

Research Article

Current Opinion in Gynecology and Obstetrics A Qualitative Analysis of Knowledge, Attitudes, and Perceptions of Family Planning Among Syrian Refugees in Lebanon

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Abstract

Introduction: The Syrian conflict has displaced approximately 1.5 million people to Lebanon. In this setting of forced displacement, child marriage, insecurity, and limited access to sexual and reproductive health services can lead to increased rates of adolescent pregnancy, which have been linked to exacerbated maternal morbidity and mortality. Family planning can help to delay childbirth, increase time between pregnancies, and empower women to make their own reproductive health choices. To date, there is limited research on the knowledge of, and attitudes towards, family planning among Syrian refugees in Lebanon.

Objective: Identify knowledge, attitudes, and perceptions towards family planning among Syrian refugees with the overarching goal of informing response strategies to improve sexual and reproductive health for displaced Syrian families in Lebanon.

Methods: A thematic qualitative analysis of focus group discussions conducted in Lebanon in January 2017 by the ABAAD Resource Center for Gender Equality. The sample of 99 participants included Syrian women, girls and men.

Results: While contraceptive use was generally deemed acceptable by women and girls, husbands' and mother-in-laws' attitudes towards fertility influenced their decisions about its use in practice. Additionally, reliable family planning services and sexual and reproductive health education were perceived as seldom available to Syrian refugees in Lebanon. Participants suggested that family planning awareness programs were needed for both parents and girls.

Discussion: Changes at the policy, service, community, and individual levels are required to increase knowledge regarding and access to family planning services for Syrian refugees in Lebanon. In the interim, non-governmental organizations may play a role in providing educational and supportive services for displaced Syrian girls and women.

Keywords: Child, early or forced marriage, Contraception, Family planning, Lebanon, Qualitative, Refugee, Syria

Abbreviations: FGD: Focus Group Discussions; FP: Family Planning; IAWG: Inter-Agency Working Group; IUD: Intrauterine Devices; NGO: Non-Governmental Organizations; OCPS: Oral Contraceptive Pills; SRH: Sexual and Reproductive Health; UNHCR: United Nations High Commissioner for Refugees

[^] RJ undertook the analysis while a Master's student at the London School of Hygiene and Tropical Medicine and obtained the data from SB at Queen's University.

Introduction

Context

Since the beginning of the Syrian conflict in 2011, Lebanon has received approximately 1.5 million Syrian migrants, who now constitute 20% to 25% of Lebanon's population [1]. Of the 1.5 million Syrian refugees in Lebanon, 52% are women and 24% are of reproductive age [2,3]. Previous research indicates that in Lebanon, female adolescent refugees often experience restricted movement and do not have the freedom to leave home and attend school due to fears about their safety [4-6]. These safety concerns have, in part, led to an increased rate of child marriage and decreased age at which many Syrian girls are married in Lebanon [7]. Reports indicate that some Syrian families feel threatened by the more 'liberal' Lebanese values, economic insecurity, lack of access to education for girls, and fear of physical harm [5,8,9], perhaps contributing to decisions to marry their daughters earlier. In 2017, approximately 35% of Syrian refugee girls in Lebanon were reportedly married before the age of 18 compared to 13% of girls marrying in Syria before the age of 18 in 2006 [10].

Child marriage is defined as any marital union where one or both parties are under the age of 18 [11]. Early marriage is associated with negative sexual and reproductive health (SRH) consequences. For instance, girls aged 15 to 19 have double the chance of dying during childbirth, while girls under 15 have five times the chance of dying during childbirth [12]. Additionally, child brides are more likely to experience intimate partner violence and get pregnant sooner than brides aged over 18 [13]. Furthermore, Alnuiami et al. found a relationship between maternal age under 19 and low birth weight [14] and in Turkey, where almost half of all women marry before the age of 18, approximately 50% of pregnancies end in miscarriage or stillbirth [15].

