Syrian Refugee Mothers in Jordan: Perceived Social Support and Postpartum Depression

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Syrian Refugee Mothers in Jordan: Perceived Social Support and Postpartum Depression

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# Table of Contents

Copyright Permission ............................................................................................................. 3  
Acknowledgements ............................................................................................................. 4  
Abstract .................................................................................................................................... 5  
Introduction .......................................................................................................................... 6  
  *Research Questions and Parameters* .................................................................................... 7  
Literature Review .................................................................................................................. 8  
Methodology .......................................................................................................................... 12  
  *Obstacles* ............................................................................................................................. 15  
  *Ethical Considerations* .......................................................................................................... 16  
Findings and Results ............................................................................................................. 17  
Discussion and Conclusions .................................................................................................. 23  
  *Strengths and Limitations* .................................................................................................... 26  
  *Recommendations for Further Research* ............................................................................. 27  
Tables ...................................................................................................................................... 29  
References .............................................................................................................................. 31  
Appendices ............................................................................................................................. 35  
  *A: Sociodemographic Questionnaire - English* .............................................................. 35  
  *B: Sociodemographic Questionnaire - Arabic* .............................................................. 38  
  *C: Perceived Social Support Scale - English* ................................................................. 42  
  *D: Perceived Social Support Scale - Arabic* ................................................................. 44  
  *E: Postpartum Depression Scale - English* ................................................................. 46  
  *F: Postpartum Depression Scale - Arabic* ................................................................. 47  
  *G: Interview Guide - English* ......................................................................................... 49  
  *H: Interview Guide - Arabic* ......................................................................................... 52  
  *I: Participant Consent Form - English* ............................................................................ 53  
  *J: Participant Consent Form - Arabic* ............................................................................ 56
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Abstract

Many women suffer from postpartum depression; migrant women experience postpartum depression at rates almost triple that of the general population. This study investigated the associations between perceived social support and postpartum depression among Syrian refugee mothers living in Amman, Jordan. Eleven mothers completed a sociodemographic questionnaire, the Edinburgh Postnatal Depression Scale (EPDS), and the Interpersonal Support Evaluation List (ISEL) - Shortened Version. Four of those mothers also participated in individual interviews, and four others were included in a focus group. Multiple recurring themes were identified from the interviews and focus group, including: perceived differences in child and social support in Syria versus Jordan, lack of freedom of movement, legal status as refugees drains psychological well-being, issues related to children’s ages, the improving situation and the resilience of refugee mothers, and suggestions for improving support systems. In addition, while no significant correlations were found between social support and PPD or between PPD and demographic factors from quantitative analyses, significant correlations were found between social support and demographic factors, including: marital status, age at marriage, number of locations lived in Jordan, and whether or not participants were still in contact with their children’s caretakers.

Keywords: mental health, public health, regional studies: Middle East
Introduction

Postpartum depression (PPD) is a very common childbirth complication; 10-15% of women suffer from it. The prevalence of PPD is almost tripled among migrant women, who experience it at varying rates of around 42% (Collins, Zimmerman & Howard, 2010). Refugees are at heightened risk of experiencing PPD due several factors. One prominent factor is the high prevalence of traumatic and stressful events they experience in their home countries, during the process of fleeing, and in host countries. Traumatic events specifically experienced by mothers include sexual and gender-based violence and birth-related trauma due to lack of access to care. At the same time, the social support networks of refugees are often interrupted or lost due to migration. As social support is a protective factor against PPD, refugees are expected to have higher rates of PPD due to both heightened risk factors and decreased buffering by social support.

Terminology

**Postpartum Depression**: depression following the birth of a child, as measured by a score of 10 or greater on the Edinburgh Postnatal Depression Scale (EPDS).

**Social Support**: the amount of perceived support a person receives from others, as measured by the abbreviated, 12-question version of the original Interpersonal Support Evaluation List (ISEL). The scale measures social support along three subscales of appraisal support, belonging support, and tangible support.

**Syrian Refugee**: a person of Syrian nationality who has fled Syria, but may or may not be officially registered with the UNHCR as a refugee.

**Mother**: a woman who has carried and given birth to a child.

Research Questions and Parameters
The focus of this study is the relationship between perceived social support of Syrian refugee mothers in Jordan and postpartum depression.

What is the relationship between perceived social support of Syrian refugee mothers in Jordan and postpartum depression, and do mothers think these two variables are related? What are other risk and protective factors associated with PPD among Syrian refugees in Jordan? What are the current modes of social support utilized by Syrian refugee mothers who gave birth to one or more children in Jordan? Do those mothers express a desire for more extensive support, and if so, what are the characteristics of the support they would like to have?

**Main Assumptions and Hypotheses**

Refugee women have higher rates of PPD due to various factors including higher rates of traumatic experiences, higher rates of births with adverse outcomes, and feelings of loneliness. As social support is considered a protective factor against PPD, and refugees have been found to have less social support than the general population, refugees who have left homes and familial support networks behind in Syria are expected to have less social support in Jordan, and as a result, to have increased risk for postpartum depression.

