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# Syrian Refugee Women in Jordan: Family Planning Preferences and Barriers in a Host Community

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Syrian Refugee Women in Jordan: Family Planning  
Preferences and Barriers in a Host Community

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Date: December 11, 2016

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### **Abstract**

The aims of this pilot study were to research and analyze the availability of birth control and family planning resources among Syrian refugee women at a reproductive age. This study took place in the host community of Karak, Jordan. Syrian women are a vulnerable population based solely on their gender. But being refugee women makes them more vulnerable and sometimes, their needs do not get met. This study is important because it will look into reproductive health aspects for this vulnerable population to ensure that there is satisfaction among women about their own health. This cross-sectional study sought to answer questions of accessibility to birth control, availability of support surrounding family planning, and overall satisfaction among Syrian refugee women about their current reproductive health care, specifically regarding birth control and family planning. The questions were answered by surveying a convenience sample of 13 Syrian women and by interviewing five Syrian women. The survey findings concluded that although 71% of the women surveyed found their reproductive health care provider to be extremely or somewhat trustworthy, nearly 86% of those women said their health care provider did not initiate a conversation about birth control, causing a lack of awareness. In regards to support mechanisms, only 36% of women surveyed had attended an informal support group. Many women interviewed stated that birth control was harder to access in Jordan than in Syria due to lack of affordability and health insurance. Limitations include small sample size and short time frame, which calls for further study on this topic. Although limitations were in place, this study suggests that birth control be more prevalent and discussed more in reproductive health clinics while being made more affordable.

*Keywords:* Reproductive health, birth control, family planning, refugee women, Syrian

## Introduction

As this moment in time, the war in Syria is continuing to cause a refugee crisis that is unprecedented. Millions of Syrians are fleeing their country in order to escape the heartbreaking chaos that occurs day in and day out in the land that they once called home. The Middle East is trying to handle the impact of refugees flooding into countries that border Syria, like Lebanon, Turkey, and Jordan. One of the countries that this crisis has had a huge impact on is Jordan, Syria's neighbor to the south. Currently, according to the United Nations High Commissioner for Refugees (UNHCR): Syria Regional Refugee Response, there are 655,404 Syrian refugees registered in Jordan (2016). Although that number may not be entirely accurate, due to the fact that there could be countless unregistered refugees in Jordan as well. This massive increase in population means that Jordan has had to rethink its strategies regarding education, the economy, and healthcare.

Syrian refugees are a vulnerable population. They've often lost their homes, they are food insecure, and they don't have access to basic human rights, like health. But a subset of that population that is even more vulnerable due to their gender is women. Women are often targeted simply because of their gender. Women and girls face additional challenges, especially being in host communities, like lack of medical care, poor access to reproductive health services, unwanted pregnancies, unsafe deliveries, and different types of sexual and gender based violence (S-GBV). Within Jordan, 50% of the Syrian refugee population consists of women (UNFPA: Jordan, 2016). This means that roughly 328,000 registered Syrian refugees are women. Additionally, of those 328,000 women, about 160,000 are women of a reproductive age (UNFPA: Jordan, 2016). That population alone makes up nearly one-fourth of the Syrian refugee population in Jordan. Being at a reproductive age is an extremely decisive and vulnerable stage

of any women's life. Protecting women at this age and ensuring they receive the care they need is tremendously important.

While being in Jordan, I have had multiple opportunities to learn about the reproductive health care available to Syrian refugee women. One of our seminars through the School of International Training (SIT) was titled "Refugees Health and Humanitarian Action". During this seminar, we had the chance to visit the United Nations Population Fund (UNFPA) in Jordan and talk about the reproductive health care of Syrian women and why they are such a vulnerable population. Being a woman of reproductive age myself, hearing the struggles that these women face regarding their reproductive health struck a cord with me. Even though I am far removed from their hardships and situation, I can somewhat understand what this struggle must be like. After our first meeting with the UNFPA, we were scheduled to be accompanied by the organization on a visit to Za'atari refugee camp. It was during this visit that my research project became clear to me.

When we visited Za'atari with the UNFPA, we had a chance to visit their reproductive health center where women sought services. We toured the maternity ward and saw various offices. It was surprising to see such a high functioning center available in a refugee camp. In addition, I also had the incredible opportunity to sit in on a session in which women were openly discussing their own experiences with birth control and reproductive health. It was a space for them to ask their most pressing questions and hear answers they needed. It was in this moment that I wanted to know more about their experiences. I wanted to study birth control for Syrian refugee women to hear their stories and whether or not their health was being cared for while so far from home. Women are often taken for granted and their needs pushed to the side. But in order to ensure effective family planning, smart choices regarding family size, and safety for



women and children, reproductive health should be at the top of priority lists and agencies in charge of providing this care should be constantly seeking ways to improve. Hearing the thoughts and concerns from refugee women themselves could potentially change policies and actions currently in place in order to aid refugee women in the future.

Because I had already seen how reproductive health care looked in a refugee camp, I wanted to embark on studying the same topic in a host community. Many sources of literature available on the topic have hinted that access to health care in a host community is more limited than in a refugee camp and there is less satisfaction among the population. It is also important to note that around 80% of the Syrian refugee population resides in host communities as opposed to the 20% who live in camps (UNFPA: Jordan, 2016), making it a vast majority of the population. The focus of this study was to research and analyze the availability of birth control and family planning resources among Syrian refugee women at a reproductive age (for the purpose of this study, the age range will be 18-49) in a host community in Jordan. The research will focus on the types of birth control offered to Syrian women, what resources they have to seek support regarding birth control and family planning, and their overall level of satisfaction within the reproductive health care facility they are utilizing. I wanted to uncover the depth of services provided regarding family planning and what could be improved in order to raise the satisfaction level among Syrian women. This study aims to answer the following questions:

- How accessible are birth control and family planning resources to Syrian refugee women in host communities in Jordan?
- What are the types of birth control offered and what support mechanisms are in place for women to have questions and concerns addressed?

- What is the overall level of satisfaction towards reproductive health care concerning birth control and family planning?

Additionally, I do not feel that this question/topic needed a hypothesis because it is a qualitative study. I did not assume what services were available or what the level of satisfaction is among women; rather I discovered these answers through my study.

