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ORIGINAL ARTICLE

A descriptive analysis of sexual and reproductive health services for refugees provided through minimum initial service package approach

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Abstract

Objective: Sexual and reproductive health (SRH) is a priority public health emergency response for women during humanitarian crisis situations as they face the risk of being neglected in health care systems of the country of arrival. This study aimed to investigate Syrian women's utilization of SRH services through Minimum Initial Service Package (MISP) approach, who received services from Women Health Counseling Units (WHCU) established as part of a collaborative Project in Türkiye.

Methods: Questionnaires were administered face-to-face by Arabic-speaking female interviewers to 413 Syrian women who previously received services from the WHCU. Descriptive statistics were used and Pearson chi-square as well as Exact chi-square tests were conducted to analyse bivariate differences between categorical variables.

Results: Child marriages were common among more than half (59%) of the participants. Majority of deliveries took place in the public hospitals (95%) and as attended by a doctor (93%). The percentage of participants using modern contraceptive methods was found to be 39.7% who were more frequently from younger age groups. However, the withdrawal method was relatively more prevalent among older participants.

Conclusion: Despite the data being gathered from a limited population of Syrian women in Türkiye, the study offers descriptive, evidence-based insights on improving women's access to high-quality SRH services in line with the MISP approach during humanitarian crisis situations.

Keywords: Sexual and Reproductive Health, MISP, Syrian Women, Humanitarian Crises

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INTRODUCTION

The prevalence of humanitarian crises is on the rise, imposing significant burdens on individuals, countries, societies, and economies, often resulting in violations of specifically sexual and reproductive health (SRH) rights. Especially as SRH services can be unforeseen due to the sensitiveness of the issue for migrants, it could bring together a high level of service gap or unmet need. Migrant women's health status and their access to health services are significantly determined by gender dynamics and some other factors[1]. These factors include age, sexual orientation, national or social origin as well as inadequate information about rights and available services[2]. Moreover, migration process imposes additional risks for women and girls, such as human trafficking, sex work, gender based violence (GBV), an increase in sexually transmitted infections, unexpected and unwanted pregnancies and limited access to services.[3,4,5,6]

When humanitarian crises are concerned, the issues of SRH and GBV as defined via the Minimum Initial Service Package (MISP), developed by the Inter-Agency Working Group (IAGW) on Reproductive Health in Crises in 1995, are priority areas of intervention[7]. Starting in 2011, the Central Asian region (EECA), comprising Eastern Europe and India, has made the MISP available. In India alone, close to 600 individuals from non-governmental organizations and government agencies have undergone MISP training[8]. On the other side, the deteriorating economic and political conditions in Venezuela have led to the inaccessibility of SRH services, notably prenatal and postnatal care services, along with heightened health protection risks. As a response, the demand for these services has been met through assistance provided by other countries[9]. Likewise, in the face of severe limitations in providing SRH services, humanitarian aid organizations stepped forward to offer services utilizing the MISP approach[9, 10]. These examples not only underscore the significance of delivering SRH services through the MISP approach but also highlight the importance of cross-country solidarity regarding this matter.

It was demonstrated that, in the year 2015, in 35 countries where contraception services were not adequately provided due to humanitarian crisis situations, maternal mortality rate was 61% of the whole world[8, 11]. Reasons for underutilization were less awareness about availability of and duley low demand for services as well as not knowing the services and the location of service delivery[12]. While the need for SRH services in humanitarian crisis situations is clear, there is limited information on the extent to which these needs are being met in diverse situations. Understanding how a unit and mechanism for service planning using the MISP approach satisfies the requirement in a conflict situation, in particular, will give evidence and experience-based data for humanitarian crisis situations in various locations. A systematic review highlights the necessity for in-depth practice-based research across diverse crisis contexts and populations to identify evidence-based interventions that effectively enhance the utilization of SRH services[13].

