





'We are trying to live in a normal way, but nothing is normal about us anymore...': a qualitative study of women's lived experiences of healthcare in opposition-controlled areas of Syria

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To cite: Alhaffar M, Hamid A, Douedari Y, *et al.* 'We are trying to live in a normal way, but nothing is normal about us anymore...': a qualitative study of women's lived experiences of healthcare in opposition-controlled areas of Syria. *BMJ Global Health* 2022;**7**:e008812. doi:10.1136/bmjgh-2022-008812

Handling editor Seye Abimbola

► Additional supplemental material is published online only. To view, please visit the journal online (<http://dx.doi.org/10.1136/bmjgh-2022-008812>).

Received 13 February 2022
Accepted 10 June 2022



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ABSTRACT

Introduction The Syrian conflict, which has included mass killings, displacement, infrastructure destruction and illegal targeting of health facilities and staff mainly by the Syrian government and allies, is in its 10th year. This study explored the lived experiences of women within healthcare, both as health workers and service users, in Syrian opposition-controlled areas (OCAs).

Methods We chose a qualitative study design, with 20 in-depth interviews conducted remotely over WhatsApp and Messenger with purposively sampled Syrian women (ie, 15 health workers, 5 service users). We analysed data using interpretative phenomenological analysis.

Results Anxiety, fear and horror affected women's everyday work and wellness. Excess workload and insecurity were major challenges for women health workers, who also had household and caring responsibilities. Coping mechanisms included: (1) normalising death; (2) acceptance of God's will; and (3) focusing on controllable issues such as health services provision while accepting the reality of insecurity and death. Conflict contributed to changing social norms and expectations, and women became key actors in healthcare provision, though this did not translate directly into greater decision-making authority. Structural biases (eg, lack of maternity leave) and gender-based violence (eg, increased harassment and child marriage) inordinately affected women.

Conclusion This is a first effort to amplify women's voices in health policy and systems research on the Syrian conflict. Women have become key healthcare providers in OCAs but remain under-represented in decision making. While the conflict-related social transformation, increasing the role of—and demand for—women health workers could be viewed positively for women's empowerment, the reality is complex and long-term implications are unclear.

INTRODUCTION

Syria's rich socioreligious diversity and inherited norms have shaped the experiences and expectations of Syrian women.^{1 2} Women's

WHAT IS ALREADY KNOWN ON THIS TOPIC

- ⇒ There has been minimal examination of women's experiences in healthcare spaces in opposition-controlled areas in Syria and virtually no amplification of their voices in research.
- ⇒ The Syrian conflict is complex and has both helped and hindered gender equity and women's space for action.

WHAT THIS STUDY ADDS

- ⇒ This is a first attempt to document some of the complexities of women's lived experiences as healthcare providers and service users during protracted conflict in Syria.
- ⇒ Women's lives are affected by physical insecurity, overwhelming workloads, and normative gender roles and social expectations that have been exaggerated by ongoing multiparty conflict, from local travel restrictions and risks to early/arranged marriages and potentially severe stigma or punishment for being harassed/raped.
- ⇒ Increased employment opportunities do not appear to have enabled increased social empowerment or leadership opportunities.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

- ⇒ Women suggested practical mitigation, such as flexible shared schedules and life insurance, to help them continue within extremely challenging work environments.
- ⇒ Interventions and research must incorporate intersectional approaches and avoid erasing lived experiences.

historic participation in the public sphere included Nazik al-Abid establishing the Syrian Red Crescent Society in 1920,³ resistance to the French *Mandat pour la Syrie et le Liban* occupation (1923–1946)⁴ and Syria being first regionally to recognise women's political