Reproductive health and family planning as a human right

Having SRH means that "people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so" [16; p.2]. The delivery of a wide range of culturally appropriate, safe, useful, and low-cost family planning (FP) services is a crucial aspect of achieving SRH [16] and FP empowers women to control their own fertility [1]. In 2004, the Inter-Agency Working Group (IAWG) found that people living in situations of conflict had particularly poor access to FP [17,18], and that many refugees do not have autonomy over use of SRH services *Cur Op Gyn Obs*, 2(1):346-353 (2019)

[3]. It is estimated that use of FP to delay pregnancy and lengthen the time between pregnancies would prevent approximately one-third of maternal deaths and approximately 19 million unsafe abortions globally [3,12]. FP can also improve children's nutrition, increase access to women's education and work opportunities, as well as increase families' resources [19].

Refugees maintain the same right to health as those who have not fled insecure situations [1]. Although multiple international documents acknowledge the reproductive health needs of refugees, public health policy and interventions often fail to adequately address these needs [1,2]. This can have dire consequences for some displaced families, particularly given that the average duration of displacement is approximately 20 years [20].

Sexual and reproductive health among displaced Syrian women and girls

Fertility patterns are a complex issue driven by a range of interconnected factors [8,21]. Earlier qualitative research with Syrian women in Lebanon identified a number of reasons for wanting children, including believing that it was god's will, believing that having more children would increase access to aid, wanting to replace children lost in the conflict, concern about the cost of contraception, and desperation to have a son [8]. Additionally, pervasive societal expectations about having a child immediately following marriage, and feeling forced to conceive out of fear that husbands would abandon them if they did not prove their fertility, may influence girls' desire for pregnancy [22,23]. In fact, a number of studies have found that younger girls desire pregnancy more than their older counterparts [1,13]. For instance, in Lebanon, 80% of married Syrian girls aged 14 to 18 indicated that they wanted to get pregnant at the time of interview and they were least likely to want to prevent pregnancy in comparison to other age groups [1]. A 2012 United Nations report mirrored these findings; in developing countries, 22% of married (or "in union") adolescent girls aged 15-19 used contraceptives, in comparison to 61% of women aged 16 - 49 [13].

Existing studies also show that pre-conflict awareness/ use of contraception, prevailing beliefs from the host country, and access to SRH services all influence women's perceptions of contraception [8]. In pre-conflict Syria, most primary care and SRH services were free [24] and estimates of contraception use ranged between 54% and 60% with approximately 84% of FP needs being

met [25-27]. Among displaced Syrian families, on the other hand, cost and access have been identified as important barriers to SRH care. Although the United Nations High Commissioner for Refugees (UNCHR) provides subsidized SRH care, contraception remains expensive, particularly when families lack employment opportunities and struggle to meet their basic needs [1]. Independent of cost, access also remains an issue and in Lebanon only 33% of participants thought SRH services were easily obtainable [26]. Despite increased efforts to provide information on FP and SRH, few girls are able to attend programs because they are often not allowed to leave home without an accompanying male adult [27,28]. Even when Syrian girls and women do access services, they often perceive that they are judged and mistreated [29] as well as viewed negatively by Lebanese health care providers [8]. Misinformation about harmful side effects as well as banning of contraception by husbands and family members were identified as barriers to FP uptake in pre-conflict Syria and continue to be cited by some refugees after displacement [25-27].

Earlier research also provides insight on current FP usage as well as knowledge and attitudes about FP among displaced Syrian refugees. In 2014, only 35% of Syrian participants in Lebanon were using FP [26] and in Turkey, 38% of participants had an unmet contraceptive need [15]. In Jordan many women accepted FP, but beliefs about fertility hindered use of available services, particularly among younger participants [27]. In a different study, 39% of adolescent girls and boys in Lebanon reported that they did not believe in contraception, possibly due to religious reasons and secondary to a desire to replace children who had died in the conflict [23]. However, females perceived contraceptive use to be more acceptable than males did [23]. Research has also identified misinformation about the possible complications of contraception to be common among displaced Syrian families [30,31] and it has been reported that approximately two-thirds of Syrian girls and boys had not received information regarding contraception [23].

