing to other two host countries.

Figure 4- *LEBANON V54 "Being a housewife is just as fulfilling as working for pay"*

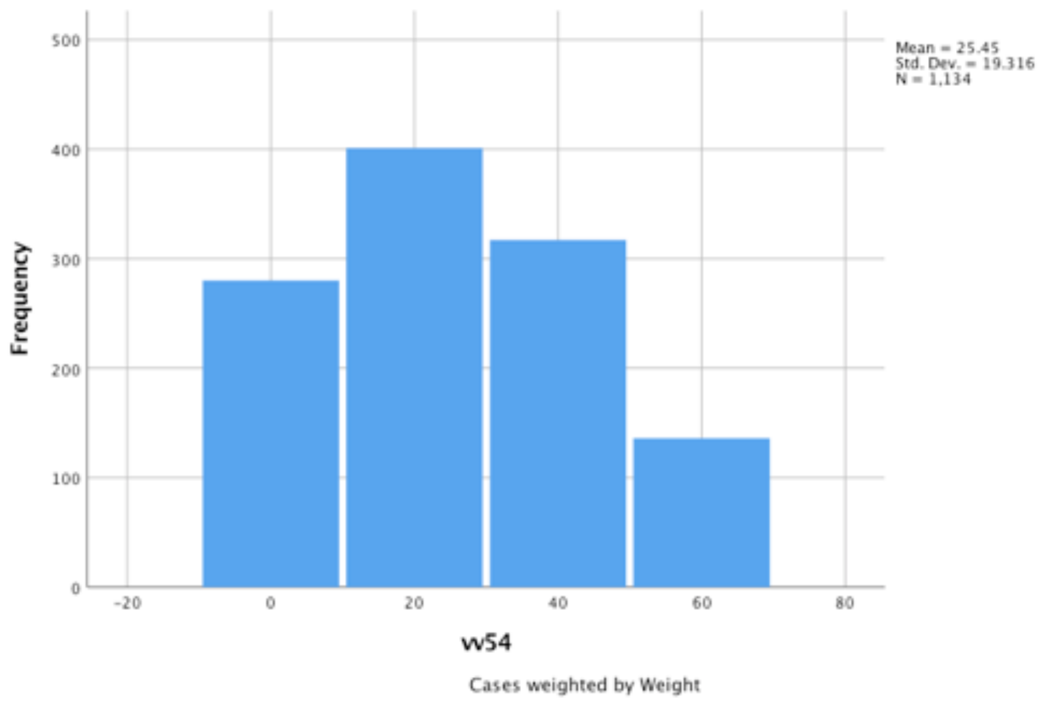


Figure 5- *JORDAN V54 "Being a housewife is just as fulfilling as working for pay"*

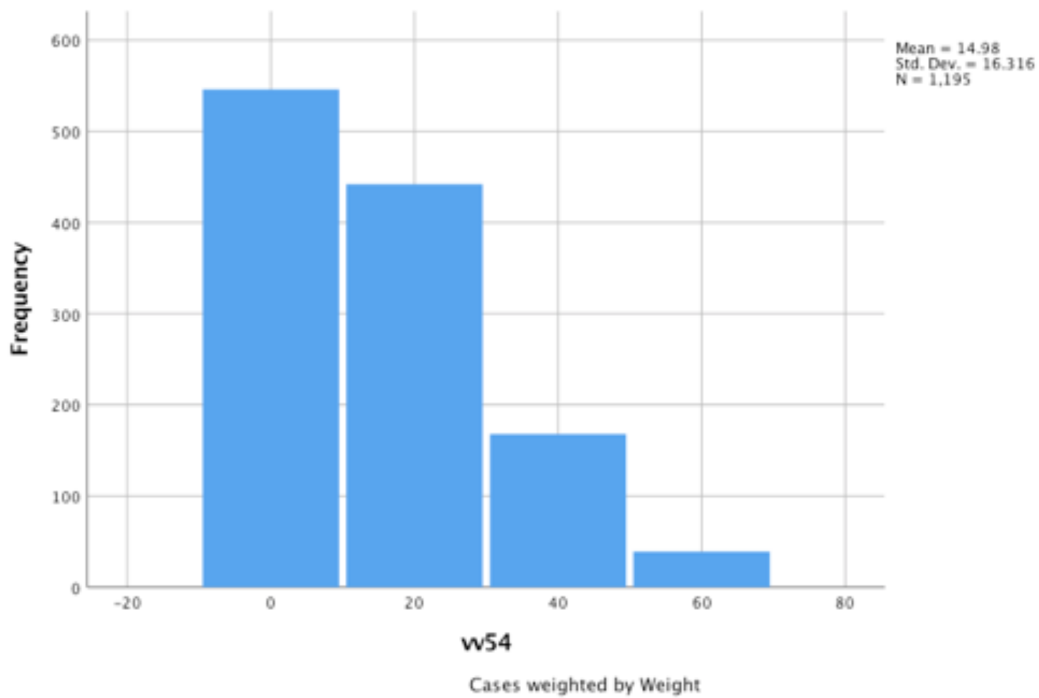
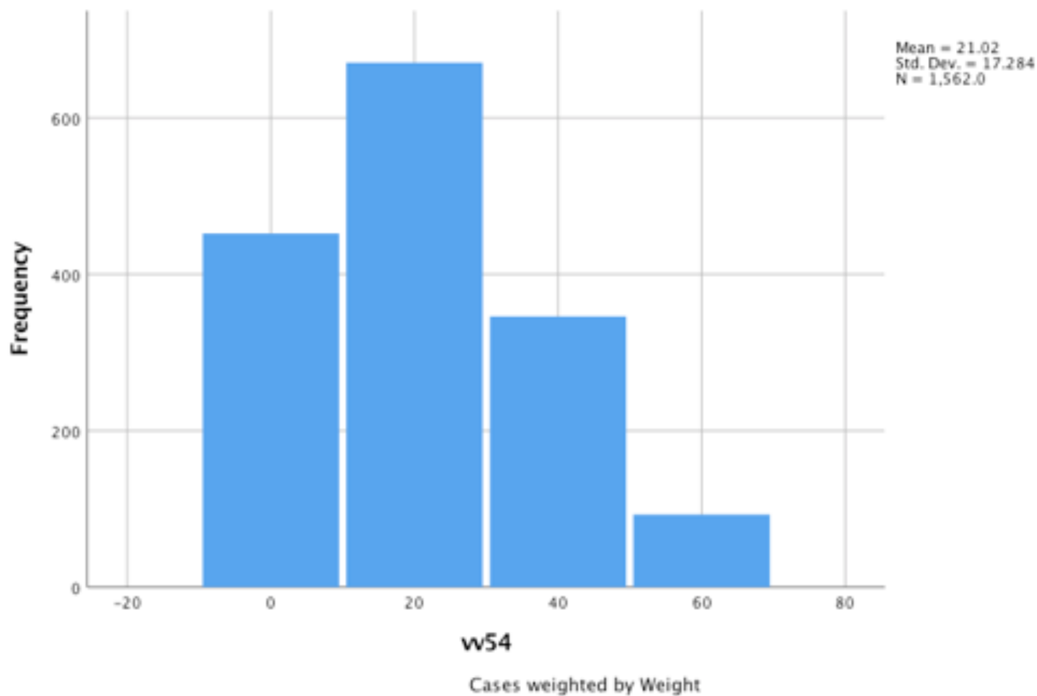