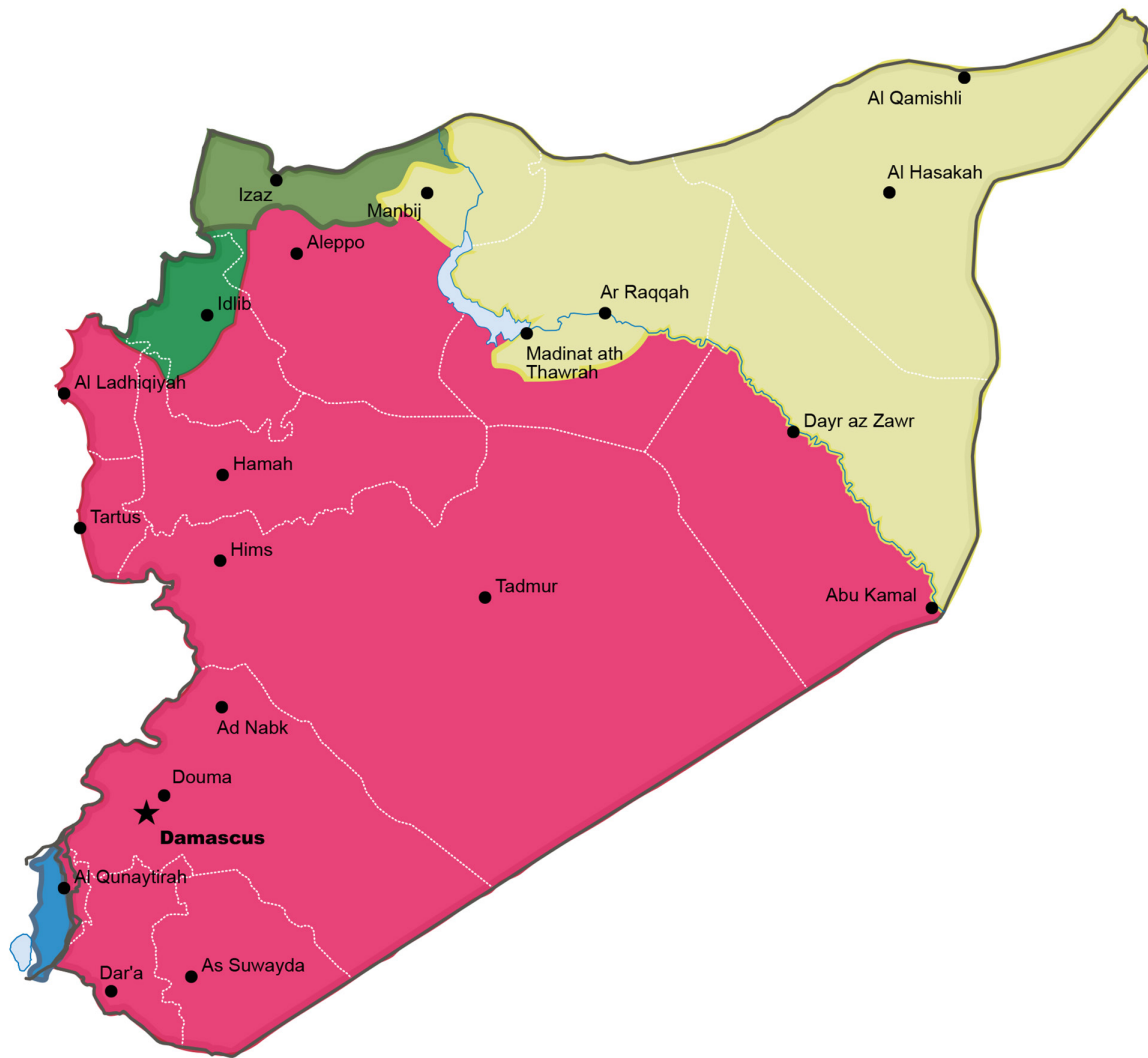
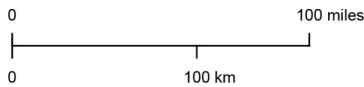


Figure 1 Syria map, indicating main areas of military control, April 2022.

NB: Autonomous administration controlled areas (AACAs) is in yellow; Government controlled areas (GCAs) is in red; Opposition-controlled areas (OCAs), along with Turkish-controlled areas, are in green. Source: Noor Albeik, 2022. Additionally, an open-access regularly-updated map can be found at <https://syria.liveuamap.com/>

rights in 1949.⁵ Similarly, during the 2011 Syrian uprising, women participated effectively in non-violent activities challenging the discriminatory and patriarchal norms.^{5 6}

As peaceful uprising morphed into complex, multi-sided revolution/civil conflict/proxy war, discriminatory violence against women has been amplified by all conflict actors.^{5 7} A decade of armed conflict has decimated Syria and its health system, fragmenting both among several areas of military control (figure 1). We use the term ‘opposition-controlled areas’ (OCAs) to refer to areas controlled militarily by several armed opposition groups^{1 8 9} or Turkish forces. The ongoing multi-party conflict has reduced OCAs boundaries in the last 5 years, for example, Eastern Ghouta is no longer opposition controlled.¹⁰ Autonomous Administration forces control parts of Syria’s northeast, and the remaining approximately 60% of territory is controlled by the

Syrian government supported by Russian and Iranian forces.^{1 8 11 12} Healthcare became politicised and weaponised through systematic human rights violations, including targeting of health workers and infrastructure mainly by the government and its allies.^{9 13–15}

Protracted conflict reinforced gender inequalities, posing disproportionate risks for Syrian women and girls.^{5 16} Many have been widowed, divorced or separated as men were killed, detained or left the country, and women and children constitute the majority of internally displaced Syrians.^{6 16} Women experience gendered risks during conflict, including gender-based violence (GBV), persecution and imprisonment,^{17 18} in addition to lower pay, fewer leadership opportunities and responsibility for most unpaid household/caring work.¹⁹ However, despite increasing literature on health and the Syrian conflict, health worker and service user voices—if included at

all—are primarily male.^{9 14 20} The limited literature on Syrian women’s healthcare experience in OCAs generally consists of reproductive health or COVID-19 issues, without explicitly considering gender or related power dynamics.^{21–24}

This study aimed, as initial corrective, to explore women’s lived experiences and perspectives of healthcare in opposition-controlled Syria during ongoing conflict. Objectives were to: (1) describe women’s experiences as health workers and health service users in this insecure setting; and (2) consider opportunities for greater health system equity for women as health workers and service users.

METHODS

Study design and methodological approach

We chose a qualitative study design, drawing from in-depth interviews with women health workers and health service users in OCAs, focusing on commonalities of women’s lived experiences. We adopted an interpretative phenomenological approach, informed by Smith *et al*²⁵, to examine how the experience of conflict and involvement in the Syrian uprising affected the space for women in healthcare, both as providers and recipients.

Research question

The research question was intentionally broad: ‘How have women experienced their roles as healthcare providers and service-users within the OCAs health system during the conflict?’.