Apart from the studies cited above, there is little research exploring Syrian women's and girls' perceptions about FP. Recent reviews note insufficient qualitative and quantitative research on SRH among female adolescents in particular [32,33]. The United Nations has also stated that qualitative research is required in conflict-affected Arab countries to inform policy development [30]. To address these gaps in the evidence base, we analyzed

focus group discussions (FGD) to critically explore the knowledge, attitudes and perceptions around FP among Syrian refugees in Lebanon. Our overarching aim was to identify barriers to accessing FP and to explore its acceptability in an effort to inform SRH services and policies for displaced Syrian women and girls.

Methods

The current work builds on an earlier cross-sectional survey conducted in 2016 examining child marriage among displaced Syrian families in Lebanon [5]. Results from that 2016 study were presented back to Syrian women, girls and men in a series of FGDs in January 2017 to elicit their understanding of the data and to inform future community-based strategies to address child marriage. Recognizing that maternal morbidity and mortality could potentially be reduced by delaying maternal age at first pregnancy and by increasing pregnancy spacing among young brides, questions about FP were incorporated into the women's and girls' FGDs. The purpose of the current analysis is to identify knowledge, attitudes, and perceptions towards FP among Syrian refugees.

Qualitative data collection

The ABAAD Resource Centre for Gender Equality and Queen's University hosted 10 FGDs in January 2017. ABAAD is a Lebanese non-profit civil association that promotes equality, protection and empowerment of women. One FGD was held with Syrian girls, one with Syrian mothers and one with Syrian fathers in each of Beirut / Mount Lebanon, Tripoli and Beqaa Valley, the exception being that there were two FGDs with women in Beqaa Valley. A semi-structured FGD guide was written in English and translated to Arabic. Translation was independently verified by a native speaker. Each FGD was facilitated by a member of the ABAAD team who had expertise in working with vulnerable women and girls. All discussions were in Arabic, lasted approximately two hours and were audio recorded with permission of the participants. Audio files were later transcribed and translated from Arabic to English for analysis. SM, CD, and SB all assisted with data collection.

Thematic analysis of FGDs

To highlight different opinions, perspectives and complex themes, the FGDs were thematically analyzed (R) using the approach described by Clarke and Braun [34]. After reading the entire transcripts and marking the text with broad labels, sections relevant to the research question on early pregnancy and FP were identified and then pasted into separate Microsoft Word documents.

Each document was printed and manifest codes were identified by hand. From these first order codes, potential themes were generated. The themes were discussed with a co-author (MD) and were then compared across FGDs with the aim of producing meaningful interpretations.

Ethical review

All FGD participants gave informed consent to participate in this research. No identifying data were collected. Participants were provided with light refreshments during the FGDs and transportation costs to the FGDs were paid by the study team. No financial or other compensation was provided. Audio recordings and subsequent transcripts were stored securely on password protected computers and were encrypted prior to sharing among team members. Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board approved the original data collection (protocol: 6020027). The first author's MSc Ethics Committee granted approval for this analysis (London School of Hygiene and Tropical Medicine reference number: 15001).

Results

A total of 10 FGDs were conducted in Beirut, Tripoli, and Bekaa Valley and the number of participants per group are provided in table 1.

Table 1: Summary of FGDs with number of participants per group.

Location	Participants	Number of Attendees
Beirut / Mount Lebanon	Girls	12
	Women	16
	Men	9
Beqaa Valley	Girls	2
	Women FGD1	15
	Women FGD 2	15
	Men	11
Tripoli	Girls	3
	Women	12
	Men	4
Total		99

Women's and girls' FGDs

Four key, interconnected themes relevant to FP emerged from the women's and girls' FGDs. Each of these

is presented below.

Theme 1: Decision-making around contraception use and fertility expectations

Pressure from husbands and in-laws to conceive a child was reported to significantly influence women and girls' decision-making around contraception use. For instance, women and girls revealed that the choice to use contraception was not solely theirs, and that they would not use contraceptives without their husband's consent, due to traditional and cultural values. However, some women claimed that they could decide to use contraceptives if their husbands were not "strict or violent" (Beirut Girls FGD).

Women also reported that a man may oppose contraception use if he does not have a son to carry on the family name and in fact, some husbands had threatened to leave their wives if they did not produce a child.