It is hypothesized that in this study, lower perceived social support will be associated with higher postpartum depressive symptoms, along with a more unstable marital status, lower income, unemployment, more moving within Jordan, and shorter time of care provided by child caretakers. In addition, it is probable that Syrian refugee mothers may feel a strong sense of loneliness, as shown by previous studies, and that because of this loneliness, may express a desire for more social support. This study will explore the current modes of social support utilized by Syrian refugee mothers in Jordan and characteristics of social support they would like to have.
The topic of this study was chosen based on personal interest in mechanisms of intergenerational traumatization and the ways that maternal mental health can either perpetuate or mitigate legacies of trauma. From a background in neuroscience and public health, the researcher has particular interest in the impact of the intersection of maternal mental health and early life experiences on childhood neurological development. As postpartum depression influences children’s early life attachments, neurological development, and future educational and behavioral outcomes, it is an important focal point for supporting healthy child development through supporting maternal mental health.

**Literature Review**

Postpartum depression (PPD) is a significant complication related to childbirth. 15 percent of expectant mothers experience depression during pregnancy and the postpartum period (Pearlstein, Howard, Salisbury & Zlotnick, 2009). This risk is almost tripled for migrant women; while native-born women experience postpartum depression at rates of 10-15%, migrant women experience it at varying rates of around 42% (Collins, Zimmerman & Howard, 2010). In addition, a significant number of migrant women are pregnant. According to the Women’s Refugee Commission, up to 14 percent of displaced women between 15 and 49 years old could be pregnant. In some countries, this number could be even higher, with pregnancy rates of displaced women reaching up to 25 percent (Simsek, Yentur Doni, Gul Hilali, Yildirimkaya, 2017). Another study found that most pregnant refugees were carrying their first child (Dopfer et al, 2019). A woman’s first pregnancy has unique risks and challenges, including a much higher risk for postpartum depression; 13 percent of first-time mothers experience depression within the first 6 months following delivery (Pearlstein, Howard, Salisbury & Zlotnick, 2009). Because of
these high prevalence rates, risk and protective factors for postpartum depression are important to understand, especially as they relate to migrant women.

The importance of understanding, preventing, and treating PPD pertains not only to mothers, but also to their children. PPD may be associated with impaired development of infants on behavioral, cognitive, and emotional measures (Murray L, Cooper P, 1996). In addition, PPD has been found to make breastfeeding difficult for new mothers and to disrupt the mother-child attachment (Collins, Zimmerman & Howard, 2010). Persistent PPD has been associated with child behavioral problems at age 3.5, lower grades in mathematics at age 16, and higher rates of depression at age 18 (Netsi et al, 2018). Thus, PPD prevention is important for supporting healthy child development.

There are several risk factors for PPD, including medical complications during childbirth, a history of other psychological disorders, stressful life events, a vulnerable personality, poor quality of current intimate relationship(s), unemployment, and lack of emotional support (Garza, 2018; Boyce, 2003). Lack of these risk factors are associated with lack of PPD, and at the same time, there are protective factors against PPD such as family savings and and strong social support networks (Fiala, Svancara, Klanova & Kasparek, 2017; Morikawa et al, 2015). For migrant women in particular, important risk factors include stressful life events, lack of social support, and various cultural factors (Collins, Zimmerman & Howard, 2010). Notably, having more people supporting a mother during pregnancy has been found to protect her against postpartum depression (Morikawa et al, 2015). However, among migrant women, this relationship is more complex, and social support networks can have a wide array of effects on women’s psychological well-being. They have been found to be either supportive or non-supportive (O’Mahony, Donnelly, Raffin & Este, 2012). Thus, further research into social
support and PPD among migrant women is needed to clarify the nature of these relationships. A study on Middle Eastern migrant women in Australia identified four main categories of PPD risk factors: loneliness due to isolation and lack of social support, helplessness due to difficulty fulfilling traditional roles as a wife and mother, fear of in-laws labeling her as a “bad mother,” and lack of knowledge about PPD and support services (Nahas, Hillege & Amashe, 1999). While this study provides support for social support networks as a protective factor against PPD, the study was conducted among Lebanese, Egyptian, and Palestinian women, and did not include Syrian women. In addition, the study was conducted in Australia, and thus, assessed migrant women in a developed country.

In terms of Syrian refugee women specifically, there have been several studies that evaluate the status of their maternal mental health. However, several of them evaluated Syrian refugees in developed countries, namely Canada. A study of Syrian refugees in Canada found rates of perinatal depression as high as 58% (Bowen, Ahmed & Feng, 2017). Another study in Canada found that some Syrian refugee women cited their strong family support around birth as a reason why they believed Syrian women experience less PPD than other women, and that giving birth in Canada without female family members would be challenging (Ahmed, Bowen & Feng, 2017). Other studies evaluated Syrian refugees in developing countries, including Lebanon and Jordan. A study in Lebanon found that as compared to low-income Lebanese mothers, Syrian refugee mothers in Lebanon experienced more PPD symptoms. More serious PPD was associated with domestic violence, previous mental health issues, and illegal residence (Stevenson et al, 2018). A study in Jordan found that up to 50% of Syrian refugee mothers experienced PPD, and that PPD risk was negatively correlated with social support, income, and length of residence in Jordan. While these studies provide insight into PPD among Syrian
refugees, more research is needed to clarify the relationship between social support and PPD in Syrian refugee populations in developing countries, such as Jordan (WTO, 2001). There is also a need to verify the rates of PPD in Syrian refugees in Jordan, identify other risk and protective factors associated with PPD, whether mothers associate social support with PPD, and characteristics of support services they would like. This study aims to begin to answer those questions.