Sampling and recruitment

Eligible participants were women who had: (1) provided healthcare services for at least a month in OCAs since the start of the Syrian uprising in 2011; or (2) received healthcare services at least once in these areas and time period. Given inherent difficulties and inappropriateness of identifying biological sex for this study, we chose the term ‘gender’ throughout for expressed identity.²⁶ We purposively selected interviewees to provide a range of roles and experiences within opposition-controlled health facilities. MA and YD drew on their professional contacts in OCAs to recruit eligible women. Interviewees were further snowballed for a broader range of providers and service users.

Data collection

MA obtained informed consent and conducted in-depth interviews in Arabic, between July and August 2019, using separate topic guides for health workers and service users. We developed topic guides, information sheet and consent form in English and translated them into Arabic. Topics included perceived health system challenges, solutions and adaptations, participation, and transparency, allowing scope to explore emerging concepts. MA did not have prior relationships with interviewees, and no incentives were provided.

After introduction by a mutual acquaintance, MA conducted an informational call with each potential interviewee to allow time to review study information sheet and consent form, discuss study objectives and researcher background, ask any questions and decide on participation. Only two eligible interviewees chose not to participate and did not provide reasons. As only four interviewees were able to send electronic copies of signed consent forms, MA recorded verbal informed consent for all interviewees prior to interview. Confidentiality and anonymity were ensured by not recording names, removing any identifying data during transcription and using identity codes in all transcripts and outputs. Privacy was ensured by conducting interviews remotely using internet apps (ie, 18 via WhatsApp, 2 via Facebook Messenger) at times chosen by interviewees.²⁷

MA conducted interviews in colloquial Syrian Arabic, taking detailed notes, and recording all but one—who refused—using an encrypted digital audio recorder. Interviews lasted approximately 60 min. MA had excellent access, so due to time and resource limitations, we determined data saturation when no new topics or conceptualisations arose in interviews.²⁸ MA reassured interviewees that they could stop at any time and skip any topics. We stored data in encrypted password-protected institutional servers only accessible to our team.

Analysis

MA transcribed interviews in colloquial Arabic and analysed them manually with AH according to the six phases described by Smith *et al*: (1) reading and rereading; (2) initial noting; (3) developing themes; (4) searching for connections across themes; (5) moving to the next case; and (6) looking for patterns across cases.²⁵ MA developed themes, connecting them with the help of AH and NH, using a combination of abstraction, subsumption, polarisation and contextualisation according to question guide topics and interview notes.²⁵ Analysis focused on commonality of lived experiences of conflict among women, with relevant quotes translated to English by bilingual coauthors. Themes were critically reviewed by NH, and discrepancies were agreed between investigators. Reporting adheres to Consolidated criteria for Reporting Qualitative research criteria.²⁹

Reflexivity

This interpretative study emphasised empathy, openness, questioning preunderstanding and adopting a reflective attitude.²⁵ The process of examining gender is itself imbued with power relations, including who collects and analyses data, who participates, when and where data are collected, who is present and where data are published.^{30 31} MA was able to conduct interviews with Syrian women health workers and service users as a Syrian pharmacist who provided healthcare

during the conflict. This increased access, trust and rapport-building with interviewees, who were able to share their experiences in their own dialect with a women researcher who shared their religiocultural background yet was not so close that interviewees were worried about confidentiality within their communities. This balance elicited rich descriptions of lived experiences and sensitive issues. Given MA's similarities with interviewees, she used reflective writing and team discussion throughout to examine theories and assumptions and maintain a critical stance.³² This is distinct from bracketing, as assumptions are part of sociocultural understanding and should not be automatically discarded.³³ Please check Supplementary Appendix SA1.

Patient and public involvement

We developed and implemented research guided by an advisory committee of Syrian academics, healthcare practitioners and laypeople. All members had experience of the OCAs health system as providers or patients and helped reflect public priorities and preferences. We included service user (patient) interviewees, conducted Arabic dissemination webinars for OCAs, ensured open access publication and will host translated materials at <https://scahr.org/>.

Ethics

Due to the difficult circumstances of women interviewed, we emphasised the voluntary nature of participation,

provided additional opportunities to interrogate the study and researchers, and remote referrals to an Arabic-speaking, London-based psychotherapist, experienced in trauma counselling and paid from research funds. Of the three referred, two subsequently cancelled and one disengaged after two sessions to flee increased bombardment.²⁷

FINDINGS

Interviewee characteristics and themes

Table 1 provides interviewee details. To preserve anonymity, we only reported aggregated characteristics. Seventeen were based in OCAs (ie, Idlib city, rural Idlib, rural Aleppo, rural Damascus during its control by opposition forces), while two providers and one service user had recently migrated from OCAs to Turkey and Germany, respectively. Interviewee ages averaged 34 years (range 25–50 years), 16 were married and 14 had children. Ten were health workers employed in more than one facility.

Findings are organised under three overarching themes: (1) gendered effects of the conflict, (2) gendered healthcare employment concerns; and (3) challenges within foreign humanitarian responses. We found, as most interviewees were health workers and all were potential service users, that reporting perspectives separately by group was unhelpful. Instead, we highlighted any differences noted.