***Figure 6**- TURKEY V54 "Being a housewife is just as fulfilling as working for pay"*



In the light of these results, gender equality index and crosstabulations have given a clear perspective for these three host countries. These nine statements have been asked to the populations in Lebanon, Jordan and Turkey, and the majority of these statements showed the same result, which pointed out that Lebanon has the highest, Turkey has the moderate and Jordan has the lowest level of gender equality.

2.2. PRE-EXISTING WOMEN'S REPRODUCTIVE HEALTH INDEX

Reproductive health includes several indicators such as maternal, infant and under-5 mortality, contraceptive prevalence, ante-natal and post-natal care and goes on (WHO, n.d.). In this part, the similarities and differences will be compared and analyzed between pre-existing women's health conditions in Turkey, Lebanon and Jordan. Women's health is an extremely crucial matter to take into account in order to measure the development level of countries. Women's health does not only show the quality level of health care system in a country, but also it shows the importance given to women's conditions within the society specifically. The biggest reason behind this is

that the health of families and even the health of society are dependent on the health of the mother. It is because maternal and infant health are bounded to each other. In order to understand this bond, women's access to maternal care should be investigated thoroughly. Mothers and children usually suffer from the lack of adequate health care system or access to it and as a consequence, the maternal and infant health are on the line. According to the World Health Statistics (2018), 303.000 women have died due to maternal causes in 2015, and nearly 73.0 percent of all maternal deaths between 2003 and 2009 were attributable to direct obstetric causes (Say et al., 2014). In order to reduce the maternal and infant mortality, women have to have access to quality health care services before, during and after the pregnancy.

Even though pregnancy rate is the main dependent variable of this research, the general pregnancy rate of women in Turkey, Lebanon and Jordan is not added to these other factors of reproductive health for measurement, because it includes the refugee women pregnancy rate as well. All these reproductive health related factors are taken from the years between 2015 and 2016, and refugees have already arrived to these host countries before 2015. Although less significant in a larger population like Turkey, in smaller populations (like in Lebanon, where one in every four people is a Syrian refugee now) the pregnancy rates of Syrian refugee women have significantly skewed the general pregnancy rates observed in the country. This is why this piece of data was kept out because of the possibility of including refugee pregnancies into comparison.

The first trimester of the pregnancy process, which is called ante-natal care, is one of the most crucial periods of maternal and infant health. In this period, mother should be provided with multiple and routine examinations within a health center in order to prevent the possible complications during the pregnancy process. The second important period is during the delivery and after the pregnancy period, which is called post-natal care. The delivery should be held in a proper health center with the company of skilled health professionals. Post-natal care should be taken seriously in order to avoid the complications in relation to the health of mothers and newborns. If the needs of these mothers and newborns are unmet, the mortality rate increases drastically.

In what follows, the pre-existing levels of general women's health in Turkey, Lebanon and Jordan will be analyzed by comparing their general maternal mortality rate, neo-natal mortality rate, infant mortality rate, under 5 mortality rate and general female life

expectancy at birth levels. To do so, a quantitative articulation of pre-existing general women's health outcomes will be established in these three host countries. This comparable articulation will be the second independent variable with which to compare the health conditions for arriving Syrian refugee women. These 5 sub-variables are attributed in a pre-existing general women's health index. This index will provide the opportunity to illustrate the variations between the women's health outcomes in these host countries. This is why tables below have been created for each one of these matters to show the difference in these three host countries.