### **Literature Review**

There has been a fair amount of research done regarding health care access for Syrian refugees in Jordan, including specific studies to analyze access of reproductive health services for this population. However, there are not as many articles that discuss birth control and family planning exclusively, which is where I aim to contribute. The purpose of the literature review is to discuss what health care access is like in general for Syrian refugees in Jordan, what the Minimum Initial Services Package (MISP) entails, what it should cover, and where it is lacking, and finally, access and barriers to reproductive health care among Syrian refugees in Jordan.

### **Health Care for Refugees in Jordan**

Syrian refugees started coming to Jordan in 2011 at the onset of the Syrian civil war. Although Jordan is not a signatory of the 1951 Convention relating to status of refugees, refugees could cross the border from Syria to Jordan, obtain “asylum seeker” status from the UNHCR and remain in Jordan (Ay, Gonzalez, & Delgado, 2016). Furthermore, in order to access health services, refugees living in host communities must go to their local police station and obtain a service card. With the aid of the UNHCR and various other UN organizations providing health care, the Jordanian Ministry of Health (MOH) was the primary provider of health care services, especially in host community urban areas (Krause, Williams, Onyango, Sami, Doedens, Giga, Stone, & Tomczyk, 2015). Established guidelines for health care, including family planning,

were adhered to during the influx of Syrian refugees entering Jordan. Reproductive health care is and should be integrated into primary health care services.

Upon arrival at health care facilities, refugees must show both their local service card and the UNHCR registration (Ay et al., 2016). Until 2014, having these two documents provided free access to health care for all registered Syrian refugees. The number of Syrians seeking health care spiked between 2012 and 2014. Due to budget constraints and pressure to take them into account by the Jordanian government, the Jordanian MOH rescinded free health care to Syrian refugees in November of 2014. This meant that registered Syrian refugees would then have to pay the same amount as uninsured Jordanians (USAID, 2016). However, during this time, the ministry stated that family planning services were explicitly exempt from any fees because they heavily subsidized public health services for uninsured Jordanians (USAID, 2016). But due to the confusion of this wording and policy, this deterred many Syrian women from seeking family planning services due to fear of high costs.

Advocacy groups pressured the MOH to allow Syrian refugees registered with the UNHCR to access maternal and child health services free of charge. In February of 2016, the MOH agreed and put this policy back in place (USAID, 2016). These services that were free of charge now included family planning mechanisms. But even with this policy in place, many refugees viewed the reproductive health care system and support services negatively and would not access them (USAID, 2016). In refugee camps and host communities, refugee women and girls viewed clinical services negatively and felt as though there was a lack of basic necessities (Krause et al., 2015). Even though there was a negative perception found about the satisfaction, many refugees claimed that accessibility to health services was relatively easy (Ay et al., 2016).

It is also important to note that Jordan is one of the first countries to have iris scan technology available for Syrian refugees in order for them to access cash grants with the UNHCR. Dunmore reports that in “partnership with Cairo Amman Bank, Jordan is the first country in the world to use iris scan technology to enable refugees to access their funds without the need for a bank card or PIN code. Currently, around 23,000 Syrian families living in urban areas in Jordan benefit from monthly cash assistance” (2015). This allows Syrian refugees to access 100 Jordanian dinars (about 140 US dollars) per month as a stipend to use. The transition was slated to be completed by August of 2016.

### **MISP in Emergency Settings and Jordan**

The Interagency Working Group on Reproductive Health in Crisis (IAWG) is tasked with improving reproductive health in communities affected by conflict. Their manual, *Reproductive Health for Refugees: An Inter-Agency Field Manual*, first introduced the idea and importance of the Minimum Initial Services Package (MISP) and the 12 reproductive health kits that accompany this manual (Chynoweth, S., 2015). MISP is a “coordinated set of priority reproductive health services designed for the onset of an emergency to prevent excess morbidity and mortality, particularly among women and girls” (Krause et al., 2015, p. 2). Because of gaps that were found in reproductive health care at the beginning of the 21<sup>st</sup> century, MISP was incorporated in the *Sphere Humanitarian Charter and Minimum Standards in Disaster* (Chynoweth, 2015). This means that any organization or NGO that is providing emergency reproductive health care in a humanitarian setting must provide the minimum standards laid out in this protocol. It is a common misconception that MISP is simply just in place to guarantee equipment and supplies. It is utilized in order to ensure specific health practices

are in place to guarantee the dignity of all women seeking reproductive health services (Sphere, 2004).

Although there was increased coordination of MISP in Jordanian settings (Chynoweth, 2015), there are still gaps in implementation including poor coordination, lack of procedures in place, inadequate knowledge of MISP, and lack of knowledge by both refugees and providers of available services within host communities (Krause et al., 2015). Coordination issues have been addressed in meetings hosted in Amman, but many of the solutions to improve coordination have been focused on Za'atari refugee camp and not host communities. Women were already able to hear about reproductive health services more easily within the camps because they are not as spread out as the women in the host communities (Krause, et al., 2015). Although free family planning services are available in both camps and host communities, less than half of women in Za'atari and almost none in Irbid City knew where access them (Krause, et al., 2015).

Family planning and birth control is addressed in the relatively new "additional priorities" section of MISP added in 2010. It states that there needs to be enough contraception available during emergencies to meet demand. Because it is a new addition, it is often bypassed and overshadowed because there is a lack of knowledge about it (Krause et al, 2015). Because of this overshadowing, only 30% of women at a reproductive age that are married or in a union living in a country affected by a humanitarian crisis use contraception (UNFPA, 2016). The IAWG also found that short-acting methods of birth control (i.e. pills, injectables) were more readily available in camps and host communities for refugees all over the world while long-acting/permanent methods were rarely mentioned, even though they are proven to be more cost-effective and ultimately

encourage women to seek birth control (Chynoweth, 2015). However, in Jordan, long-acting birth control methods, like IUD's were more widely available in both camps and host communities as compared to other host sites for refugees in different countries (Krause, et al., 2015).