Following the outbreak of war and subsequent migration influx in Syria in 2011, the registered Syrian population under temporary protection has continuously increased in Türkiye. Subsequently, the provision of health

care services to Syrian migrants has been a collaborative effort involving the Turkish Ministry of Health (MoH), various UN agencies, donors, and other organizations. As a project run by the authors of this article and as an example of gender-sensitive and migration-focused support services, *'Strengthening Access to Sexual and Reproductive Health, and Sexual and Gender-Based Violence Services for Syrian and Other Refugees through Women and Girl Safe Spaces (WGSS)/Women Health Counselling Units (WHCU) Project'* was conducted by Hacettepe University Women's Research and Implementation Center (HUWRIC) with technical support of the United Nations Population Fund (UNFPA) Türkiye Office and financial support of European Civil Protection and Humanitarian Aid Operations (ECHO) in Ankara. Under the project, services on SRH (training on SRH issues, providing individual and group counselling and services on family planning, antenatal and postnatal care etc.) and GBV were provided to Syrian women in three WHCU established in the Migration Health Centers of the MoH, using the MISP approach. To overcome social, linguistic and cultural barriers and facilitate open communication on matters concerning GBV and SRH, Arabic-speaking female personnel were recruited and the Syrian 'health mediators' were incorporated into the working team. Five health mediators working in each of the three WHCU were employed and regularly trained to serve as a bridge between their respective communities and the WHCU aiming to effectively establish an accessible as well as a safe health care setting where cultural diversity has been addressed. This unique structured model necessitated a comprehensive evaluation to assess how Syrian women utilize their SRH rights and services specifically in relation to MISP approach and to gain insights into the SRH health risks, needs and expectations of Syrian women in this context.

METHODS

Objective of the study

The objective of this study was to identify utilization and practices of Syrian women regarding SRH services and rigths, with a focus on MISP as a critical component of the humanitarian response to crises.

It is noteworthy to mention that, this article focuses only on SRH, excluding GBV component of the services provided, considering the extensive scope of both SRH and GBV, each deserving separate studies to comprehensively address their complexities. Accordingly, hereupon, findings and discussions were contextualized by considering solely SRH issues.

Study setting and study population

The research was conducted in three WHCU strategically located in three different districts of Ankara, specifically chosen for their accessibility to the Syrian female population, offering essential health care services. During the data collection phase between June 30th to August 15th a total of 445 women who had previously utilized services from one of those three WHCU submitted applications to receive further services. All applicants were extended an invitation to participate in the study; of these, 413 women accepted to be participants and were subsequently included in the research. As a descriptive study, although the results of this survey do not claim to represent the whole Syrian women population, it provides insights into how

Syrian women utilize SRH services delivered through the MISP approach.

Data collection tool

The questions and format of the survey were adapted using the global surveys on SRH. The questionnaire was designed so as to identify SRH related awareness, practices and service utilization of Syrian women applying to WHCU. The questionnaire encompassed a comprehensive set of questions covering various crucial topics including demographic characteristics of Syrian women and their household members, the rationale behind their preference for the arrival country, pertinent information prior to migration, aspects pertaining to marital relations, pregnancy and childbirth experiences, the utilization of contraceptives and the reasons for seeking services at the WHCU as well as their levels of satisfaction and expectations from these health care centers. Prior to finalizing the questionnaire, interview-based pre-tests were conducted in three centres serving as a pilot study.

Data collection and data analysis

The fieldwork of the research was conducted one and a half years after the project started and interviews were conducted from June 30th to August 15th by female Turkish interviewers possessing a background in social sciences and fluent in Arabic. The questionnaires were administered through face-to-face interviews, taking place in the WHCU settings. To eliminate the social desirability effect, women were included in the research without obtaining their names or any personal information. Additionally, the women conducting the interviews were individuals unknown to the research subjects, ensuring that the subjects did not feel pressured during the interviews. Before commencing the interviews, written informed consent was obtained from all participants, ensuring their voluntary participation and adherence to ethical principles. In the study, which achieved a response rate of 93%, all individuals who had previously utilized services from the centers and consented to participate were included in the research without any randomization during the period in which the study was conducted.