In the table below, the maternal mortality rate of Turkey, Lebanon and Jordan can be seen. This data is measured in 2015 which allows for accurate comparisons in the same temporal period. According to this data, the female mortality per 100.000 live births is 58 in Jordan which is the highest rate, while Turkey's female mortality rate is 16. However, Lebanon's female mortality rate is the lowest, which is 15. The difference between Lebanon and Turkey does not seem like a big difference, however, even one-point difference in the rate can matter. Maternal mortality can be the cause of many complications, infections, lack of access to health care services or health care professionals during the pregnancy, in delivery and after pregnancy periods. Considering these problems, a one-point difference in the maternal mortality rate actually indicates hundreds of maternal deaths in these countries.

Table 11: GENERAL MATERNAL MORTALITY RATE

Female deaths per 100,000 live births	TURKEY	LEBANON	JORDAN
General Maternal Mortality Rate	16	15	58

Source: The World Factbook, CIA, 2015

A ranking system of maternal mortality values list which is based on the World Factbook, Central Intelligence Agency (2016) has been created. 184 countries are included in this list. The measured and estimated data is adapted to 2015 which allows for accurate comparisons in the same temporal period. It includes Turkey's, Lebanon's and Jordan's annual number of female deaths per 100.000 live births from any cause related to or aggravated by pregnancy or its management. The ranking starts with Sierra

Leone, which has the highest maternal mortality rate, and ends with Greece, which has the lowest maternal mortality rate.

In the original ranking system, Sierra Leone has 1360 female deaths and Greece has 3 female deaths. In order to make a comparison between these countries, this ranking system creates problems because it does not allow for a meaningful quantitative measurement. The differences in between these 184 countries are not equal and this inequality leads to a conclusion where the countries with the same maternal mortality rate would have a different ranking which does not give an accurate result. Thus, to avoid this failure, we give the lowest point to the country with the highest maternal mortality rate and from that point onwards every 1 point difference in mortality rate is taken as 1 point in the new adapted system. However, as a crucial difference I did not skip the numbers between the countries that have maternal mortality rate gaps. We also gave 1 point to each one of these potential rates as a ghost number, because even though these ghost numbers are not on the list, they still have a rate. By counting the ghost numbers as well, the new adapted ranking system became more organized and well-designed, and it shows the definite difference between countries.

Here the new adapted system will be illustrated which allows for meaningful quantitative comparisons. We gave a score of 1 to Sierra Leone as it is the worst qualified country regarding its maternal mortality of 1360 female deaths. The second worst country is Central African Republic with 882 female deaths, but the maternal mortality difference between them is 477 female deaths per ten thousand. Since Sierra Leone has 1 point in the new ranking system, Central African Republic has 478 points, because there are 477 ghost numbers between them. In short, the ghost numbers between the countries are added to the next country in order to make the gaps in the adapted ranking system quantitatively meaningful, because in my ranking system, as the female deaths decrease, the score a country gets increases. After calculating the countries and the ghost numbers in the original list, Greece which is the best qualified country for maternal health gets the highest number which is 1347. Subsequently, Jordan has 1292, Turkey has 1334 and Lebanon has 1336 points in this adapted ranking system. These numbers show that Lebanon has the highest number comparing to Jordan and Turkey, which means that Lebanon has the lowest maternal mortality rate. This result could be reached in the original ranking system as well, but the score differential

is now arithmetically meaningful and correspondence to how these countries compare to each other.

Infancy period describes the period starting from the first month to 12 months age of a baby. After the first month is passed, the possibility of fatal complications drops as newborns grow into infants. When the infant mortality is considered, the mother's health condition and her accessibility to health services play a crucial role. If the mother's health outcomes are optimal, the infant mortality rate decreases. In the table below, the difference between Turkey, Lebanon and Jordan with their infant mortality rates can be seen and this data is estimated and measured in 2017. The original data is taken from World FactBook, Central Intelligence Agency (2016) which shows the global ranking of countries according to their infant mortality rates.

In order to compare Turkey, Lebanon and Jordan, the ranking system has been changed as to give values to their rates, much like the previously explained adapted ranking system, and for the same concerns. In the original ranking system, there are 225 countries and territories included and each one of them has a number with fractions. This is why a different ranking system had to be used compared to the previous one. In the new ranking system, between 0.5-1.00 is considered as 1 point. For example, the first country in this list is Monaco as holding the lowest infant mortality rate, having 1.80 deaths in every 1000 live births. The country following Monaco is Japan with 2.00 infant deaths in every 1000 live births. To establish an accurate scoring system between them, 1 point is attributed between 1.00-1.50, and 1.50-2.00 takes another 1 point and so on. In the table below, it will be explained in more detail.