### **Access and Barriers to Reproductive Health Care and Family Planning in Jordan**

In 2010, the IAWG made a statement about family planning as a life saving intervention in humanitarian settings. Comprehensive family planning can avert up to 32% of maternal deaths and nearly 10% of newborn deaths (Chynoweth, 2015). Even given this evidence, there are still multiple barriers that women have to overcome in order to access family planning mechanisms. One of the main issues is the lack of knowledge about services provided, especially in host communities. Almost of all of the participants in Irbid City surveyed in Krause's study were unaware of locations available for free family planning, even though they expressed a strong need for it (2015). A similar sentiment was echoed in Chynoweth's study stating that reproductive health services were in place, but utilization lagged because the population was unaware of existing services (2015).

This lack of knowledge and lack of awareness causes other perceived barriers to access. Many women believe that their options are limited and are afraid that these options will cause negative side effects. Additionally, married women only knew of intra-uterine devices (IUDs), oral pills, and condoms as options for birth control and were not aware of the vast array of options that are available (USAID, 2016). There is also a fear of embarrassment due to socio-cultural barriers when seeking any type of birth control because there is little knowledge about the benefits birth control provides (Chynoweth, 2015). Other factors that proved to be barriers were the fear of high costs of medications (especially in host communities), inconvenient and

long wait times in health care centers, and lack of trust in health care providers (Ay et al., 2016). One study suggested that lack of trust stemmed from disrespect that was shown towards refugee women by their health care providers (Krause et al., 2015).

## Methodology

### Participants

Participants for this pilot study were chosen based on convenience sampling. All of the participants were Syrian refugee women who sought assistance at an NGO in Karak. This particular NGO also had ties to the UNHCR, meaning the participants were all registered refugees. Additionally, some women were asked if they would like to further their participation by being interviewed. Each survey had the same questions included. While, the interview questions were all the same on the guide, some additional questions were asked if I felt there was a need to probe further or take the interview in a different direction, making it a semi-structured interview. In total, 16 surveys were completed and five interviews were conducted. However, two surveys were not taken into account due to the participants being over 49 years old and one was discarded due to incompleteness of the questions.

**Table 1: Demographics of Respondents (Survey and Interview Combined)**

Syrian Refugee Women (n=18)			
Variable		Frequency (n)	Percent (%)
Age	18-23	1	5.56
	24-29	8	44.44
	30-35	5	27.78
	36-41	1	5.56
	42-47	3	16.67
Past Location in Syria	Damascus	12	66.67
	Babbila	3	16.67
	Homs	3	16.67
Number of Children	1	4	22.22
	2	2	11.11
	3	11	61.11
	4+	1	5.56

Unplanned Pregnancy	Yes	9	50.00
	No	9	50.00
Plans for Children in the Future	Yes	4	22.22
	No	12	66.67
	Maybe	2	11.11

As illustrated in the table above, a majority of the respondents were from Damascus, the capital of Syria, but the data did come from women who lived in other regions of the country.

Additionally, 66.67% of the participants were not planning on having children in the future and were still of reproductive age. This is an ideal number when discussing birth control because one can assume that this would be the population most interested in seeking birth control. It is also worth noting that half of the respondents had experienced an unplanned pregnancy.

### **Procedure**

Before commencing this study, my research proposal, which included my research question and objectives, my ideal participants, and copies of my interview and survey questions, was sent to a local review board in Amman. Research professionals, medical professionals, and academics in the city unanimously approved it without modification. My initial proposal claimed that I would do a comparative analysis of birth control satisfaction between Za'atari refugee camp and the host community of Karak. However, due to the time constraint and the difficulty of conducting research in a camp, it was decided by both Dr. Bayan Abdulhaq, the academic director at SIT Jordan: Refugees, Health, and Humanitarian Action program, and my research advisor, Dr. Reema Safadi at the University of Jordan, that I should focus on one location to develop a qualitative analysis of a particular area. Before conducting any research, I met with Dr. Reema to review the questions I would ask and expanded the questions to include more demographic based information as well as relevant follow up questions.



Once the questions for the interview and survey guides were set, I was able to meet with workers from a local NGO in Karak who deal with Syrian refugees. My first visit to this NGO was on November 21, 2016. During that visit, I was able to accompany workers from the NGO conducting house visits with the UNHCR. With the permission of the household, I was able to conduct one interview on this day. A woman who works with the NGO was able to translate my questions to the participant and the answers back to me. She also helped to translate the informed consent form, which the participant signed. The participant also agreed to be recorded so I could code the data at a later time.

I went back to this same NGO on November 26, 2016. My surveys were distributed to women attending a “session” during the workday. Six surveys were distributed with the help of two women working for the NGO. After explaining the purpose of my study and explaining informed consent, both of them helped read the questions to the participants in order to garner an accurate response. During this session, the women were invited to participate in an interview with the same translator from before and myself. Four women were then interviewed at the NGO office. The same procedure took place with these four participants. Each one agreed to be recorded and signed informed consent forms.

My last visit to this NGO was on November 28, 2016. I was again accompanied to a household with another women working with this NGO. Within the same family, four surveys were distributed. The NGO worker was able to read the questions to the participants in Arabic and recorded their answers. During this visit, there were multiple students conducting their own research at the same time. Although I was anxious this would overwhelm the participants, they were welcoming and open to answering our questions.

Once the data was collected, I entered the surveys into an SRSS (Version 24) data table in order for them to be analyzed and to find correlations between the data. These results were used for quantitative statistical analysis. I then transcribed all of my interviews (in English) into a Word document. Once transcription was completed, the data was coded in order to notate important and relevant information for the topic and to cross-examine each interview to recognize themes and patterns.

### **Research Instruments**

The questionnaire was an original questionnaire. It was composed of 18 questions, some of which contained sub-questions. The first section of the questionnaire addressed demographic information in order to understand who was completing this survey and what background they had. The rest of the survey asked questions pertaining to reproductive health care satisfaction, history and knowledge concerning birth control, concerns about birth control and family planning, and attendance of support groups regarding reproductive health, if applicable. The participants were able to add any other comments or concerns at the end of the survey that they did not feel were addressed, although none of the respondents chose to do so.