Table 1 Interviewee characteristics

ID	Profession	Location	Facility type	App
HP1	Nurse	Idlib	Hospital	WhatsApp
HP2	Nurse	Idlib	Hospital	WhatsApp
HP3	Specialized doctor	Idlib	Hospital	Messenger
HP4	Midwife	Idlib	Field hospital	WhatsApp
HP5	Nurse (non-clinical)	Eastern Ghouta	Primary health facility	WhatsApp
HP6	Pharmacist	Idlib	Private pharmacy	WhatsApp
HP7	Midwife	Idlib	Clinic	WhatsApp
HP8	Specialized doctor	Rural Aleppo	Hospital	WhatsApp
HP9	Nurse (non-clinical)	Eastern Ghouta	Field hospital	Messenger
HP10	Pharmacist	Idlib	Hospital	WhatsApp
HP11	Midwife (non-clinical)	Western Ghouta	Field hospital	WhatsApp
HP12	Lab technician	Idlib	Hospital	WhatsApp
HP13	Nurse	Idlib	Private hospital	WhatsApp
HP14	Specialized doctor	Idlib	Maternity hospital	WhatsApp
HP15	Nurse	Idlib	Maternity hospital	WhatsApp
SU1	Unemployed	Rural Aleppo	Hospital	WhatsApp
SU2	Local non-governmental organization (NGO)	Rural Aleppo	Hospital	WhatsApp
SU3	Pharmacist	Idlib	Hospital	WhatsApp
SU4	Teacher	Idlib	Hospital	WhatsApp
SU5	Media officer	Idlib	Hospital	WhatsApp

Gendered effects of conflict

Two inductive subthemes were: (1) changing social norms; and (2) GBV.

Changing social norms

Providers explicitly described changes in social attitudes towards working women and the complexities this added to women's social roles. Patriarchal norms remained, such as underestimating women doctors' qualifications, underestimating nursing as a profession or considering it inappropriate for women. However, the conflict imposed additional needs that favoured working women.

Women's situation is better now. They have more chances to work [...]. Previously, it was hard for women to get a job. Now it's the other way around. The situation [conflict] imposed this change. HP15

Increasing demand for women health workers was due primarily to major health worker losses because of deaths and emigration and partly to increasing radicalisation among armed groups, resulting in some husbands not wanting, or not allowing, their wives to be examined by a male doctor.

Women would die of some disease because their husbands wouldn't allow them to be checked by a male doctor... SU4

Due to the low numbers of women gynaecologists and high demand for women to be examined by women, healthcare managers intentionally recruited female doctors whenever possible.

This new attitude increased women's employment chances. They [managers] prefer female professionals in health facilities. HP4

Some providers also described how the conflict had forced them to develop strong leadership skills so they could support their families. Two dissenting interviews described patriarchal Syrian traditions positively, in that men usually prioritised women and helped them as a way of demonstrating protection.

We as women don't suffer from oppression. I have my own car. There is no harassment, just respect. I don't feel anything bothering me [as a working woman]. Currently, it's not acceptable for men to work as gynaecologists. Women work in jobs that are suitable for them and vice versa. There is balance. HP7

Gender-based violence

Views on what constituted sexual harassment or assault and ways these had changed or increased were mixed. An interviewee mentioned a young girl who was raped and later found drowned, without clarifying whether this was suicide or murder. Another discussed a girl raped by boys in a displacement camp, suggesting overcrowding was to blame rather than perpetrators.

Women described varied management reactions to sexual assault in hospitals. In one case, the woman married her perpetrator, though it was unclear whether this was her choice. In another, management initiated

a formal investigation and the perpetrating doctor was subsequently prohibited from working in any OCAs health facility. One described the challenges of reporting harassment, as it would normally be considered the woman's fault, while another described how the conflict enabled new opportunities to hold perpetrators accountable, while demonstrating victim blaming by suggesting women should not 'make mistakes' and conflating expressing opinions with achieving accountability:

I think a woman is able to report harassment if she was the victim, I mean if she didn't make a mistake. Previously, they used to blame women for sexual harassment. The whole perception has changed. Now, it is better. You can express your opinions... HP15

Interviewees described stigma and fear associated with reporting sexual violence or seeking related healthcare.

You know the environment we live in and the type of people here. In war zones, these things increase. It is difficult to activate a reporting system for such things. HP14

Women normally felt pressured to conceal GBV experiences when seeking health services. For example, if an unmarried woman were raped and needed to check if she got pregnant, she might tell the doctor during examination that her husband had died recently for fear of criminalisation or death for out-of-marriage sex.

A form of GBV most women noted had increased during conflict was early marriage. For families, protecting daughters from hunger, besiegement, kidnapping and rape were major responsibilities they were increasingly unable to meet during conflict and many chose early marriage for them instead. Some women community health workers risked themselves by advocating against forcing girls to marry and thus criticising extremist interpretations of *shari'a* (Islamic law). Another suggested that NGO campaigns telling girls to avoid early marriage were not helpful given they had no choice about marriage and should instead target decision makers (eg, fathers, religious leaders) with religious and health education.

A 17-year-old widow with a child... what does she know about her health or about her child's health? SU2

Several providers discussed the negative health consequences of child marriage, such as more girls requiring caesarean sections.

Can you imagine a 15-years-old girl who has had two caesarean sections already? HP7

Gendered healthcare employment concerns

Three emergent sub-themes were: (1) living with daily insecurity and restrictions; (2) overwhelming 'double' workloads; and (3) insufficient women health workers.

Living with daily insecurity and restrictions

All providers identified physical insecurity as the most challenging aspect of providing healthcare in OCAs, describing multiple stressors.