***Table 12**:* ORIGINAL INFANT MORTALITY RANKING SYSTEM

RANK	COUNTRY	DEATHS/ 1000 LIVE BIRTHS
1	AFGHANISTAN	110.60
2	SOMALIA	94.80
3	CENTRAL AFRICAN REPUBLIC	86.30
4	GUINEA- BISSAU	85.70
5	CHAD	85.40
6	NIGER	81.10
7	BURKINA FASO	72.20
8	NIGERIA	69.80
9	MALI	69.50
10	SIERRA LEONE	68.40

Source: The World Factbook, 2016

The table above shows the worst 10 countries and their infant mortality rates. As it can be seen, the highest infant mortality rate is in Afghanistan with 110.60 deaths per 1000 live births. In the new ranking system, Afghanistan has a score of 1 point. If we continue to increase the score by 1 point in each 0.50 interval, between 110.50-110.0 will have 2 points, between 110.0-109.5 will have 3 points and between 109.5-109.0 will have 4 points and so on and so forth. This means that if Afghanistan gets a score of 1, the second country Somalia gets a score of 33, the third country Central African Republic gets a score of 50. Between these countries there are ghost numbers and in order to calculate the difference among them properly, we added the ghost numbers into calculations as well. Between Nigeria and Mali there is only 0.30 difference and this small difference seems like one-point difference in the original ranking system. On the other hand, the huge difference between Afghanistan and Somalia also seems like a one-point difference in the original ranking system. However, in my new adapted ranking system, the big difference between Afghanistan and Somalia is 32, while the difference between Mali and Nigeria is 1. Thus, as the infant mortality rate decreases, the score that the countries have increase. After the calculation of these rates, the data below shows that, compared to other two countries, Turkey has the highest infant mortality rate with 17.60 deaths per 1000 live births. In the new ranking system, Turkey has 183 points, Jordan has 188, while Lebanon has 201 points. In this sense, since Monaco with 212 points describe the highest quality for infant health, Lebanon as holding 201 points has a better quality for infant health in the comparison with Turkey and Jordan, which is pretty close to the best available care in the world.

Table 13: INFANT MORTALITY RATE

Infant deaths per 1000 live births	TURKEY	LEBANON	JORDAN
General Infant Mortality Rate	17.60	7.40	14.10

Source: The World Factbook, 2016

At the later stage, the children period who are under the age of 5 comes. Even though they are not newborns anymore, the possibility of fatal complications of these children is still at the forefront. These complications can be diseases caused by nutrition-related factors or common childhood illnesses which are preventable and treatable through simple interventions (WHO, 2019).

The World Bank Group (2016) measured the level of under 5 mortality among 265 countries and territories, and created a worldwide ranked list of under 5 mortality rate in 2016. In this list, Finland has the lowest under 5 mortality rate with 2.0 deaths per 1000 live births. Somalia, on the other hand, has the highest under 5 mortality rate with 129.4 deaths per 1000 live births. In order to make a proper comparison between these countries, the ranking system is adapted again and given values to each 0.5 point in the original ranking system a score of 1 in the new adapted system. In the new ranking system, between 129.5-129.0 is given the score of 1. Somalia as being the first country regarding to its high under 5 mortality rate has the score of 1. This ranking system will be shown with a table below.

Table 14: ORIGINAL UNDER-5 MORTALITY RANKING SYSTEM

RANK	COUNTRY	DEATHS/ 1000 LIVE BIRTHS
1	SOMALIA	129.4
2	CHAD	126.6
3	NIGERIA	123.9
4	CENTRAL AFRICAN REPUBLIC	123.9
5	SIERRA LEONE	115.5
6	GUINEA	105.3
7	MALI	105.1
8	SOUTH SUDAN	98.6
9	BENIN	97.6
10	DEMOCRATIC REPUBLIC OF CONGO	94.0

Source: The World Bank Group,2016

In table 14, the worst 10 countries are shown with their under-5 mortality rates. Since Somalia has the score of 1 in the new ranking system, Chad has the score of 6, Nigeria has the score of 11 with the ghost numbers added to the calculation. In short, the higher score a country has, the better its quality in under 5 health care outcomes. The table below shows the original numbers of under 5 mortality rate of three host countries. However, according to the new ranking system Jordan has the score of 214, Turkey has the score of 225 and Lebanon has the score of 232. From this result, it can be seen that once again Lebanon has a better quality for under 5 children in the country's health care system, although the difference in between these three countries is not very large.

Table 15: GENERAL UNDER 5 MORTALITY RATE

Under 5 deaths per 1000 live births	TURKEY	LEBANON	JORDAN
Under 5 Mortality Rate	11.9	8.0	17.2

Source: The World Bank Group,2016

Lastly, the female life expectancy levels at birth in Turkey, Jordan and Lebanon will be compared. Life expectancy at birth is known as the average number of years that a newborn is expected to live and female life expectancy involves the overall mortality level of female population (WHO, 2006). The female life expectancy at birth differentiates from country to country, and gives an idea about the development level of that country with respect to health outcomes. The variation in female life expectancy has a direct relation with maternal and infant health because it affects the average of how long a newborn can expect to live and it also shows how good the living standards are (OECD, 2019). In the table below, the variation in female life expectancy at birth is shown in Turkey, Lebanon and Jordan.

Table 16: GENERAL FEMALE LIFE EXPECTANCY AT BIRTH

General Population	TURKEY	LEBANON	JORDAN
Female Life Expectancy at Birth	79.4	77.7	76

Source: The World Factbook,2016

According to this data, Turkey has the highest female life expectancy at birth with 79.4 compared to Jordan and Lebanon, where the highest rate belongs to Japan which is 87.1.