The interview guide was created to be a semi-structured interview. Although there were specific questions on the guide, I went in knowing that follow up questions were expected to be asked, based on the information the participants gave me. This type of interview allows for more probing and explanation of the answers to obtain a more in-depth history and response from some of the participants. Rima Akramami, language coordinator at SIT, helped to translate both the survey and interview guide from English to Arabic. While conducting the interviews, an observation sheet was utilized to note any changes in emotion or behavior during the interview and notable reactions to specific questions.

In addition to these guides and questions, I also had “Informed Consent” forms for each participant to sign. These consent forms explained to the participants their right to privacy, confidentiality, and withdrawal, meaning they could end their participation in the study at any time and their answers would not be recorded. To further protect the answers, all of my interviews were recorded on a cell phone, which is password protected, as were the files. All of the data and statistics were saved on my laptop in password-protected files. I will delete all of the files once the research is complete, as I stated in my research proposal. These are all the steps I took to protect the integrity of the participants and the data.

### **Obstacles**

Going into this study, I knew that time would be the greatest obstacle to overcome. Time management and seizing of opportunities were the strategies used to overcome this hurdle. After approval from the local review board, there were about four weeks allotted to seek a target population, collect and analyze data, and complete a final report. With that time constraint, the obstacle of small sample size became an issue. In order to complete the study within the deadlines, the number of participants and data collected do not make the following results generalizable or statistically significant.

As mentioned earlier, another obstacle was the change of course this study took. Although it was originally going to be a comparative analysis study between a host community and a refugee camp, the time constraint made the case to choose one community, the host community. This change made it necessary to expand the interview guide in order to gather more qualitative information about a single place to produce more valuable research for this particular location.

## Results/Findings

### Survey Results (Quantitative Data)

**Demographics of survey respondents.** Survey participants were first asked to fill out questions regarding demographics and family size. These questions included age, where in Syria she lived before moving to Jordan, how many children she had, and if she was planning on having any more children. Additionally, the survey asked whether or not the woman had ever experienced an unplanned pregnancy to discover whether this had anything to do with her current birth control choices. As stated earlier, there were a total of 13 surveys analyzed. Two surveys were discarded due to the respondents being over 49 years old and one was discarded due to incompleteness.

**Table 2: Demographics of Survey Respondents (n=13)**

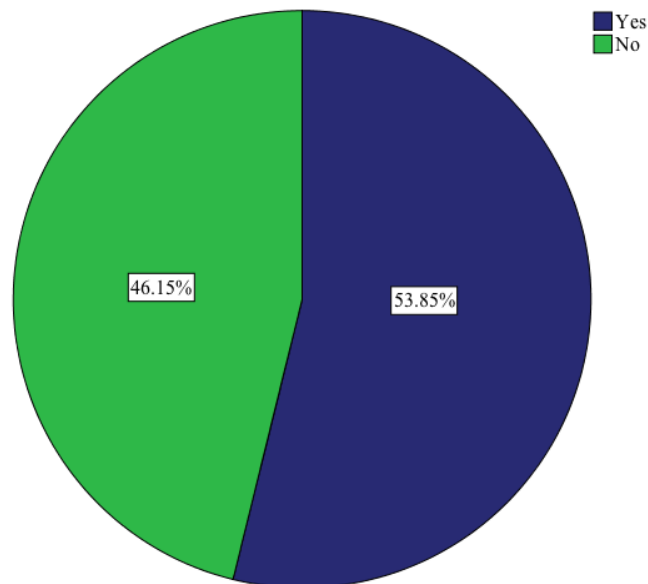
Variable		Frequency (n)	Percent (%)
Age <sup>1</sup>	18-23	0	0
	24-29	6	46.15
	30-35	4	30.77
	36-41	1	7.69
	42-47	2	15.38
Past Residence in Syria	Damascus	7	53.85
	Babbila	3	23.07
	Homs	3	23.07
Number of Children	1	3	23.07
	2	2	15.38
	3	7	53.84
	4+	1	7.69
Plans for Children in Future	Yes	3	23.07
	No	8	61.54
	Maybe	2	15.38
Unplanned Pregnancy	Yes	6	46.15
	No	7	53.84

<sup>1</sup> For age, the mean was 31.76, the maximum was 47 with the minimum being 24, and the standard deviation was 7.47.

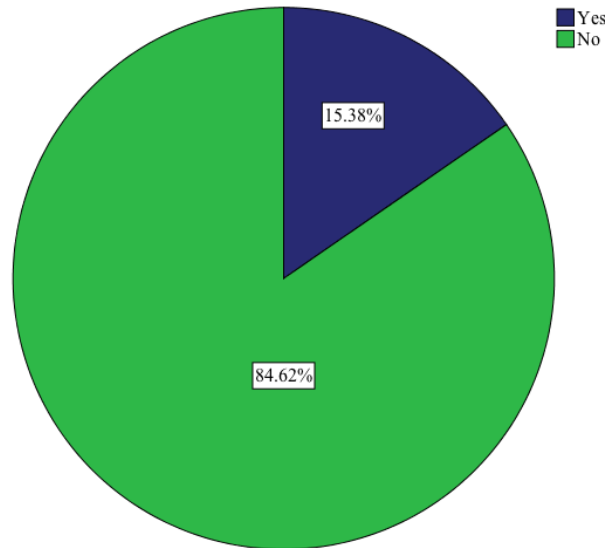
The women who answered that they were planning to have children in the future were all 29 years old or younger. The women who answered “maybe” to having children in the future were 32 years old and younger. As the table shows, nearly half of the participants answered that they had experienced an unplanned pregnancy, which will be compared to choices made regarding their current birth control.

**General reproductive health questions.** The following portion of the survey asked a series of questions about the women’s reproductive health care experience, knowledge, and inquiry about birth control. These questions were asked in order gauge whether or not the subject was ever brought up in their current health care environment. Additionally, there were questions asked about the trustworthiness of their current health care provider to see if those results had any correlation to future answers on the survey. Last, women were asked about their awareness of the various types of birth control available.