Shelling, kidnapping, air raids, explosions... We always face a new challenge. Our life here is full of challenges... HP7

Conflict-related psychological stressors affected women's mental health. Providers described horror, anxiety and fear as pervasive emotions affecting their work, particularly when hearing about another health facility bombing.

People don't understand that we are tolerating more than we can bear. They think we are made of iron... HP4

Several women highlighted the perceived insecurity of the new 'mixed-society' in Northern Syria, as foreign combatants and their families moved into Syrian communities. Interviewees used the term 'mixed-society' to describe influxes of foreign combatants, affiliated with foreign powers (eg, Turkey, Qatar and USA) and using very conservative ('extremist') interpretations of Islam to justify their involvement in Syria.

I can't leave my daughters home alone. They are always with me. There is no safety here. People [foreign combatants] came from different ethnic backgrounds... Each is free to do whatever he wants. HP15

Interviewees described foreign combatants imposing extremist ideology, including restricting women's participation in public spaces. One provider mentioned struggling with not knowing women patients' names, as extremist restrictions stipulated women should not be publicly recognisable. Regular aerial bombardment by government and allied forces, combined with 'mixed-society' extremism, made roads insecure for all women, whether healthcare providers or service users. Combatants recruited boys for combat and extremist indoctrination.

When the regime brought those people [foreign combatants], it made the situation much worse [...]. They recruited 15-year-old boys at their checkpoints to tell us a woman driving a car is 'haram' [i.e. forbidden in Islam]. HP4

Women health workers experienced restrictions on their appearance that men did not. For example, facility managers required women health workers to wear loose clothing and avoid makeup to reduce confrontations with increasingly radicalised combatants.

You feel trapped. You don't have the freedom to behave normally. HP15

Indirect consequences of conflict were often gendered. An interviewee in besieged Eastern Ghouta reported that when hospital management stopped providing staff transportation during the prolonged blockade, to allocate scarce fuel for crucial electricity generators, women were most affected. She noted that men could ride bicycles or motorcycles, a socially unacceptable option for women, while she had to walk four miles each day during aerial bombardment experiencing greater risk of injury or death.

Every day, we go to work filled with fear. Would we reach there or not? HP4

Health worker shortages and financial hardships meant many women worked in multiple facilities, increasing their risks of kidnapping, rape or murder. All were common while travelling, especially of people considered sufficiently important or wealthy (eg, politicians, military leaders, health workers with foreign salaries).

We were living in a place that looked like a state, but it wasn't a state. HP3

Women's coping strategies included normalising death because living while anticipating death seemed senseless, trusting God's will and interpreting any death while providing health services as honourable.

The regime forces were targeting the hospital with barrel bombs while we were operating on some patients. These bombs were so powerful, the dust went into the open wounds. We didn't stop. We cleaned and continued operating. It happened many times [...]. When it comes to death, we didn't mind dying while working [...]. Praise God that we are alive to deliver our voices... HP11

Overwhelming 'double' workload

Women described 'double' workloads of providing financially for their families alongside unpaid household responsibilities.

We must deal with many tasks. It's like holding two watermelons in one hand... SU5

Providers all described increasingly overwhelming daily workloads, due to continuous bombardment, complex injuries (eg, chemical attacks in rural Damascus and rural Idlib) and mass influxes of displaced people.

Today I did 11 caesarean sections. The other day I did 14. It's exhausting. HP14

Many described working 24-hour days, with days off a luxury due to staffing policies and shortages. This took a heavy toll on their well-being and productivity, with the only choices tolerating it or quitting their job.

People don't care how overwhelmed we are, being up all night, three operations [...]. Their perception is we must be active in delivering health service no matter what [...]. I get mentally and physically tired. I am unable to do anything else when I get home. HP7

Besieged areas were additionally challenging. Providers reported not having specific work hours and expectations of always being on standby. Some health facility managers lived at their facility.

A senior manager described the additional workload required of her promotion.

It was an add-on to my already full schedule. More problems to be solved, dealing with beneficiaries, following up staff, managing [...]. I wasn't keen on taking this position

because it's an extra burden. It affects my physical and mental health, but no one else was available to take over... HP14

Insufficient women health workers

Health facilities had insufficient health workers, particularly women, as many left the country, could no longer work or had been arrested or killed. Many women had household responsibilities incompatible with high workloads and 24-hour shifts expected of health workers during conflict. Others provided private healthcare from their homes or clinics to avoid working in public facilities that were systematically bombed.

Some doctors don't dare work at health facilities because of the attacks. Their solution was to provide healthcare from home... SU4

In besieged areas, numbers of health workers were particularly limited. Women were traditionally under-represented outside nursing and midwifery, which only worsened during conflict.

Before the revolution, the proportion of female to male doctors was unequal. Women used to consider studying pharmacy or dentistry rather than medicine. HP3

Female surgeons were particularly rare.

Of course, there are more male health providers, for example, 75% more. We really lack female doctors. Most female doctors left the country. We have no female surgeon in [this town]. HP4

Many women with non-medical backgrounds received nursing and midwifery training, while others were requested to perform tasks outside their role due to severe staff shortages. While necessary, accelerated training and task-shifting were sometimes brutal.