Data entry and analysis in the survey was conducted by using IBM Statistics Package for Social Sciences (SPSS ver. 23.0). In analyses, descriptive statistics were presented through mean, standard deviation, counts and percentages for categorical variables. Pearson chi-square and Exact chi-square tests were conducted to examine bivariate differences between categorical variables. Statistical significance was determined as p value <0.05.

Ethical considerations

Ethical Committee approvals were obtained from the Hacettepe University Clinical Research Ethics Board (Decision No: GO 17/243-30) and the MoH. Subsequent to receiving written informed consents, interviews were conducted by unknown interviewers in the WHCU buildings as Syrian women had already established trust and felt secure in those familiar environments. This approach also facilitated a comfortable and conducive environment for data collection, fostering open and candid responses from the respondents. The survey was carried out in the Syrian women's own language, minimizing any potential discomfort, misunderstandings, or translation errors that could have arisen from language barriers. Confidentiality and

privacy were safeguarded throughout and following the interviews. Measures were taken to maintain the anonymity of the participants, ensuring that their personal information and responses remained strictly confidential.

RESULTS

Fifty-six percent of 413 women were from the age group 25-44. The mean age of applicants was 33.98 ±11.66 (median: 31.00, min=15, max= 68). The majority of women taking part in the study were literate (81%) while one in every five women was illiterate (19%). Eighty four percent of women had their educational background as secondary education and lower while the number of those with high school or higher education was quite limited (Table 1).

Before their migration to Türkiye almost all used to live in Syria. Being in Türkiye for 3 years in average, women's average duration of stay in Ankara was 2 years. Their preference for Türkiye was based on factors including having relatives or acquaintances in Türkiye (32%); Türkiye's welcome policy for Syrians (24%); ease in transportation (20%) and confidence in Türkiye (17%). When income generating activities outside home considered, it was highlighted via the figures that only 16% of women were working before migration whereas this ration was 5.1% after migration. An overwhelming majority (97%) of Syrian women were currently married. (Table 1).

Table 1. Distribution of Syrian women by their basic characteristics

Basic characteristics of women	n	%
Age (n=413)		
15-19	30	7.3
20-24	61	14.7
25-29	83	20.1
30-44	150	36.3
45+	89	21.6
Literacy (n=413)		
Literate	334	80.9
Illiterate	79	19.1
Educational status* (n=359)		
Uneducated/primary incomplete	49	13.7
Primary education first level	139	38.7
Primary education second level	115	32.0
High school and higher	56	15.6
Marital status (n=413)		
Never married	12	2.9
Married	401	97.1
Income generating activity after migration (n=413)		
Yes	21	5.1
No	392	94.9
Duration of stay in Türkiye (n=413)		
Shorter than 1 year	36	8.7
1 year	47	11.4
2 years	104	25.2
3 years	152	36.8
4 years and longer	74	17.9
Duration of stay in Ankara (n=411)**		
Shorter than 1 year	48	11.7
1 year	77	18.7
2 years	122	29.7
3 years	134	32.6
4 years and longer	30	7.3
Reasons for preferring Türkiye (n=413)		
Having relatives/acquaintances in Türkiye	133	32.2
Türkiye's welcome of Syrians	100	24.2
Ease of transportation	83	20.1
Confidence in Türkiye	72	17.4
Religious reasons	15	3.6
Other	10	2.4
Working for income before moving to Türkiye (n=413)		
Yes	64	15.5
No	349	84.5
Average household size	6.0±2.5	

*Missing data for 54 women ** Missing data for 2 women

Almost 6 out of 10 women in reproductive ages were married before the age of 18. The proportion of child marriages was common in age groups and the difference is statistically significant (Table 2).