**Figure 1: Response to the question, “Have you inquired about using birth control with a health care professional?”**

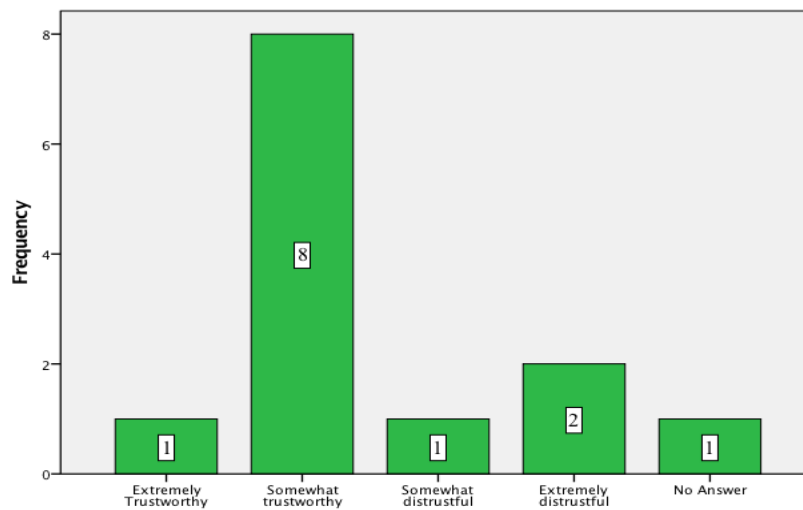


**Figure 2: Response to the question, “Has your health care provider raised the subject of birth control with you?”**



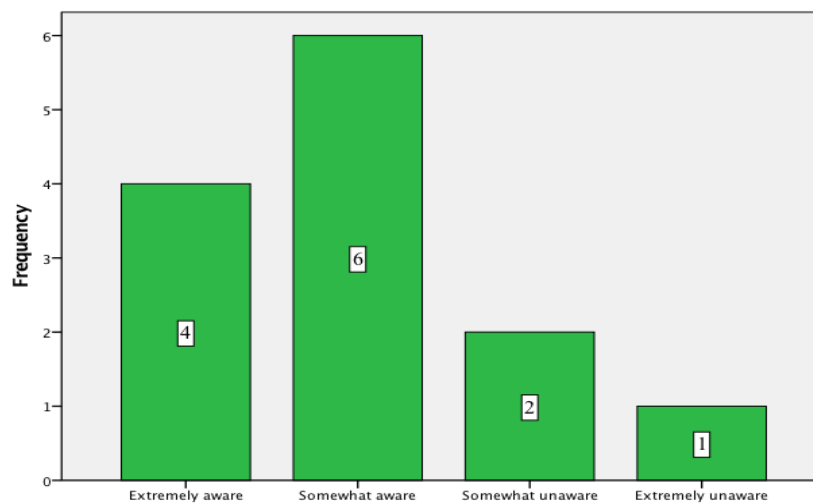
The research shows that although a little over half of the women (53.85%) have asked about birth control, the health care professionals are not likely to be the ones to bring up the subject with them (84.62% did not have it brought up with the woman).

**Figure 3: Response to the question, “To what degree do you find your health care provider to be trustworthy?”**



The respondent that replied with “no answer” made a note on the survey stating that she doesn’t deal with health care professionals, which could mean she either doesn’t seek health care in her community or she misunderstood the question.

**Figure 4: Response to the question, “How aware are you with the various types of birth control available?”**



This research shows that a majority of respondents find their health care professional to be somewhat trustworthy (61.54%) or extremely trustworthy (7.69%) while a similar majority thought they were either extremely aware (30.77%) or somewhat aware (46.15%) of various birth control methods. However, there was no statistical significant of correlation between these two variables.

**Personal birth control choices.** Participants were then asked about their current and past methods of birth control and whether or not they were satisfied with the method they were currently using. Questions included whether or not they were currently using birth control, if they had used birth control in the past, and the specific types they are or were using. Last, they were asked about their overall level of satisfaction regarding their current birth control method.

**Table 3: Birth Control History (n=13)**

Variable		Frequency (n)	Percent (%)
Currently on Birth Control	Yes	7	53.85
	No	6	42.15
Taken Birth Control in Past	Yes	4	30.77
	No	2	15.38
	N/A <sup>2</sup>	7	53.85

<sup>2</sup> N/A = not applicable throughout this report.

The question read, “Are you currently taking birth control?” following by “If not, have you taken birth control in the past?” prompting the women who answered “yes” to the first question to not answer the following question. There was no statistical significance between whether women were on birth control and their plans for future children ( $p\text{ value}=.193$ ). All the women who stated that they were planning on having children in the future were not currently on birth control, while two of the three planning on having children had never used any modern method of birth control.

**Table 4: Specific Method of Birth Control (Current and Past) (n=13)**

Variable		Frequency (n)	Percent (%)
Current Method of Birth Control	Male condom	1	7.69
	Female condom	1	7.69
	Oral pills	1	7.69
	IUD <sup>3</sup>	4	30.77
	None	6	42.15
Past Method of Birth Control	Male condom	3	23.07
	Female condom	3	23.07
	Oral pills	1	7.69
	IUD	4	30.77
	None	2	15.38

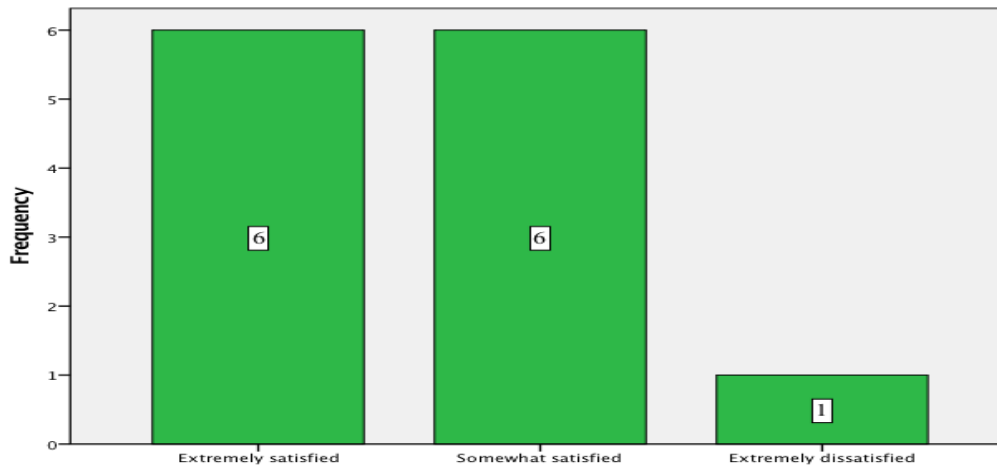
Although respondents had the opportunity to choose as many options as they liked, each respondent chose one for each question. It is also important to note that there were other options (including birth control vaginal ring, birth control patch, birth control implant, and birth control injection) which none of the respondents chose. The data proves that the IUD is the most popular form of birth control among respondents at 30.77%. Women who were currently taking birth control also specified which ones they had tried in the past. Three respondents who had not used the IUD in the past are currently using it. Reasons for no longer using the IUD had a trend of wanting more kids in the future or maybe wanting more kids, thus, no longer needing or wanting

<sup>3</sup> IUD = Intra-Uterine Device



birth control at this time.