You don't have the luxury to think about it [...]. It is a life or death situation. If I consider referring the case, it means I'm sending that woman to death [...]. You can't imagine how horrifying it is, very scary, dealing with these complicated cases for the first time. HP4

Challenges within foreign humanitarian responses

Women highlighted how multiple competing responsibilities (eg, primary/sole household wage earners and caregivers, multiple employments) created implicitly gendered employment policy implications. Two inductive subthemes were: (1) adverse employment policies; and (2) mitigation measures women enacted or advocated.

Adverse employment policies

Many health facilities at which interviewees worked were remotely financed or operated by international non-governmental organisations (INGOs). Working for international organisations was new for most women. INGOs provided capacity-building trainings, particularly for nursing, midwifery and community health workers. Providers described these positively, as crucial for women

from non-medical backgrounds. However, they noted that INGOs typically lacked health worker incentive structures, instead relying on penalties such as warnings, salary reductions or dismissal. Only one mentioned incentives, that is, monthly well-being days at her facility.

Most women agreed that INGO policies prioritised service user needs (eg, establishing 'patient-friendly' facility complaints systems), while health facilities pre-conflict had prioritised providers. For example, INGOs usually allocated representatives at each facility to help supervise workflow and address service user complaints.

They [INGOs] care about patients. Now, I think INGO-supported hospitals are better than private ones... HP10

Insecure employment was the main challenge described by all and particularly affected women breadwinners who had less geographical and temporal flexibility than men due to household commitments. INGOs could halt funding at any time without notifying facility managers or staff. Women described working in INGO health facilities as challenging and not always fair. For example, the requirement for 24-hour shifts caused high turnover for women health workers with caring responsibilities at home.

Is any human being able to work 24 hours per day? We are not robots... HP12

Reasons for such INGO policies were unclear, though most women suggested it was to reduce expenses by having fewer employees work longer hours.

They always make sure to reduce the expenses as much as they can. [Hiring more staff] is costly. HP12

Women primarily attributed facility staff constraints to low budgets rather than lack of qualified candidates. Attitudes to INGO employment policies were mixed, with several providers unsure about INGO regulations or whether they had employee rights. Many described 'unfair policies', such as not hiring additional needed staff.

INGOs who claim to be humanitarian, they impose work conditions incompatible with their claims. A salary of one more employee wouldn't affect the INGO. Salaries of ten more employees wouldn't affect the INGO. HP7

Employee leave policies were inconsistent across facilities and employers and particularly difficult for women. One mentioned an INGO having a clear employee leave policy, which management ignored. Another described a nurse in her facility being fired because she got pregnant and there was no maternity leave policy. A woman was given 15 days leave after the death of a relative, while another received none because nobody could replace her.

When my brother died, I couldn't take leave. It was my shift. Even if you're dying you must show up to work. These are the rules here. I'm unfamiliar with this kind of treatment. Each of us should have the same rights. HP12

Some women reported working without contracts, as income needs required risk-taking, though it was unclear how widespread this was. However, even health workers with fixed-duration INGO contracts could be dismissed at any time. Despite these issues, major population needs inspired many to continue working even voluntarily.

Even though we don't get paid when no donor sponsors the facility, it is very hard for us to leave the population without healthcare. HP7

Mitigation measures women enacted or advocated

Women were resourceful and described several working condition improvements they were able to enact. For example, some successfully lobbied facility managers to provide a practical solution for 24-hour shifts by dividing the workday into three shifts with two health workers sharing one contract.

Having two semi-contracts from two different workplaces is better than having one that involves long working hours. HP2

One interviewee recommended that 'foreign' INGOs should be coordinated by a unifying local authority to help organise responses and ensure equitable distribution of vacancies and salaries.

This is a mess, complete chaos. Each INGO has different policies. Why don't we [Syrians] have the stewardship? I don't have a place to suggest this. We don't have freedom [to speak out]. HP12

Women gynaecologists reported that midwives provided tremendous contributions to healthcare in OCAs and a midwife suggested developing a midwives' association to organise and support their work.

Doctors are protected. We midwives are the vulnerable group. Any medical mistake, they would blame us and ignore all our great efforts... HP7

Another suggested life insurance schemes for health workers in conflict-affected areas, supported by INGO funding. As nobody had sufficient authority to stop health facility attacks, having access to affordable life insurance could help ensure their families would be provided for if health workers were permanently disabled or killed.

DISCUSSION

To our knowledge, this study is the first to amplify Syrian women's descriptions of their lived healthcare experiences in opposition-controlled areas of Syria. This is important both given the dearth of such research in Syria and because it was Syrian led, unlike much global health research that excludes or minimises 'local' coinvestigator contributions.^{34 35} We argue that research investigating health sector experiences of women in Syria was needed, as research in conflict-affected settings often ignores the socially constructed power relations and gender norms that lead to different health system experiences, needs and outcomes.³⁶

Our findings showed the significant role women play in the OCAs health system and the physical, mental and professional overwhelm and precarity they experienced. This supports findings from other settings, for example, Afghanistan and Somalia, which described health worker shortages, preferences for women health workers, gender inequalities, multiple employments and donor dependence amid ongoing insecurity.³⁷⁻³⁹ Many challenges women health workers encountered were similar for men, but impacts often affected women disproportionately.⁴⁰⁻⁴⁴ Women described complexities and challenges in how conflict influenced professional and social gender norms, including increased but more precarious work opportunities, harassment and violence. Differential treatment by managers, often based on INGO policies, increased work stress and precarity. However, many continued to volunteer after INGOs stopped funding their facilities, choosing to help where they could. Identifying conflict-imposed changes in gender roles requires accounting for pre-existing inequities, for example, Syrian women always had greater household caring responsibilities and more socially restricted access to education or employment opportunities.^{45 46}