After creating a new ranking system for maternal mortality rate, infant mortality rate, under 5 mortality rate and female life expectancy at birth independent variables, we build a 'pre-existing women's health index' (PWHI) by combining these independent variables for Turkey, Lebanon and Jordan. All adapted scores for each of the five sub-variables were automatically scaled between 1-999 by SPSS while these variables bound together in the pre-existing women's health index (PWHI). The PWHI has the highest potential score of 650, and the lowest potential score of 1. At this index, Turkey scores 548, Jordan 530, and Lebanon 550, as shown in the table 17, because these numbers are meaningfully comparable, we can conclude that even though Lebanon scores the highest, the quality of pre-existing women's health outcomes were very similar between Lebanon and Turkey, whereas Jordan scores substantially lower.

Table 17: PRE-EXISTING WOMEN'S HEALTH INDEX

INDEX	TURKEY	JORDAN	LEBANON
Mean	548	530	550

2.3. THE OFFICIAL IMPORTANCE GIVEN TO NATIONAL HEALTH CARE SERVICES INDEX

In this section, the similarities and differences between official importance given to national health care services in Turkey, Lebanon and Jordan will be compared and analyzed. To begin with, every country has a goal to reach a good quality of health care because the level of quality in a health system shows the development level of a country. Governments have a purpose to provide efficient, ideally and mostly egalitarian, and effective health care to the people who need these services.

Every state in the world has a budget for its health care system which is distinct from other social services such as the education system. Governments allocate specific amounts of money to upkeep and to improve their health profile. However, because the amount earmarked for health care services is contingent on a country's general economic status and can drastically vary, it is better to compare what percentage of the

national GDP is designated for health care. Since the social services that governments need to provide are distinct from each other, we can see what percentage of the national GDP a country has spared for the health care system which would provide us with a proxy for the official importance given to national health care services in a country's national budget.

This distinct budget affects the health care profile of a country. Most countries in the world, especially the developed ones, mostly prioritize private sectors and support their financial status. Specifically, in the health sector, this distinction is increasing with the prioritization in governments' budgets for health. With the excessive prioritization in the private health sector, people who are in urgent need suffer more from the accessibility and affordability of these health care services. This bizarre situation puts great pressure both on patients and public health sector services at the same time. How should countries decide on their national budget for the health sector then? In 1980s, WHO recommended that countries should spend at least 5 percent of their national budget on health sectors (Savedoff, 2003). But of course, after an excessive increase in population and the diversity of diseases worldwide, this number is not reasonable anymore.

The point here is to understand the budget distribution of these three host countries because governments try to provide an efficient delivery of public services, especially of health care services, and the ultimate goal is to give universal health to citizens. However, countries' different cultural and economic background changes their purchasing of services. Thus, this is why we need to compare the health budgets of these countries because it would lead us to analyze how much money needed in health sector in order to administer, maintain and deliver a qualified health care service to a population.

Because of these reasons, the third variable 'the official importance given to national health care systems' is chosen to understand how the health care services are proportionated at a governmental scale in Turkey, Lebanon and Jordan. In this way, it will be possible to see whether or not the adequate importance is given to the health care system in these three host countries. World Health Statistics (2018) measured the percentage of domestic general government health expenditure (GGHE-D) as a percentage of general government expenditure all around the world and created a ranked

list of countries estimated for 2015. According to this list, Turkey spares %10.1 of its expenditure for health care services in a total of general government expenditure, while Jordan spares %12.4 of its general government expenditure for health care services. Lebanon has the highest percentage compared to the other two host countries, holding %14.3 of its general government expenditure for health care services. This data shows that Lebanon has given more importance to health care services than the other two host countries at a governmental scale. Because in some countries, health care services have less economic capacity in order to improve its services compared to other social services. Also, the defined financial targets can be quite different from the initial budgets when it comes to the allocation of these targets in such an important system as health.

Table 18: OFFICIAL IMPORTANCE GIVEN TO NATIONAL HEALTH CARE

Domestic general government expenditure (GGHE-D) as a percentage of general government expenditure	TURKEY	LEBANON	JORDAN
%	10.1	14.3	12.4

Source: World Health Statistics,2018

IV. FINDINGS

In this section of the research, the relationship between the dependent variable and the three independent variables will be analyzed. The goal is to identify any potential connections between the dependent variable, namely ‘refugee pregnancy rate’, and the three independent variables, respectively ‘gender equality index’, ‘pre-existing women’s health index’ and ‘official importance given to national health care’. The table below shows the values of the dependent and the three independent variables each in their respective ranking system. The first column shows the dependent variable ‘percentage of pregnancy rate of Syrian refugee women’ in Turkey, Lebanon and Jordan, which is respectively %6, %6.9 and %7.9 estimated in 2015 (UNFPA, 2015). The second column shows the first independent variable ‘gender equality index’ in its own ranking system between a value of 0 (zero) which equals to the lowest gender equality level, and 60 which equals to the highest gender equality level in Turkey, Lebanon and Jordan estimated between 2012 and 2014. The outcomes of this index show that the level of gender equality in Turkey is 29.31, meanwhile in Lebanon it is 31.20, and in Jordan it is 22.77 out of 60. The third column shows the second independent variable ‘pre-existing women’s health outcomes’ in a newly adapted ranking system which includes the minimum number as 1 for the worst pre-existing health outcomes for women in a given country and the maximum number as 650 for the best. In this system, Turkey holds 548, Lebanon holds 550 and Jordan holds 530. The last column shows the last independent variable ‘official importance given to national health care’ in Turkey, Lebanon and Jordan in percentage, which is respectively %10.1, %14.3 and %12.4 estimated in 2015. These outcomes will be compared and interpreted separately and in detail below.