"So women are subject to yelling and humiliation and threat that the man will marry another woman. So she is forced to give birth."- (Beirut Girls FGD)

When asked if there was pressure to give birth even if under the age of 18, most participants agreed that there was. Participants reported that the husband's family, particularly the mother-in-law, sometimes pressured them to bear children. One participant contradicted this, however, stating that the decision to get pregnant was hers.

"If they [husbands] allow them [in-laws] to interfere, then yes there is pressure from man's family mainly." - (Beirut Women FGD)

The above quote suggests that while in-laws play a role in pressuring girls to give birth, the husband may ultimately be able to mediate this pressure.

Societal pressure to have children was also discussed, with many women reporting that they could not use contraception until they had had one or two children. Some women stated that this trend was also prevalent in Syria before the conflict.

"In Syria, they advise her to take contraceptives after having two babies." (Beirut Women FGD).

Theme 2: Recognition of physical and emotional

immaturity for marriage and childbearing

Both women and girls reported that girls' bodies were not ready for early marriage and its consequent sexual relations and childbirth. One participant said:

"Marriage is an ugly thing. I don't know if a girl can handle it because her body cannot handle it." (Tripoli Girls FGD)

Many other participants reiterated this sentiment. In fact, there were many examples of women and girls believing that young bodies could not "endure" the physical consequences of marriage (whether they are referring to sexual intercourse, pregnancy, birth or some combination is not clear). One child bride reported experiencing dizziness and severe bleeding while she attempted to get pregnant under extreme pressure from her husband to conceive.

"[A girl should marry] when her body is mature enough to endure, when she is young she cannot endure." (Beirut Girls FGD)

"[Marriage] could put her in danger. Her body cannot endure so she might die." (Beirut Girls FGD)

Theme 3: Attitudes about and knowledge of FP methods and services

As reported above, the decision to have children, and in turn, attitudes towards contraception, were influenced by pressure from husbands and in-laws to conceive. However, disparate views emerged. In response to being asked if they would use contraception, one participant reported that her mother's experience of handling many children made her want to restrict her own family size. Another girl stated that her love of children meant that she *"would not use them [contraceptives]"* (Tripoli girls FGD). In one instance a girl said contraceptives should be used to control population levels.

A desire to control their fertility, in terms of number of children and maternal age at time of childbirth, was also evident. When asked how many children they wished to have, the majority of responding girls indicated a maximum of three.

"If she was young in age it is better if she delays having a baby." (Beirut Women FGD)

"I wouldn't use them [birth control methods], I love

children...but one or two children are enough." (Tripoli Girls FGD).

Knowledge of FP emerged as two subthemes:

1. Knowledge of the services available and how to access them

There were varying opinions with regard to the availability and accessibility of contraceptives for Syrian refugees in Lebanon. Multiple women and girls stated that intrauterine devices (IUD) and oral contraceptive pills (OCPs) were available through dispensaries, doctors (specifically gynecologists), and non-governmental organizations (NGOs) such as ABAAD and international agencies, regardless of women's/girls' age. However, some participants reported negative experiences with an international NGO, including having to provide family registration documents to be eligible for contraception and requiring monthly visits to get OCPs to ensure that pills were not sold for profit. Other women reported that Lebanese healthcare personnel did not provide contraceptives unless the individual could prove that she was married and already had one or two children. It was unclear whether participants were speaking from personal experience, or whether this was a belief in the community.

"Even a mother of one child they don't give them contraceptives." (Beqaa women and girls FGD)

"She cannot use an IUD unless she has two kids." (Beqaa women and girls FGD)

Women also reported that transportation was a barrier to accessing contraceptives. Participants mentioned that there are dispensaries in various areas, but when asked if married women could access OCPs, one participant noted *"some live in far places, we need transportation, but if we need them we get them." (Beirut Women FGD)* Many also claimed that their mobility was restricted by male relatives due to fear of sexual harassment and assault, and this likely represented another barrier to accessing contraceptives.