OCAs remain insecure, having undergone frequent governance shifts and fragmentation during years of conflict.^{1 9 11 43 47 48} Women's accounts suggested potential opportunities in healthcare spaces, particularly in increased demand and broadened roles for women health workers. The increased demand for women health workers versus their limited space for action and leadership in health facilities reflected the tensions inherent in the new 'mixed-society' they described. Findings are comparable with those in Afghanistan, with increasingly repressive patriarchal structures increasing demand for qualified female staff to provide for women.⁴⁹⁻⁵¹ Further reforms may thus be possible in OCAs after conflict, as women described sociopolitical norms as malleable, to improve gender equity within the health system.⁵² However, if changes remain linked to radicalised 'mixed-society,' excess workloads, or insecure contracts, improved gender equity seems unlikely. Importantly, more job opportunities do not automatically increase women's empowerment, as conflict is transforming Syrian norms in complex and fragmented ways. Further intersectional inquiry is needed to avoid assumptions about 'Syrian traditions' or gender that fail to capture diverse experiences.⁵³

Examining health impacts of gender inequity is often undermined by a lack of consensus regarding data interpretation.⁵⁴ However, discussion and engagement with those affected is crucial.⁵² Syrian women, as health workers and service users, offered context-driven priorities with implications for policy, practice and further research. There is an urgent need for a legitimate authority to organise health responses across OCAs and coordinate international and Syrian actors. In the meantime, a functional and equitable humanitarian response is essential. Women often play an essential role during conflict and

reconstruction,^{41 45} but interviewees were essentially penalised for taking on additional responsibilities (eg, by their ‘double burden’, inadequate contracts, unfair leave policies). International donors and NGOs should further coordinate in promoting equitable working conditions for Syrian staff, so women health workers have contracts aligned with international human rights and employment standards. Improving gender equity in healthcare during conflict is not limited to celebrating women’s achievements in adversity but must support employees’ additional responsibilities and enable men and women to share in strategic decision making.

Our findings on GBV support the literature indicating disproportionate impacts on women and girls during conflict, due to erratic rule of law and breakdown in social norms.^{5 55} Under-reporting and the lack of a unified safeguarding system for sexual harassment are particularly problematic given the fragmented health system space for action at health directorate and facility level. Women deserve safe spaces to report and address sexual assaults, which is a responsibility of both international and local authority partners. Child marriage is a form of GBV, which negatively affects Syrian girls’ health and well-being, and existed to some extent preconflict.⁵⁶ For example, UNICEF found that in 2002–2011, 13% of Syrian women aged 20–24 years were first married before age 18 years.^{57 58} While it remains challenging to estimate current prevalence,⁵⁷ the complex conflict, forced displacement, financial challenges and weak protection systems likely drive increases in such marriages.⁵⁹ Conflict-imposed complexities, including physical and socioeconomic hardship and insecurities, require multi-sectoral support by Syrian and international partners to address.²⁴ Given fragmented local authorities, community outreach campaigns on the harmful consequences of child marriage, initially targeting religious leaders and fathers, could help.^{43 60} Engaging fathers is essential, as girls seldom control such decisions.⁵⁶ Any approach must take a sensitive and nuanced stance, incorporating inquiry and intervention beyond individual and familial levels. Solely investing in campaigns in the absence of intervention at multiple levels simply decontextualises systemic violence, portraying it as an interpersonal issue, instead of challenging structural power norms.⁶¹

Interventions and research must incorporate intersectional narratives to strengthen gender equitable initiatives.^{62 63} Further researching intersections, for example, between gender, occupation, ethnoreligious identity, socioeconomic position and stage/area of conflict, would help explain different lived experiences of women in healthcare. For example, disparities between the experiences of midwives and clinicians we interviewed were significant but could not be explored in depth. Thus, considering women homogeneously without acknowledging these differences can oversimplify overlapping categories of marginalisation and oppression.⁶⁴ As Hankivsky *et al* argue, existing structures provide benefits and opportunities for men,⁶⁵ from default health sector

and INGO decision-making positions^{52 66} to inclusion as default key informants in research on Syria.¹⁴ If, as findings thus far suggest, the tragedy of the Syrian conflict may open policy or social spaces to shift gendered norms and power dynamics, intersectional research and engagement can contribute to these processes.⁶⁵ However, further research is needed on potentially gendered effects of INGO policies for national health workers.

Limitations

We approached participants through trusted contacts, as security concerns made recruitment and rapport-building challenging. MA’s background as a Syrian health worker during the conflict was crucial but also contributed emic/etic tensions and complex subjectivities to interactions (eg, Fassin’s ‘political subjectivation’).⁶⁷ For example, interviewing women with similar predispositions reduced perceived researcher impartiality, while familiarity with OCAs issues contributed feasibility and depth to our research. Data collection was challenged by bombardment, poor internet connectivity and scheduling difficulties due to women’s multiple roles and overloaded schedules. Including real names and workplaces was inappropriate, and findings should be judged accordingly. Despite reassurances of not including any identifying information, some participants were particularly concerned about their families in government-controlled areas being targeted. This required great care and constant checking about what could and could not be written, which may have reduced some richness but was necessary for safety.