Table 2. Distribution of Ages of Syrian women by their age at first marriage

	Age at first marriage					
	Under age 18		Over age 18		Total	
Age	n	%	n	%*	n	%
15-19	22	88.0	3	12.0	25	100.0
20-24	32	54.2	27	45.8	59	100.0
25-29	44	53.7	38	46.3	82	100.0
30-44	83	56.8	63	43.2	146	100.0
45+	54	60.7	35	39.3	89	100.0
Total	235	58.6	166	41.4	401	100.0

*12 women did not answer the question

$\chi 2$=10.538, df=4, p<0.05

Reproductive health status of Syrian women

According to data cases of stillbirth, spontaneous or self-induced abortion were among most important factors affecting reproductive health (RH) status of women. Evaluating information about Syrian women's fertility pattern and RH together, it was found that large majority of women experiencing spontaneous, self-induced abortions or stillbirths were 45 years or older (49.4%, 32.6% and 20.2% respectively). Women with first level primary education were more likely to have spontaneous, self-induced abortions or stillbirths (46%, 19.4% and 10.8%, respectively). There is statistically significant difference between all groups. (Table 3)

Table 3. Distribution of cases of spontaneous and induced abortion and stillbirth among Syrian women by their basic characteristics

Basic characteristics	Spontaneous abortion				Self-induced abortion				Stillbirth			
	Yes		No		Yes		No		Yes		No	
	n	%*	n	%*	n	%*	n	%*	n	%*	n	%*
Age												
15-29	43	24.7	131	75.3	4	2.3	170	97.7	3	1.7	171	98.3
30-44	66	44.0	84	56.0	32	21.3	118	78.7	14	9.3	136	90.7
45+	44	49.4	45	50.6	29	32.6	60	67.4	18	20.2	71	79.8
Total	153	37.0	260	63.0	65	15.7	348	84.3	35	8.5	378	91.5
	χ^2=20.319, df=2, p<0.001[a]				χ^2=46.285, df=2, p<0.001[a]				χ^2=26.207, df=2, p<0.001[a]			
Education												
No education/primary incomplete	17	34.7	32	65.3	11	22.4	38	77.6	1	2.0	48	98.0
Primary education first level	64	46.0	75	54.0	27	19.4	112	80.6	15	10.8	124	89.2
Primary education second level	35	30.4	80	69.6	9	7.8	106	92.2	8	7.0	107	93.0
High school and higher	15	26.8	41	73.2	4	7.1	52	92.9	3	5.4	53	94.6
Total	131	36.5	228	63.5	51	14.2	308	85.8	27	7.5	332	92.5
	χ^2=9.637, df=3, p=0.022[a]				χ^2=11.970, df=3, p=0.007[a]				χ^2=4.683, df=3, p=0.197[a]			
Number of children living												
0	1	50.0	1	50.0	1	50.0	1	50.0	---		---	
1-2	44	31.4	96	68.6	22	15.7	118	84.3	12	8.6	128	91.4
3-4	69	40.4	102	59.6	26	15.2	145	84.8	14	8.2	157	91.8
5+	31	56.4	24	43.6	14	25.5	41	74.5	8.	14.5	47	85.5
Total	145	39.4	223	60.6	63	17.1	305	82.9	34	9.2	334	90.8
	χ^2=9.637, df=3, p=0.010[b]				χ^2=4.854, df=3, p=0.163[b]				χ^2=2.351, df=3, p=0.498[b]			

* row percentage; [a]Pearson chi-square test; [b]Exact chi-square test

Pregnancies in Türkiye

Twenty-eight percent of women experienced pregnancies in Türkiye and 36 women (9%) were pregnant at the time of the research. 28% of women had their pregnancies after arriving at Türkiye. The vast majority of births of participants occured in public hospitals (95%) and are attended by doctors (93%) in Türkiye. Among deliveries without the attendance of a doctor (7%), 4% were assisted by relatives, and only 1% of deliveries were attended by nurses and 1% were attended by a Syrian doctor. (Figure 1) These findings can be interpreted as indicating that the women participating in the research had high levels of access to vital antenatal care services.