2. Knowledge of contraception types and their side effects

Women and girls were clear about their lack of FP knowledge. A considerable number of women said, *"we didn't know anything"* about FP before getting married (Beirut Women, Beqaa Women and Girls FGDs). One

participant gave an example of her friend taking two birth control pills twice daily because she was unaware of how to use them. Misinformation regarding the side effects of contraceptives was also prevalent. Some women reported a belief that contraceptives could cause infertility, while others were aware that they solely delayed pregnancy. In terms of preference for contraceptive methods, there was some agreement in the Beqaa women and girls FGD that IUDs were preferred, with one participant saying, *"The most comfortable contraceptive for women is an IUD"* (Beirut Women FGD). However, one participant mentioned that contraceptive choice was dependent on the woman's body.

Theme 4: Sources of SRH information

Awareness of FP did not seem to stem from any formal education programs. Girls reported speaking to their mothers about FP and women with children corroborated this. Other women, however, were skeptical and said that aunts were in a better position to discuss SRH with young girls.

"Your mom is like your friend. You can ask her or you can ask an older person like your aunts and grandma." – Beirut Girls FGD

"Some girls are shocked when they hear about these things...but these things are better if they hear them from their aunts." (Beqaa Women and Girls FGD)

In other cases, girls claimed they learned about SRH from their older friends. In one instance, a woman reported that girls who do not have friends are more likely to be unaware of SRH.

"If they are not social, they will not know anything." (Beirut Women FGD)

Men's FGDs

The purpose of the men's FGDs was to discuss the earlier results around child marriage and men were not directly asked about FP. However, some of the men's discussions related to child marriage and its associated health consequences are relevant to the research question and are therefore included in the analysis.

One key theme emerged concerning recognition of physical and emotional immaturity for marriage and childbearing. Like girls and women, men also suggested that young brides are not physically or emotionally mature

enough for marriage and childbearing. For instance, men in all three FGDs spoke about how young girls were immature and were unaware of marital obligations. A few male participants told stories about how some husbands abandoned their young Syrian wives, pointing out that the girls were not emotionally or physically strong enough to raise children, especially alone. The following two stories were about young girls left to raise their children on their own:

"My 14-year-old daughter married her cousin and she got pregnant directly. He didn't know what she wants, how to treat her, and now she is back home." (Beqaa Men FGD)

"With young girls it is difficult because she is not mature enough to understand what is happening." (Beirut Men FGD)

Results also point to men understanding the toll that childbearing under the age of 18 can have on girls.

"Below the age of 18, no she can't, she will suffer, she will get tired in her life, at the age of 20 she will be old." (Tripoli Male FGD)

One participant contradicted this and stated that maturity level is associated with the individual girl, and not necessarily age. He stated that in some cases, a 14 or 15-year-old girl is better suited to take care of her husband than an older woman.

Recommendations for change from male and female FGDs

Both male and female participants provided insights on potential interventions for change. For example, Syrian women and girls agreed that 'girl groups' (as introduced by NGOs in other contexts) could provide valuable support for girls in Lebanon. Many participants reflected on the importance of social support and education for girls, with some mentioning that safe education (meaning they can get to and from school without coming in harm's way) would help to better their situations.

Participants clearly felt that increased awareness about early marriage and its associated health consequences would help to protect girls, and many expressed the belief that awareness raising should target men and boys, who are often the major decision-makers. Additionally, some participants suggested that information on SRH be disseminated through brochures, television shows, and campaigns.

*"So awareness should be for parents, especially fathers."
(Beirut Women FGD)*

*"We should go to every Syrian home and provide awareness for the mothers because she is the role model of the girl."
(Tripoli Girls FGD)*

Participants also discussed their perceived lack of protection from sexual assault and harassment, specifically indicating that the Lebanese government did not protect them and they were left to rely on external organizations for help.

Discussion

With 99 participants across three geographic locations and including the perspectives of women, girls and men, the current work analyses knowledge, attitudes, and perceptions towards FP among Syrian refugees in Lebanon. The data were collected within a larger discussion around child marriage, thereby situating the results and contributing to the evidence base about access to FP for child brides and for young couples. Overall both male and female participants agree on raising awareness about FP among girls and their parents while also emphasizing the importance of concurrently creating job opportunities to reduce financial hardships, and increasing girls' educational opportunities to prevent early marriage. Although SRH services exist for Syrian refugees in Lebanon and numerous organizations provide contraceptives, the results highlight important barriers to accessing FP, and Syrian women, girls and men all perceive an unmet need for comprehensive SRH care.