***Table 19**: The rates of dependent and independent variables of host countries*

	Pregnancy rate of Syrian refugee women (%)	Gender equality index (min. 0-max.60)	Pre-existing women’s health outcomes (min.1-max.650)	Official importance given to health care (%)
TURKEY	6	29.31	548	10.1
LEBANON	6.9	31.20	550	14.3
JORDAN	7.9	22.77	530	12.4

1. GENDER EQUALITY INDEX (GEI) AND PREGNANCY RATE

As mentioned before, the gender equality index is created with multiple questions and statements taken from the World Value Survey, and the three host countries' gender equality levels are quantified. According to the gender equality index, Jordan's GEI is 22.77, Turkey's GEI is 29.31 and Lebanon's GEI is 31.20. The pregnancy rate for refugee women of Jordan is %7.9, Turkey's is %6 and Lebanon's is %6.9 (see table 20).

Table 20: *The comparison between GEI and pregnancy rate of host countries*

	Pregnancy rate of Syrian refugee women (%)	Gender equality index (min.0 - max.60)
TURKEY	6	29.31
LEBANON	6.9	31.20
JORDAN	7.9	22.77

The first piece of observation to mark is that Jordan holds the lowest gender equality level compared to the other two host countries. The socio-cultural environment of Jordan is often thought of as more religious than those of Turkey and Lebanon, which might be contributing to the lower levels of gender equality in the country. When it comes to the reproductive health of women, especially the reproductive health of refugee women, the statistics show that Jordan has the highest percentage of pregnancy rate. The %7.9 shows the population of Syrian refugee women who live in Jordan in 2017 and it indicates hundreds of thousands of refugee women who are pregnant, presumably at a time in their lives when pregnancy is the least desired and most complicated. A further interpretation that would come out of this comparison is that it makes sense that Jordan simultaneously scores the lowest GEI and the highest refugee pregnancy rate. This may indicate that the level of gender equality in a host society potentially has an impact on the refugee women's health outcomes. This might be a fruitful area for future research that could investigate the internal mechanisms of this potential connection.

The second piece of observation to mark is a comparison between Turkey and Lebanon. As the table above attests, Turkey and Lebanon score a very similar gender equality

level (Turkey:29.31 and Lebanon: 31.20), whereas the pregnancy rate of Syrian refugee women in these two countries are drastically different (Turkey:6 and Lebanon:6.9) which is almost as big a gap in pregnancy rate as from Lebanon to Jordan. Additionally, the order of pregnancy rates in Turkey and Lebanon are also not intuitively connected to the GEI of these countries. Even though the difference is small, Lebanon has a higher GEI than Turkey, and the refugees in such a host country would have been expected to score a lower pregnancy rate. This might indicate that certain other factors, for instance accessibility of resources, might overcome the level of gender equality, which is certainly possible. However, it would not imply that the level of gender equality in a host country would never matter in comparison to more structural factors.

Consider resource accessibility, in the form of contraceptives, in these host countries, for instance. There is no data about contraceptive accessibility among Syrian refugees in Turkey. However, data from both Lebanon and Jordan should be cited. In Jordan, contraceptive use among Syrian refugee women dropped from %83.8 in 2015 to %61.9 in 2017 (WHO, Health Profile Jordan, 2015), indicating a growing resource allocation problem in the country under pressure from the ongoing refugee crisis. In Lebanon, contraceptive use among Syrian refugee women dropped from %83.1 in 2015 to %63.8 in 2017 (WHO, Health Profile Lebanon, 2015), which is a very similar trend to what Jordan experienced in the same time frame. And yet, the pregnancy rate among Syrian refugee women in these societies remain divergent, even though they experience very similar resource allocation problems. This divergence might be caused by the different levels of gender equality in these societies. Perhaps a refugee woman who is being hosted in a society that scores a higher level of gender equality is better empowered to negotiate her own reproductive health and better make use of the scarce tools she is given.

Thus, the hypothesis 1A. “The pre-existing levels of gender equality suggests a relation to Syrian refugee women’s health outcomes in Turkey, Lebanon and Jordan.” is partially accepted. In the Jordan case, there seems to be a relation between the gender equality and the reproductive health of Syrian refugee women, however, in Turkey and Lebanon, this relation between gender equality and pregnancy rate of Syrian refugee women does not necessarily prove that the pregnancy rate differences among Syrian refugee women are the results of gender equality levels in Turkey and Lebanon, which means, the hypothesis 1B. “The pre-existing levels of gender equality do not suggest a

relation to Syrian refugee women's health outcomes in Turkey, Lebanon and Jordan." has been denied. The hypothesis 1A.A. "The higher the gender equality level in a host country, the lower will be the Syrian refugee women's pregnancy rate." refers specifically to Jordan where we have the lowest gender equality level and the highest pregnancy rate among refugee women. When it comes to Turkey and Lebanon, a higher gender equality level suggests a relation to Syrian refugee women's pregnancy rate, but it might not be the only reason behind this result. On the other hand, the hypothesis 1A.B. "The higher the gender equality level in a host country, the higher will be the Syrian refugee women's pregnancy rate." has been denied.