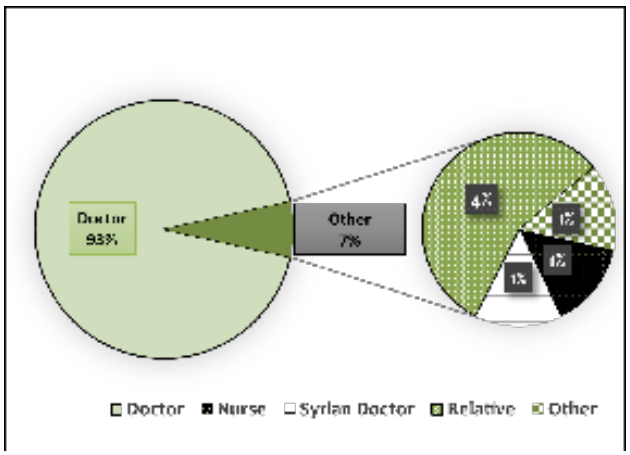

Figure 1. Percentage distribution of Syrian women by their birth attendants

Contraceptive method use

When asked about the contraceptive methods they have ever used, 69% of the interviewed women reported having used at least one method. However, only 39.7% of women were currently using a modern contraceptive method, indicating a lower percentage compared to those who have ever used contraception. Among the current contraceptive users, 23.2% of women were using intra-uterine devices (IUD), 7.7% were using oral contraceptives, 6.1% were using condoms while 6.3% of women were using the withdrawal method. (Figure 2)

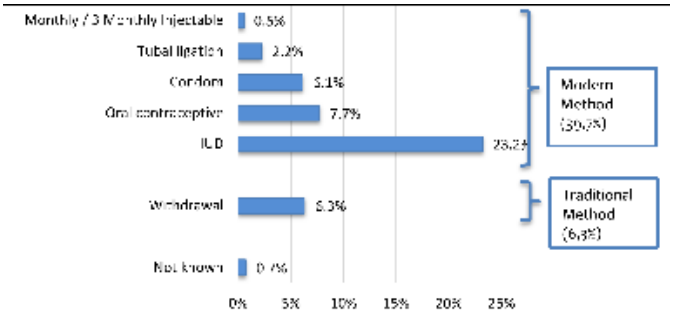

Figure 2. Percentage distribution of Syrian women by method of contraception they currently use

The findings demonstrate that both modern and traditional contraceptive methods were more preferred by those in the midst of their years of fertility. Younger age groups showed a wider usage of modern methods, while the withdrawal method was relatively more common among older age groups. No statistically significant difference was found between the level of education (p=0.436), age groups (p=0.758) and how many alive children they have (p=0.052) in terms of contraceptive method use (Table 4).

Among women using any contraceptive method, 87% expressed no desire to change their current method, while 13% wanted to switch to a different one. The primary reasons cited for not using any contraceptive method were the absence of their spouses or infrequent sexual intercourse (23%). The second most common reason was pregnancy or being in the postnatal period (24%). Additionally, 10% of women stated they chose not to use contraceptives because they wanted to become pregnant, while 12% mentioned their menopausal status or having undergone a hysterectomy as reasons for not using any contraceptive method.

Table 4. Distribution of contraceptive method use by Syrian women by their basic characteristics

Age (n=190)	Modern methods		Traditional methods		Total		p
	n	%[a]	n	%[a]	n	%[b]	
15-29	64	87.7	9	12.3	73	38.4	0.758 [1]
30-44	83	87.4	12	12.6	95	50.0	
45+	18	81.8	4	18.2	22	11.6	
Education (n=169)							
No education/primary incomplete	19	79.2	5	20.8	24	14.2	0.436 [1]
Primary education first level	66	89.2	8	10.8	74	43.8	
Secondary education and higher	60	84.5	11	15.5	71	42.0	
Number of children alive (n=188)							
1-2	37	78.7	10	21.3	47	25.0	
3-4	92	86.8	14	13.2	106	56.4	0.052 [1]
5+	34	97.1	1	2.9	35	18.6	

[a] row percentage, [b] column percentage, [1] Chi-Square was used.