Avenues for change

Based on the results above, recommendations for improving FP services for Syrian refugees in Lebanon are situated within the 'Framework for Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights' as illustrated in figure 1. Developed in 2012 and intended to provide high-standard, available, accessible, and acceptable FP services in diverse settings, the framework is based on the three tenets of SRH rights outlined by Erdman and Cook "the right to sexual and SRH services, information, and education" [35,36].

Policy level

Our results identify multiple policy-level barriers that impede Syrian refugees' access to FP services in Lebanon, and according to the above framework, addressing such policies is important for improving SRH

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services [36]. Participants in this qualitative study noted economic hardships for refugees in Lebanon, which is highly relevant since cost is an important barrier to contraceptive use [20,29,37,38]. In Lebanon, patients must pay a portion of the health care fees out-of-pocket [39], and with Lebanon's relatively expensive health care system along with UNHCR's reduced subsidization of health services [40], the required fees are prohibitive for some individuals. Further, Syrian refugees do not have the right to work in Lebanon since Lebanon is not a signatory to the 1951 Refugee Convention [41], which greatly exacerbates the economic need of many families. Therefore, working with the Lebanese government and UNHCR to ensure that healthcare is affordable for all refugees is a necessary first step in improving SRH services for displaced Syrians.

Service level

The framework's first and second service level recommendations pertain to FP-related advice from professionals, stating that SRH discussions should be of high-caliber, should be delivered with respect, and that healthcare providers should be trained on SRH rights. However, our results show that this level of SRH service provision is often perceived to be lacking in Lebanon with some refugees citing negative experiences with health care providers, including having to prove that they had met particular criteria (marital status and/or having had at least one child) in order to receive contraception. Participants also reported negative interactions with a high-profile NGO which was perceived to limit access to OCPs out of fear that recipients would sell them for profit. As a result, the NGO reportedly required women to visit the clinic monthly to get a four-week supply, which was highly problematic from economic, safety and practical perspectives. While it is quite possible that OCPs were sold for profit at some point, particularly given the economic strain faced by many Syrian families in Lebanon, introducing an across the board policy that negatively impacts access to contraceptives, may undoubtedly cause harm. If such policies do exist, we recommend that organizations and healthcare providers consider other options and work with Syrian women and girls to better understand how to meet their SRH needs while also working to ease the economic strain that would lead to OCPs being sold for profit.

The framework's third service provision recommendation is that providers should use unique approaches to ensure that at-risk populations like refugees are able to access FP. One such example is