**Figure 5: Response to the question, “How satisfied are you with your current birth control?”**

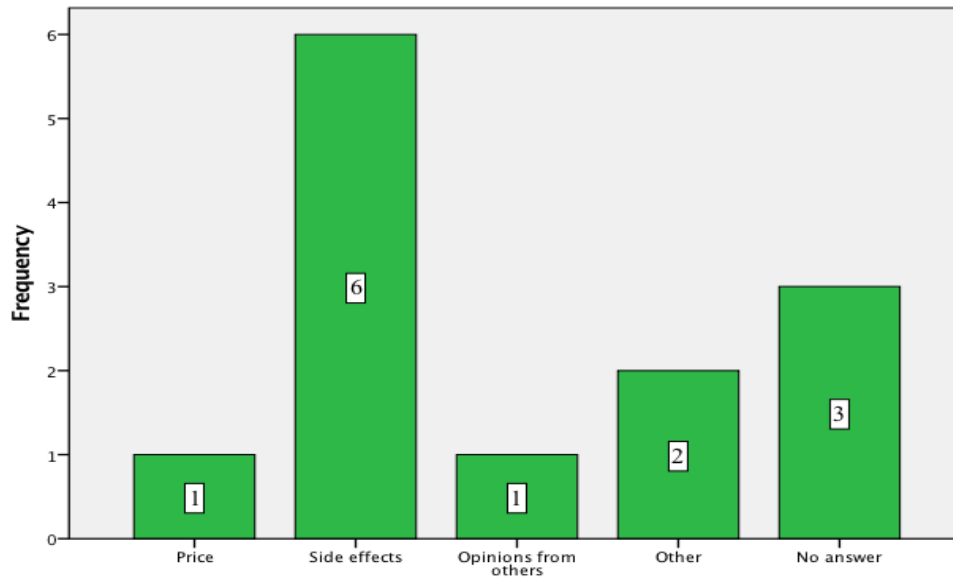


For the above question, a third option of “somewhat dissatisfied” was available but not utilized.

Every respondent answered this question, even if they were not currently on birth control, causing the results to be slightly misleading. Further look into the data shows that the one respondent who answered “extremely dissatisfied” is currently not on birth control but had used “female condoms” in the past. All seven respondents currently on birth control were either extremely satisfied (57.42%) or somewhat satisfied (42.86%).

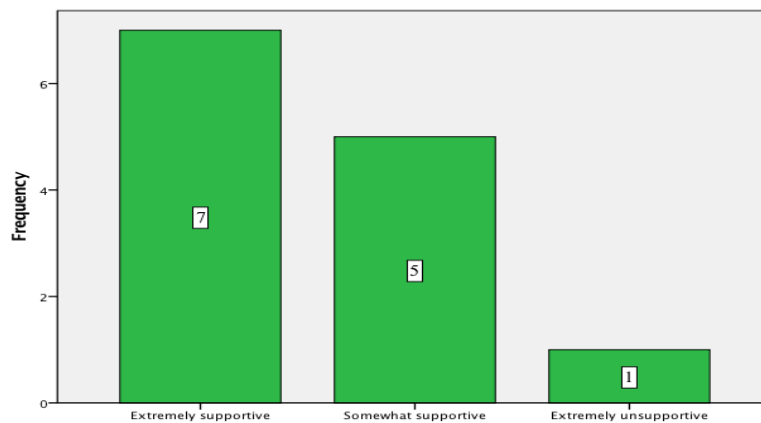
**Barriers/concerns about birth control.** Respondents were asked to list any concerns they had about birth control and any barriers that may prevent them for accessing it efficiently. Questions were asked about the price they had to pay, the concerns they had, and whether or not their husband was supportive of their choice to use birth control. Surprisingly, price was hardly listed as a concern with many of them not paying more than 10 Jordanian dinars (the currency of Jordan, equal to \$1.41), if anything at all. This could be due to the permanent option of the IUD being used, which does not require continuous payment.

**Figure 6: Response to the question, “What concerns do you have about birth control?”**



Respondents were able to answer with as many choices as they would have liked, but each respondent choose one. The research shows that the most prevalent concern is the side effects that birth control can cause (weight gain, mood swings, changes in menstrual cycle, etc.) at 46.15%.

**Figure 7: Response to the question, “How supportive is your husband about you taking birth control?”<sup>4</sup>**

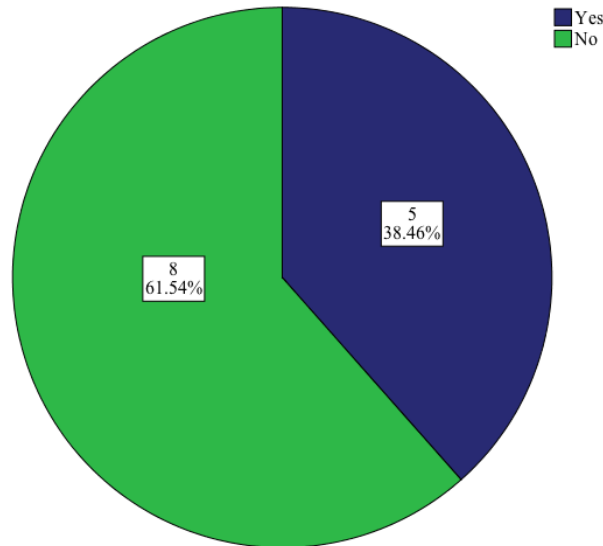


<sup>4</sup> There was a note before this question telling participants to skip this question if they were not married. Since every participant answered this question, one can assume each participant is married.