DISCUSSION

During war, Syrian people were forced to migrate to other countries and two thirds of them settled in neighbouring countries such as Türkiye, Lebanon and Jordan[14]. As of April 2024, this population reached 3,116,713 people, with women and girls accounting for 47.8% of the Syrian population[15]. In humanitarian crisis situations refugee women face numerous obstacles accessing SRH services and are confronted with the violation of sexual and reproductive rights[16], therefore planning and accessibility of SRH services are crucial. It was mentioned in the Sustainable Development Goals (SDGs) to guarantee the universal access to SRH without leaving anyone behind[17]. Nairobi Summit -the 25th anniversary of the ICPD (ICPD+25)- was held in 2019 with an agenda that set forths ensuring high-quality SRH services to populations in most difficult environments in line with the MISP approach and meeting the SDGs. These standards are expected to be implemented through national plans that safeguard and uphold everyone's right to bodily autonomy, integrity, and reproductive rights, while also ensuring access to services that support these rights[18]. This study, along with the established WHCU mechanism, serves as a response to aforementioned universal standards.

Although further research is needed to establish the direct impact of receiving services from WHCU, the research findings indicate a high utilization rate of SRH services and rights among applicants. This observation also extends to the use of contraceptive methods. It was revealed that, in the period 2007-2014, the prevalence in use of contraceptives was 54% in Syria[19]. However, in this research, it was found that 69% had ever used any contraceptive method and 46% (39.7% modern method, 6.3% traditional method) were currently using one. When reasons for not using any method were examined, participants cited the absence of sexual partners, not currently engaging in sexual intercourse, being in the postnatal period or menopause, rather than inaccessibility of services or cultural restraints. These findings can be considered positive regarding health service delivery in

relation to the implementation of the MISP approach.

In terms of contraceptive use, in the 2018 Türkiye Demographic and Health Survey (2018 TDHS-Syrian sample), which provide information about population, fertility and use of health care services regarding Syrian women aged 15-49 living in Türkiye[20], 21% of women were found to have an unmet need for contraception. Further, 54% of the Syrian sample was found to be using any modern method, while only 24% were still using a modern method. However, in this study 39.7% of the participants were using modern contraceptive methods. In both studies, the preference order of the most commonly used contraceptive methods was the same, namely IUDs, oral contraceptives and condoms (first 2018 TDHS Syrian sample and in the current study respectively; 13%-23.2%, 6%-7.7% and 2%-6.1%). Furthermore, the withdrawal method was found to be widely used in both studies, with a rate of 19% in the 2018 TDHS Syrian sample and 6.3% in the current study. The difference in modern contraceptive use between the findings of the two studies could be attributed to the counseling and awareness-raising activities conducted at the WHCU. Women have the opportunity to learn more about contraceptive methods, SRH services, their availability and SRH rights, which may account for the variation in results. Additionally, the health mediator mechanism can be considered effective in expanding the reach of WHCU to a larger Syrian population. As a significant finding, this explanation was further supported by the statistics from WHCU, which revealed that 65% of the women who sought services at the centers were referred to WHCU through the guidance of health mediators.[21] The existence of WHCU within MoH's Migration Health Centers is thought to promote higher applications to the centers as well. According to Cankurtaran and Albayrak[22], spouses of women do not object to their wives' visits to WHCU, which allows women to access SRH services as part of primary health care. Hence, it can be interfered that, WHCU model has some unique aspects regarding implementation of the MISP during humanitarian crises including a mechanism that integrates complementary components into primary health care services provided by public institutions, eliminating language barriers by providing services in women's native languages and employing health mediators in service provision who act as a bridge between the Syrian population and the center thus ensuring a culturally sensitive environment.

In a study that reviewed 24 researches conducted in Türkiye, researchers found that the percentage of child and consanguineous marriages among Syrian women was 56%[23]. According to the results of the 2018 TDHS Syrian sample, adolescent marriages were very high, accounting for 49% of cases. Additionally, 39% of Syrian women between the ages of 15 and 19 were already mothers or pregnant with their first child. In another study, conducted among women who gave birth at Mardin Maternity Hospital in 2018, where early pregnancies were reported to be a common problem among Syrian women; adolescent pregnancies were found to be 2.2 times higher among Syrian women than the resident adolescents[24]. In line with those findings, the fundamental findings of this research indicate that the prevalence of child and forced marriages emphasize the need for consideration in the planning of SRH programs targeting the Syrian population.