2. PRE-EXISTING WOMEN'S HEALTH INDEX (PWHI) AND PREGNANCY RATE

The second binary comparison is between the pregnancy rate of Syrian refugee women and the pre-existing women's health outcomes in Turkey, Lebanon and Jordan. As it is mentioned above, pre-existing women's health outcomes index is created with multiple dynamics such as maternal mortality rate, infant mortality rate and so on, which are given above, and with the light of all these dynamics, a scale for pre-existing women's health outcomes is built. This scale starts with a minimum number of 1 and ends with a maximum number of 650. Table 21 shows that Lebanon has 550 points as being the highest score, following with Turkey having 548 points, while Jordan has 530 points as being the lowest score out of 650.

Table 21*: The comparison between Pre-existing women's health and pregnancy rates of host countries*

	Pregnancy rate of Syrian refugee women (%)	Pre-existing women's health outcomes (min.1- max.650)
TURKEY	6	548
LEBANON	6.9	550
JORDAN	7.9	530

Jordan has the lowest pre-existing women's health outcomes and the highest pregnancy rate of Syrian refugee women. Once again, this is an intuitive match. This result shows that the existent health of Jordanian women has a connection to the health of refugee women arriving in Jordan. The reasons of this outcome might be the quality and the conditions of the health institutions and centers in Jordan. As the pre-existing women's health index above shows, Jordan has the highest numbers of maternal mortality (see table 11) and under 5 mortality (see table 15), and has the lowest female life expectancy rate (see table 16) among Jordanian women, compared to women in Turkey and Lebanon. Especially the maternal mortality rate is extremely high which is 58 female deaths per 100,000 live births, while Turkey has 16 female deaths and Lebanon has 15 female deaths in general women population. This result shows us that if the local women in a host society already have a poor health status, the refugee women's who arrive are likely to have poor health outcomes too.

On the other hand, Turkey and Lebanon hold a very close numbers of the pre-existing women's health outcomes, respectively 548 and 550 out of 650. Since they have very similar general women's health outcomes, but a very different pregnancy rate of Syrian refugee women, much like the previous bivariate comparison certain other factors might be overriding the most intuitive outcome. In the case of Turkey and Lebanon, one reason might be that Syrian refugee women in these two countries have differential access to health care services. In Lebanon, only the registered refugee women can have free access to primary and reproductive health care which is funded by UNHCR, while in Turkey registered and unregistered refugee women have free access to emergency and primary health care. Thus, the difference in the access to health care services might have resulted in such different pregnancy rate of Syrian refugee women in Lebanon and Turkey.

Thus, the hypothesis 2A. "The host countries' pre-existing levels of women's health outcomes suggests a relation to Syrian refugee women's health outcomes in Turkey, Lebanon and Jordan." is proven. While the hypothesis 2B. "The host countries' pre-existing levels of women's health outcomes does not suggest a relation to Syrian refugee women's health outcomes in Turkey, Lebanon and Jordan." has been denied. Also, the hypothesis 2A.A "The higher the pre-existing women's health outcomes are in a host country, the lower will be the Syrian refugee women's pregnancy rate." has shown that there is a contrary relationship between these variables, while the hypothesis

2A.B. “The higher the pre-existing women’s health outcomes are in a host country, the higher will be the Syrian refugee women’s pregnancy rate.” has been denied.

3. THE OFFICIAL IMPORTANCE GIVEN TO NATIONAL HEALTH CARE (OIGNHC) AND PREGNANCY RATE

The third binary comparison is between the official importance given to national health care and the pregnancy rate of Syrian refugee women. Every country has a goal to create and maintain a qualified health care system. It is important to improve the standards of health care services in order to achieve a healthy national profile. What makes a health care service qualified is not only the quantity of the given service, but also the high standards of that service. These high standards should provide effective, safe, affordable and patient-centered health care to its users. This is why we choose this independent variable as it is very relevant in order to understand how much importance the governments give to their health systems.

The official importance given to national health care has different values for each of the three host countries. All of them have a significant discrepancy in their distribution of health care services. To be more specific, according to the 2015 results, Turkey reserves %10.1 of its general government expenditure to maintain and improve the health care services. Lebanon, on the other hand, reserves %14.3 of its general government expenditure for health care, while Jordan reserves %12.4 (see table 22).

Table 22: *The comparison between Official importance given to national health care and pregnancy rate of host countries*

	Pregnancy rate of Syrian refugee women (%)	Official importance given to national health care (%)
TURKEY	6	10.1
LEBANON	6.9	14.3
JORDAN	7.9	12.4

What immediately stands out from this cross-tabulation is that the ranking of Syrian refugee women's pregnancy rates does not match with the ranking of the official importance given to national health care in these countries. Lebanon spends the highest percentage of its national GDP to health care, which one might intuitively expect would translate into the lowest pregnancy rates among the refugees who are hosted there. However, Lebanon ranks in the middle with regard to Syrian refugee women's pregnancy rates. Turkey spends the lowest percentage of its national GDP to health care, which one might have expected would translate into the highest pregnancy rates among the refugees who are hosted there. Contrarily, the Syrian refugees hosted in Turkey have the lowest pregnancy rates. It might be useful to interpret this mismatch in two parts.

The way Lebanon and Jordan are ranked in this framework seems to make sense. Lebanon spends a higher percentage of its GDP on health care than Jordan does. In other words, Lebanon gives greater importance to its health care infrastructure and is able to allocate a greater amount of resources to it. It is intuitive that the refugees who are hosted there might benefit from this better kept health care infrastructure, and, consequently, refugee women in Lebanon has better health outcomes than Jordan.