CONCLUSION

Women participate actively in opposition-controlled healthcare spaces and contribute to governance processes in Syria. However, while the demand for women health workers is increasing, women are not routinely included in healthcare leadership or decision making thus minimising their voices in policy debates and making further sociopolitical transformation crucial.

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Acknowledgements We are grateful to participants who gave their time to share personal experiences and make this research successful. We thus dedicate this work to the Syrian martyrs and detainees who sacrificed their lives and freedom for a better Syria. We are thankful to the members of the advisory committee and their valuable contributions to this study. We would also like to thank Aula Abbara of Syria Public Health Network and Diana Rayes of Johns Hopkins University for topical discussions.

Contributors MA and NH conceived the study with inputs from YD. MA collected and analysed data with YD and NH contributing to interpretation. MA drafted

the manuscript with help from AH. NH revised for critical content and serves as guarantor. All authors approved the version for submission.

Funding Data collection was funded by a Chevening MSc Scholarship. Manuscript development and publication were funded by NH's Medical Research Council Health Systems Research Initiative foundation grant (MR/S013121/1). Funders were not involved in study design, data collection, analysis, decision to publish or manuscript preparation.

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Competing interests None declared.

Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Not applicable.

Ethics approval The MSc research ethics committee at the London School of Hygiene & Tropical Medicine in the UK provided ethics approval (reference 16996) as there was no legitimate ethics review board in Syria able to provide approval at the time of research.²⁷ Participants gave informed consent to participate in the study before taking part.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement No data are available. Not sharable due to ethics restrictions.

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Alhaffar Supplementary Appendix 1: Reflexivity Statement

1. How does this study address local research and policy priorities?

This study amplifies Syrian women's voices on their lived healthcare experiences in opposition-controlled areas of Syria during the conflict. This is of high priority considering the limited literature on Syrian women's experience within and outside the health system in Syria and specifically in opposition-controlled areas.

2. How were local researchers involved in study design?

MA and YD are both Syrian health-workers, with extensive experience in providing healthcare during the conflict in Syria.

3. How has funding been used to support the local research team?

The Chevening scholarship supported the lead author (MA) to undertake MSc studies in the UK, including the time needed to conduct the study. MRC funding supported study costs, including for MA and YD to prepare the manuscript for publication and open access fees.

4. How are research staff who conducted data collection acknowledged?

The lead author collected the data for this study.

5. Do all members of the research partnership have access to study data?

Yes, study data is accessible to all researchers involved in this study and all researchers are co-authors.

6. How was data used to develop analytical skills within the partnership?

MA led data collection and analysis as part of her MSc studies under NH's supervision and YD's mentorship. Authors worked closely together throughout to ensure MA, as an early-career researcher conducting her first study, was able to develop the knowledge and skills needed to conduct qualitative health system research effectively. MA was able to leverage analytical skills developed leading this study into a Research Assistant position at London School of Hygiene & Tropical Medicine.

7. How have research partners collaborated in interpreting study data?

MA conducted initial coding with support from YD and developed and mapped themes with support from AH and NH. All authors collaborated in data interpretation and agreed final themes and sub-themes.

8. How were research partners supported to develop writing skills?

MA drafted the manuscript and AH, who has experience in writing qualitative research for publication in English, provided initial feedback and support on the writing. NH then worked back and forth with MA and YD through iterations of feedback and revisions until all authors were confident that the writing effectively expressed in English our interpretations of the Arabic data.

9. How will research products be shared to address local needs?

The manuscript will be published as open access. We will write an English-Arabic blog summarising published findings on our website linked to our social media feeds (ie, Facebook, Twitter, LinkedIn). We will translate results into Arabic and post them online with a link to this article. We will also continue to conduct Arabic webinars for Syrians and international humanitarian actors to share research outputs and collaboratively discuss next steps.

10. How is the leadership, contribution and ownership of this work by LMIC researchers recognised within the authorship?

All researchers involved in this study are acknowledged as co-authors. The lead author (MA) and YD, i.e. half the research team, are LMIC researchers from Syria.

11. How have early career researchers across the partnership been included within the authorship team?

Half the research team (MA and YD), including the lead author, are early career researchers. We acknowledge that they are from Syria and based in the UK.

12. How has gender balance been addressed within the authorship?

Three of the four researchers (MA, AH, NH), including the lead author, are women. This was important due to the nature of this research and to acknowledge the historical under-representation of women in health research generally, and in Syrian health system research particularly.

13. How has the project contributed to training of LMIC researchers?

The research-author team is led by an early-career LMIC researcher and composed of three early-career and one mid-career researcher. All researchers helped each other, while NH took overall responsibility for social science research training and capacity-building of both LMIC authors in addition to their MSc studies.

14. How has the project contributed to improvements in local infrastructure?

This was a small exploratory study conducted by early-career researchers and was therefore unable to directly contribute to improvements in subnational infrastructure in Syria.

15. What safeguarding procedures were used to protect local study participants and researchers?

Due to the difficult context of the Syrian conflict, we were acutely aware of safeguarding concerns - particularly related to security and re-traumatisation. We emphasised the voluntary nature of participation, ensured participants were somewhere sufficiently comfortable before conducting interviews, and provided online access to an Arabic-speaking London-based psychotherapist, experienced in trauma counselling and paid from research funds - for both interviewees and research team members as needed.