There was a third option of “somewhat unsupportive” in which no one utilized. The one respondent who answered “extremely unsupportive” was planning on having kids in the future and was not currently using birth control. However, she had been using oral pills in the past, perhaps without the support of her husband.

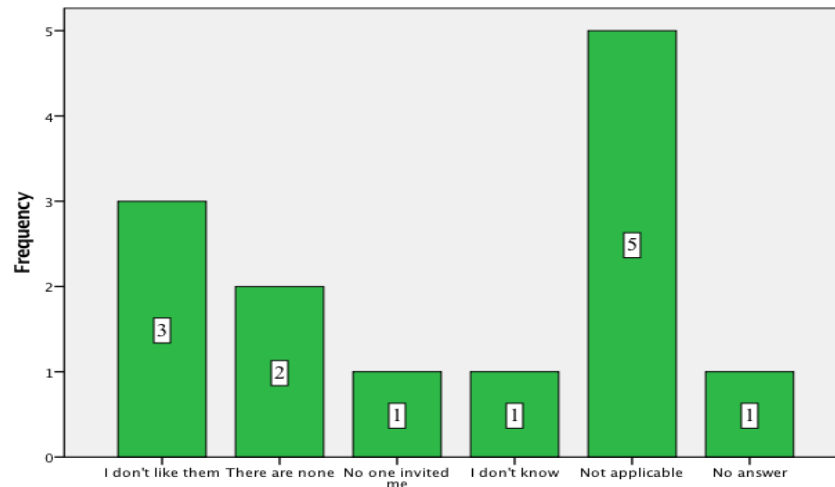
**Support groups.** The last portion of this survey was dedicated to discovering whether informal support groups were utilized, if they were available. There were also questions that pertained to the satisfaction of the groups (if attended) and the reasons for not attending.

**Figure 8: Response to the question, “Have you attended any support groups/discussions about birth control?”**



Less than half of the respondents (38.46%) had ever attended a support group or discussion regarding birth control and family planning. Of the five that did attend, three (60%) replied “yes” to being satisfied with the information learned while two (40%) replied they were “kind of” satisfied. There was no statistical significance of correlation ( $p$  value = .226) between women who were “extremely” or “somewhat” aware of the types of birth control options and whether or not they attended support groups.

**Figure 10: Response to the question, “Why haven’t you attended (support groups/discussions)?”**



Because five of the respondents had attended the support groups, their responses are displayed as “not applicable”. Although respondents were able to fill in the answer to their liking, three respondents (37.5% of those who did not attend) said, “I don’t like them” while two (25% of those who did not attend) said, “There are none”.

### **Interview Results (Qualitative Data)**

As previously stated, I interviewed a total of five women to gather qualitative data. Three of the women had completed the surveys prior to the interview. The interview questions expanded upon some of the survey questions and allowed participants to go more in depth about their satisfaction with birth control, accessibility and affordability of birth control, awareness, and support mechanisms. Common themes were discovered upon coding the interviews that are important to this study.

**Infrequent visits to reproductive health centers.** Four of the five respondents stated that they do not visit their local reproductive health centers often. One respondent said she had only been once in six months with another saying she only went twice in a year and a half. The

one respondent who attended regularly did so because she was pregnant, but did not seek any other services while there. The reasons for the infrequent visits were not because of distance to the clinic or dissatisfaction with the clinic itself. Every respondent mentioned the financial burden that accessing reproductive health clinics presents, with three specifically mentioning the lack of valid documentation to access money for health care. They mentioned not having “*bassmeit 3ein*”, the Arabic translation of the iris scan used to access the UNHCR stipend. One respondent went so far as to obtain illegal documents to access necessary prescriptions: “I go to someone who has health insurance and I write, you know, my medicine on his name so I can have the ability to have it for free.” Because of this financial situation, four of the five respondents believed it would be easier to access birth control in Syria than in Jordan.

**Lack of awareness.** All five respondents mentioned only knowing of the IUD and oral pills as forms of modern birth control, with one mentioning she had heard of condoms being available as well. Additionally, none of the respondents said that their health care provider had approached them about birth control. They either had to ask for it themselves, or didn’t inquire at all. This lack of awareness has caused some women to make uninformed decisions about their birth control, with one woman saying, “I was thinking of having the tabs, just people around me, they are not working at the reproductive clinic, okay, they advise me not to have the tab because it will make me more nervous, and I am from the first place nervous. And also, it will make me gain weight and I didn’t want to gain weight”. This lack of awareness also prompted four of the five respondents to mention a fear of the unknown side effects that birth control can cause.

**Birth control as a positive mechanism.** All five respondents agreed that birth control is a positive thing and important for women’s lives. Four of the five respondents believed that birth control could help families be more financially stable. Birth control helps control how many kids

one has and with less children, they can have better access to education and health care. One respondent also mentioned that it could help decrease the chance for early marriage among Syrian refugee girls.

**Need for support/discussion groups.** None of the respondents answered “yes” to attending any kind of support group or discussion about birth control within their communities. Three mentioned that they talk openly with women in their family, but not with any sort of health care professional present. Upon further questioning, four believed that it would be a good thing to introduce support groups about birth control and family planning into the community because of the benefits it could provide. One woman said, “It is very beneficial actually because, you know, the amount of information is different from every person to another. So, if I have zero information and she has 10% information, I can have it from her. It is going to be a benefit for me.”

## **Discussion**

The data from both the surveys and interviews shows the reality of how policies in place about reproductive health care affect women and how well international standards are being represented within host communities. The research shows that there is still confusion over how to access health care and family planning services, even if it is free. The document cited above in the literature review from the USAID (2016) mentioned that there was confusion about the policy that has changed over the past few years. Until 2014, health care access was free to all Syrian refugees who were registered with the UNHCR. From 2014-2016, they had to pay the same amount for health care as uninsured Jordanians. But then in February of 2016, registered Syrians could access maternal and child health services, including family planning, free of charge. However, the some of the women interviewed mentioned that without the new “*bassmeit*

*3ein*” iris scan, they cannot access the UNHCR’s monthly stipend to cover this kind of health care. This data suggest that there needs to be better accessibility and implementation of “*bassmeit 3ein*” and clearer communication about policies in place.