The real mismatch is embedded in the place of Turkey in this framework, which allocates the smallest percentage of its national GDP to health care, but has the best health outcomes for a refugee population it hosts. One reason behind this mismatch might be the total size of the national economies in these countries. The Turkish economy ranks the 19th biggest in the world, whereas per the World Bank 2018 numbers, the Lebanese economy ranks the 79th in the world, and the Jordanian economy ranks the 88th. This is to say that when Turkey spends about %10 of its GDP on creating and maintaining health care infrastructure, the sum total value of that resource allocation is considerably greater than %14 of the Lebanese economy.

Thus, the hypothesis 3A. "The host countries' official importance given to national health care suggests a relation to Syrian refugee women's health outcomes in Turkey, Lebanon and Jordan." and the hypothesis 3B. "The host countries' official importance given to national health care does not suggest a relation to Syrian refugee women's health outcomes in Turkey, Lebanon and Jordan." are neither proven, nor denied, because according to the results, there might be a relation between those but not

necessarily in this context. Also, the hypothesis 3A.A. “The higher the official importance given to national health care is in a host country, the lower will be the Syrian refugee women’s pregnancy rate.” and the hypothesis 3A.B. “The higher the official importance given to national health care is in a host country, the higher will be the Syrian refugee women’s pregnancy rate.” are neither proven nor denied.

V. CONCLUSION

This research project aimed to understand whether or not the pre-existing conditions in the host countries like Turkey, Lebanon and Jordan might suggest an impact on the Syrian refugee women's differential reproductive health outcomes. The existent conditions of host countries eventually affect the conditions of refugees who arrive to those countries. One reason could be the socio-cultural environment in the host country which shares a big part in shaping the physical conditions of refugees who have arrived to that host country. Other reason could be the already existent conditions of local women in the host country which might better or worsen the conditions of refugee women after their arrival to the country. And another reason could be the financial support of the government to its health services which might cause differential health conditions for the refugees who inevitably rely on the basic health infrastructures of the countries they have sought refuge in.

These factors have been discussed one by one with the collected data and compared both by quantitative and qualitative methods. The quantitative method has relied partly on the SPSS statistical program to construct indexes and partly on comparisons of crosstabulations and re-coded orders. The qualitative aspects of this study relied on interpretations of the potentially relevant concepts that emerged from the literature.

Gender equality has a certain impact on shaping the socio-cultural conditions in a country. In order to measure the gender equality level in Turkey, Lebanon and Jordan, the survey questions, which were asked to the citizens of these three host countries by the World Value Survey, were taken into account. After creating a comprehensive index from relevant questions, the results showed that Jordan has the lowest gender equality level and the worst pre-existing women's health outcomes while having the highest pregnancy rate among Syrian refugee women. On the other hand, Lebanon has the highest level of gender equality and better pre-existing women's health outcomes compared to the other two host countries, which might be because of a high possibility of being a multi-ethnic and a multi-cultural society which eventually would spare a bigger room for a higher gender equality level and a better pre-existing general women's health outcomes. However, even though Lebanon has the highest amount of governmental share in health expenditure, it seems it did not affect the pregnancy rate of Syrian refugee women in a positive way compared to the results of Syrian refugee women in Turkey. Turkey, out of these three host countries, has the lowest amount of

governmental share in health expenditure but has the lowest level of pregnancy rate of Syrian refugee women. The reason behind this can be the higher quality of health care services in Turkey and a higher availability of access to those health care services by refugees. On the other hand, Jordan has a higher governmental share in health expenditure than Turkey, but the difference in the pregnancy rate of Syrian refugee women is great. This leads us to the conclusion that Jordan has fundamentally different results compared to Turkey and Lebanon in terms of gender equality level, the pre-existing general women's health outcomes and also the official importance given to national health care services in the country.

This research shows several possible relations between these factors which open a door for further studies about refugee women and their reproductive health conditions that can delve deeper into the individual explanatory powers of gender equality, general women's health outcomes and governments' budget for health care services. However, from the initial exploratory outcomes that emerged from this work project, one can suggest that socio-cultural levels of gender equality in a host society need more attention with regard to designing interventions and policies for refugee women's health outcomes. Importantly, because such socio-cultural factors only change slowly, investing in long-term policies to increase gender equality in countries and regions that host or are likely to host the overwhelming majority of refugees in the foreseeable feature would be a good idea. As such, we need a permanent international policy as part of refugee response policies which covers specifically gender equality, especially in the regions such as Middle East and Sub-Saharan Africa, where the overwhelming majority of world's refugees reside and are likely to reside in the near future.

According to the findings of this research, Turkey has the lowest governmental budget share for health care services but also has better conditions for reproductive health of refugee women compared to Lebanon and Jordan. This shows that there is not a steadfast rule about the relative economic importance allocated for health care services in a country and their quality. In fact, it would seem that there are diminishing returns to holding the same percentage of GDP allocated for this purpose. The greater the economy of a country, the more this percentage can drop, because the quality of health care matters more once a basic absolute number is reached. Therefore, hypothetically, a host country with a low percentage of health care budget but with a high quality in health care services may provide a better environment for both citizens and the refugees

compared to another host country that allocates a greater share of its GDP to health care. This also suggests that not only international policy, but also national policy might be better off gradually decreasing the ratio of the resources invested in health care infrastructures and instead increasingly allocating those freed resources in the service of creating greater gender equality in society as far as refugee women's health outcomes are concerned.

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