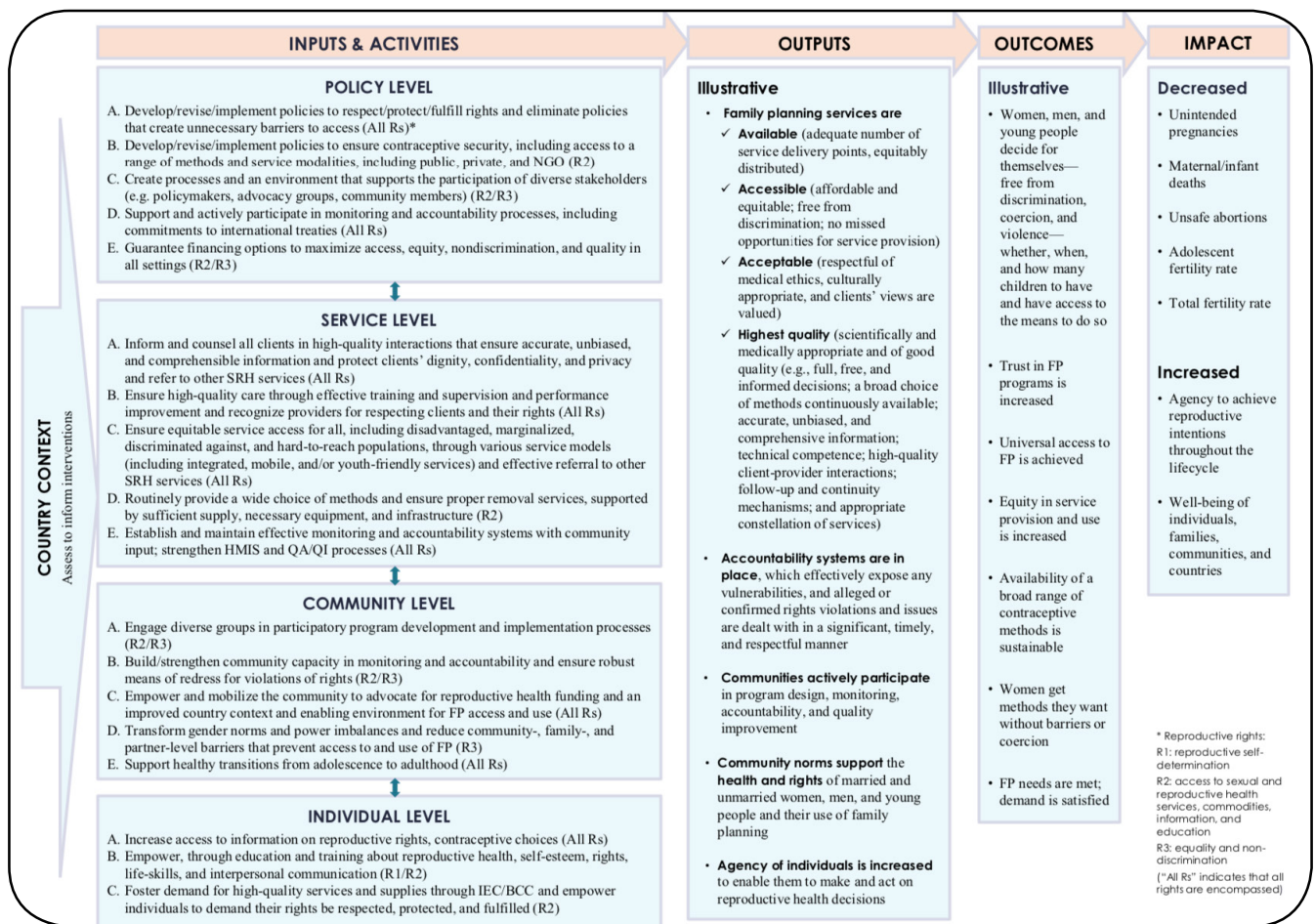


Figure 1: Framework for voluntary family planning programs that respect, protect, and fulfill human rights (Hardee et al., 2012, used with permission of corresponding author).

mobile clinics, which have been recommended based on a number of studies [42-44], and would address some of the concerns raised by participants in this study, namely transportation, restricted mobility, and knowing where to go. Other research supports the use of mobile clinics for Syrian refugees in Lebanon reporting that it mitigated barriers such as women’s restricted movement, cost, and transportation [43]. In 2012, the International Rescue Committee reported that approximately 10,000 Syrian and Lebanese women had accessed mobile clinics in Lebanon, thus indicating acceptance for this model of care [45]. Adolescent-specific programs are another of the framework’s recommendations and there seemed to be support for adolescent programs among participants in our FGDs.

Community Level

The current work highlights the need to raise awareness about FP among Syrian girls and young women and a variety of dissemination strategies could be useful. While some mothers reported being

comfortable talking to their daughters about SRH, others were not. Furthermore, UNFPA previously reported that some girls were told about SRH just a few days prior to their weddings but that the girls themselves would have liked to have had information earlier [46]. In that study, mothers agreed with their daughters, stating that young girls required education on pregnancy and childbirth. In this respect, our findings are similar to those of others, and collectively the data indicate that formal SRH education programs are necessary and desired (at least by women and girls). Such FP information sessions could be hosted by NGOs in schools, abandoned buildings, or informal tented settlements [47]. Television programs could also raise awareness around FP although just one participant suggested this, not everyone will have access to a television, and the effectiveness of TV programs to disseminate SRH information remains unclear [22]. SRH information brochures were also recommended in the current FGDs. However, reports have indicated low literacy rates among female Syrian refugees in Lebanon which would be a barrier to disseminating health-related information in this way [22,48]. On the

other hand, guidelines exist for the use of culturally appropriate pictures when sharing SRH information among populations with low literacy skills [49] and this may be a more effective means of sharing information in this context. Finally, many Syrian refugee families in Lebanon have a mobile phone and use apps such as 'WhatsApp' [22], raising the possibility of using technology to disseminate SRH information. However, cell phones are often shared and tend to be controlled by male family members, service may be inadequate, and there is no formal directory of telephone numbers.