Another issue that came up across both the surveys and interviews was the lack of awareness. Although 76.92% of survey respondents said they felt “somewhat” or “extremely” aware of the birth control methods available, many of them had only heard of the IUDs, oral pills, and condoms. Similarly, the interviewees only mentioned these three birth control methods as well and did not mention patches, injections, etc. These exact methods were also the only ones known among married Syrian women, as the USAID report mentioned in the literature review. This shows a need for better communication from health care professionals in the reproductive health field about the types of birth control offered. The more knowledge that women have about the types of birth control available, the more options they have. These options could help dispel fears about the side effects of birth control. 80% of interview participants mentioned this concern while 46.15% of survey respondents mentioned side effects as their top concern about birth control. Women would be able to see what would work with their bodies and lives if they know the multiple options that are available.

Another common theme between the surveys and the interviews was the lack of knowledge and/or lack of attendance regarding support groups, discussion groups, and/or support mechanisms. Only 38.46% had attended a support group while none of the women interviewed had attended one. The interviewed women further elaborated on that question, with many of them agreeing that support groups would help increase awareness, share information, and help make informed decisions about family planning on a personal level. Furthermore, some women who were surveyed mentioned they didn’t attend because they don’t like them, signifying there

are some in place already, but not desirable. Groups and support mechanisms should constantly be evolving and listening to the needs of those attending in order to be a positive resource that women want to access.

### **Conclusion**

Women are a vulnerable group. Syrian refugees are a vulnerable group. Being Syrian refugee women heightens that vulnerability, especially in a foreign land. Reproductive health care for refugee women should always be at the top of priority lists due to the benefits quality health care provides to all aspects of life. Unfortunately, some aspects of reproductive health care access and satisfaction among Syrian refugee women about access is lacking. Women in this study mentioned that finances hold them back, they are not as aware as they believe they can be, and support groups are not in place to provide mechanisms to seek knowledge about birth control and family planning.

The discussion group I witnessed occurring at Za'atari refugee camp first inspired me to pursue this topic with emphasis on support mechanisms available. I believe the benefits of having these groups available is invaluable. It gives women the space to own their bodies and ask personal questions that they have not been able to ask before. Having women engage in body-positive dialogue among their friends and family fosters a feeling of safety. Within this safety, health care professionals can hear the truth of women's concerns, take it back to their place of work, and continue to improve reproductive health care for so many women who have lost everything. In order to increase awareness, I also think that it would be beneficial for refugee women to be able to attend regular, informal support groups in order from them to learn what their options are regarding birth control. These support groups should be community driven, coordinated among different partners and agencies, and mobilized throughout various parts of the community. The support groups should also consistently ask the women attending what they



like and do not like in order to ensure satisfaction and return attendance.

Based on the research that is complied and the research that I hope is to come, I believe that now more than ever there needs to be affordable birth control available to every single refugee woman, with or without health insurance. Women are starting to see positive outcomes that modern birth control can bring, especially during emergency situations. I believe that it is necessary that at the onset of all emergency crises, reproductive health should be a top priority and free birth control (in any form) should be readily available and accessible. Letting Syrian refugee women regain ownership and autonomy of their health and their bodies is a vital step to take in order to ensure safety and dignity of them and their families. Living with dignity does not have to be a far-fetched notion that seems unattainable. By attending to the health and well-being of women, that notion can become a reality. It is a reality that every single woman, refugee or not, deserves to have the chance to experience. It is time that their voices are heard.

### **Study Limitations**

Although the purpose of the study yielded important information, there were various limitations that hindered the process of this pilot study. The first one was the time constraint. Due to the nature of SIT and the program dates, data collection took place over the course of one week in order to ensure adequate time to analyze the data and write up the report. The local review board approval process took slightly longer than expected, which pushed back the original timeline. Because of this time constraint, the sample size was smaller than desired. This small sample size, especially the sample size of survey responses, means that the data is not statistically significant, nor is it generalizable.

Another limitation that needed to be overcome was the language barrier due to my lack of knowledge of Arabic. My original interview and survey questions were written in English and

were then translated into Arabic. This translation may have caused a loss in the meaning of some of the words that I wanted to use, because many of the terms used for birth control differ between English and Arabic. The word I use for birth control oral pills is “pills” while in Arabic and in the Middle East it translates more closely to “tabs”. Another issue I ran into while transcribing the interviews was the use of the word “loop”. The translator said this word during the interview. While she was translating the word meaning “intra-uterine device”, I kept hearing “lube”, thinking she was referring to spermicide. However, upon going over the data with my advisor, she told me that most women called the IUD a loop. Nuances like this were issues that came up and caused me to re-analyze some data during this study.

As stated in the methodology section, there was an original plan to make this a comparative analysis between a host community and a refugee camp. However, there were some issues when trying to conduct research in a refugee camp, like confidentiality, legality, and safety. In order to make sure I had enough time to analyze data, I decided to focus on just one specific host community. I had to reword some of the questions to cater towards the women of the host community and not women in refugee camps. Luckily, focusing on one place and one population helps to gather more qualitative data about one place and can more effectively provide recommendations catered to that population.

### **Recommendation for Future Studies**

Women and girls are a vital part of any society. Making sure that they are adequately cared for is necessary to make any society thrive due to the contributions that they provide. Caring for their reproductive health is a necessary part of making sure their needs are met and women’s dignity remains intact. I think it would be valuable if this research were continued with a longer time period in order to reach a larger population of Syrian refugee women within Karak.

Additionally, I think it would be important to do a comparative analysis between various host communities and refugee camps in Jordan in order to discover where they are both lacking and thriving. This type of comparative study would provide the opportunity for various communities to learn what is working and what isn't. Communities could then compare themselves to others to see where they could improve their reproductive health care services and birth control availability. Furthermore, I believe it would be worthwhile and beneficial to do this same study specifically targeted towards Syrian refugee women who are not registered with the UNHCR.

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