Marriage under age 18 was found to be 59% in the current study. This result, together with the previously mentioned studies's results, points to the fact that child marriages could be defined as an important social, right-based and health problem for Syrian population that needs to be taken into consideration in health policy and practices.

Çöl et. al. demonstrated that, SRH issues still need improvement for Syrian women in areas such as child marriages, adolescent pregnancies, inadequate antenatal care, access to modern contraception and sexual violence[23]. In the aforementioned literature review, the extent of the need for RH services, the specific risks and needs of being refugee women, language and cultural barriers as well as difficulties in accessing services have been stated as crucial SRH challenges faced by Syrian women in Türkiye. In their research, Kahsay and his colleagues[25] assessed RH service utilization at a refugee camp in Ethiopia and attributed the positive difference compared to some other studies to the availability of facility supply, health education provided about MISP RH and the absence of language barriers. Considering all these issues along with the findings of the current study, the need for incorporating MISP for SRH service delivery in native language, by personnel who have received pre-service and in-service trainings on gender equality arises.

Revisiting lessons learned and illuminating the path for future policy, program, practice and research

Given that the MISP is specifically designed to be implemented in the early stages of humanitarian crises, providing guidance to health care providers on prioritizing SRH services, facilitating the transition to comprehensive SRH services[26], it becomes essential to integrate this approach into primary health care policies and practices from the outset of such crises. An effective coordination program, designed with the active participation of the migrant population, prioritizing the needs of disadvantaged individuals and incorporating basic SRH services are crucial. The program should also take into account the unique needs of the region affected by the crisis and match the necessary resources and materials accordingly with those needs.

During crisis, continuous information gathering is essential to assess the evolving needs of the affected population. It is vital to identify a dedicated service unit to implement MISP requirements and provide essential SRH services. Moreover, the program should offer training to service providers and users to ensure proper utilization and sustainability of services. In line with aforementioned issues, shedding light on to needs and best practices, is expected to have positive impact on the MISP's wider recognition as a critical component of the humanitarian response to crisis and to encourage its inclusion in global programmes, plans and standards. This could also be guiding for the responsible institutions to initiate necessary training, support and legislative actions in the context of SRH services as part of the MISP for women in situations of forced displacement.

Although in this research, data obtained only from women who have previously received services from WHCU, there is a need for a comprehensive research that also examines the needs and barriers of those who have not accessed service units and services.

Addressing gender inequalities is central

to effective SRH responses. Indeed, gender-based stereotyping and harmful traditional practices are some of the key elements leading to SRH problems especially for migrant women including child and forced marriages. Therefore, when addressing SRH services within the scope of MISP during humanitarian crises situations, it is considered important for research to have a gender equality perspective.

While the study does not represent the entire Syrian female population and is limited to a specific group, it offers insights into the SRH services provided within the framework of MISP in humanitarian crisis situations. Revising and updating the MISP in response to different situations experienced in different regions, new researches, emerging best practices and changing global health priorities is a beneficial strategy. In this context, conducting researches those consider diverse situations and sharing the findings at the international level would be beneficial for building upon the experiences and knowledge of one another.

CONCLUSION

As a conclusion, this descriptive study, demonstrated the SRH service utilization of Syrian women who have previously received services from WHCU. While the study is limited to a specific group of Syrian women in Türkiye, it offers valuable descriptive data supporting the enhancement of women's access to high-quality SRH services in line with the MISP approach. The findings are believed to serve as a guiding framework for the development of more comprehensive SRH service provision. It is also considered that the outcomes could be inspiring for international programs during humanitarian crisis situations.

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development: ŞB-Ö, İY-K, Coordination of the fieldwork and supervision during analysis process: İY-K, Data cleaning, statistical analysis and analysis result writing: HK-Ü, Analysis result interpretation: İY-K, Obtaining Ethical Comittee approvals: TE, Reporting of the research, literature search and preparation of the manuscript: TE, Critical review of the manuscript: ŞB-Ö, İY-K, HK-Ü, TE.

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