It is noteworthy that despite some recognition of a need for FP programs for Syrian girls, the authors' (SB and CD) earlier discussions with local NGO stakeholders in Lebanon consistently concluded that it would not be culturally appropriate to talk to unmarried girls about SRH. The discrepancy between participants in the current FGDs requesting SRH programming for Syrian girls and the NGO sector's perception that parents would not support unmarried girls attending such programs warrants further research. A participatory approach ought to be considered to understand what sorts of SRH education programs would be acceptable and how to deliver them in a culturally and contextually sensitive way.

Engagement of men and boys around FP is also key since they hold much of the decision-making power around contraceptive use, and ideally men and boys also would attend FP awareness programs [36]. In addition to programs focused on FP, gender sensitization is also needed to address community-level inequitable gender norms that create "power imbalances," and prevent women and girls from being able to negotiate for their own SRH [36].

Individual level

The framework's final recommendation advocates for programs to empower women and girls to increase their say in their own SRH through educational programs aimed at improving self-esteem and communication skills. Many Syrian children in Lebanon do not attend formal school because parents fear for their safety and because of the associated costs [47]. Additional efforts are therefore needed by the Lebanese government as well as international and Lebanese communities to ensure that all refugee children have affordable and safe access to education. In situations where access to formal education is not feasible, 'girl groups' may be a valuable alternative for empowering female adolescents.

Strengths and limitations

This study has several important limitations. First, we used a convenience sample of women, girls and men who were accessing programs and services provided by ABAAD. However, in light of previous findings, there is no reason to assume that the themes which emerged are specific to the participants in the current study. Second, the FGDs were primarily intended to explore results from an earlier study on child marriage [5] and therefore FP was not the sole focus. As a result, details on knowledge, attitudes, and perceptions towards FP were possibly less rich than they may otherwise have been. Additionally, it proved difficult to recruit girls for the FGDs and some participants were somewhat hesitant to talk about FP given the sensitive nature of the topic. Finally, the FGDs were conducted in Arabic with transcripts translated into English for analysis. It is possible that some details and nuances were lost in the translation process.

This study also has several strengths, including the fact that women, girls and men were all included, refugees from three different geographical locations were represented and that the analysis was gender- and age-specific. Also, because the FGDs were conducted through a community-based partner known to the participants, this likely increased trust and allowed participants to speak more openly and comfortably. And finally, because the discussion of FP was situated within a larger discussion of child marriage, the results are particularly relevant to child brides and for young couples.

Conclusions

Our data suggest that Syrian refugee families in Lebanon face a number of barriers to affordable, acceptable, and accessible FP services including external pressure for young wives to conceive / prove their fertility and lack of comprehensive SRH education for girls. Cost and restricted movement for women and girls were also identified as important obstacles to accessing SRH care. Improved access to FP for Syrian refugees in Lebanon should be made at policy, service-, community- and individual levels.

Declarations

Ethics approval and consent to participate

The Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board approved the original data collection (protocol: 6020027). The London School of Hygiene and Tropical Medicine (RJ) MSc Ethics

Committee granted approval for this analysis (reference number: 15001).

Consent for publication

Authors give their consent for publication in *Current Opinions in Gynecology and Obstetrics*.

Availability of data and material

Available upon reasonable request to corresponding author.

Competing interests

None of the authors have any competing interests to declare.

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Authors' contributions

SB conceived of the original study. SB, SM and CD assisted with the FGDs. The literature review and thematic analysis was conducted by RJ with the support of MD. RJ drafted the initial manuscript with all authors contributing to writing. All authors read and approved the final manuscript.

*RJ undertook the analysis while a Master's student at the London School of Hygiene and Tropical Medicine and obtained the data from SB at Queen's University.

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