The theoretical framework behind this study is the stress vulnerability model of postpartum depression. This model states that if a mother has genetic, hormonal, and cognitive vulnerabilities, she may experience postpartum depression triggered by stress (Beck, 2002). The genetic and hormonal risk factors constitute biological predispositions to developing depression, and family histories of depression are usually used to determine genetic risk (Yim et al, 2015). The main focus of many biological theories concerning postpartum depression is on hormonal withdrawal and system dysregulation following the sudden drop in hormones after birth, including estradiol (O'Hara, Schlechte, Lewis & Varner, 1991), cortisol, and estrogen (Chrousos, Torpy & Gold, 1998). On the other hand, psychological models address the cognitive vulnerabilities and roles of stress in developing postpartum depression (Yim et al, 2015). One important cognitive variable is attributional style (O'Hara, Rehm & Campbell, 1982), and several types of stressors are associated with the development of postpartum depression, including relational, financial, and traumatic stress (Qobadi, Collier & Zhang, 2016). In addition, social support has been shown to be involved in prevention of postpartum depression (Ugarriza, Brown, Chang-Martinez, 2007). This study investigates PPD through the psychological side of the stress-vulnerability model of PPD. It assumes greater risk of PPD among migrant women due to the prevalence of stressors related to migration and acculturation (Bustamante, Cerqueira,
Leclerc & Brietzke, 2018) and sexual and gender-based violence for women in particular (Pottie et al, 2016), higher rates of adverse medical outcomes during childbirth due to lack of access to care (Dopfer et al, 2018), and a lack of social support as a consequence of migration (Lu, 2012). This study aims to verify social support as a protective factor among Syrian refugees in Jordan, identify other risk and protective factors for this population, and explore potential characteristics of support networks they would like. The graphical theoretical framework of PPD utilized in this study follows:

**Methodology**

*Data Collection*

*Participants:*
The participants in this study were Syrian refugee mothers. They were chosen because they are mothers, and thus have been at risk for postpartum depression either currently or in the past, and because they are refugees, and thus have experienced or are currently experiencing a change in social support networks associated with migration. Participants were located through community based organizations which included housing complexes specifically for Syrian refugee women and mothers.

**Interviews:**

Qualitative interviews were incorporated into the study to allow for more personal, in-depth analysis of the issues. Interviews were conducted by the researcher with the help of a translator. The researcher asked select questions in English (Appendix G), and the translator asked the participant the same questions in Arabic. The translator was trained and experienced in translation and was provided the questions in Arabic in advance of the interviews (Appendix H). The translator then translated the participant’s answer into English. All interviews were audio recorded for reference during analysis.

**Focus Group:**

A focus group was incorporated into the study to allow for more collection of qualitative data while allowing mothers who lived together to discuss issues amongst each other and build off of each others’ responses. The researcher asked selected questions in English (Appendix G), and the translator asked the participants the same questions in Arabic. The translator was trained and experienced in translation and was provided the questions in Arabic in advance of the interviews (Appendix H). The translator then translated the participants’ answers into English. The focus group was audio recorded for reference during analysis.

**Surveys:**
Surveys were used in order to incorporate quantitative data into the study that could be statistically analyzed in order to draw conclusions based on statistical significance.

*Sociodemographic Questionnaire*: A survey to assess sociodemographic variables such as age, income, marital status, etc. was self-designed (Appendix E). The survey was translated into Arabic (Appendix F) and administered to participants along with the other surveys.

*The Edinburgh Postnatal Depression Scale*: The Edinburgh Postnatal Depression Scale (EPDS) is a ten question scale which assesses mothers’ depressive symptoms within the past seven days. Answer choices range from 0 (no, not at all, never, hardly at all) to 3 (most of the time, very often, quite a lot), with questions 3 and 5-10 reverse scored. Total scores range from 0 to 30, with a score of 10 or higher indicating possible depression. A translated version of the EPDS in Arabic which has been shown to be valid and reliable was administered to participants along with the other surveys.

*The Interpersonal Support Evaluation List - Shortened Version*: The Interpersonal Support Evaluation List (ISEL) - Shortened Version is a 12-question scale used to assess people’s perceived social support. Answer choices range from 1 (definitely false) to 4 (definitely true) with total scores ranging from 12 to 48. Higher total scores indicate greater perceived social support; lower total scores indicate less perceived social support. Items 1, 2, 7, 8, 11, and 12 are reverse scored. The scale includes three subscales of social support including appraisal support, belonging support, and tangible support.

*Data Analysis*

*Qualitative*: Interviews and the focus group discussion were transcribed in English by the researcher. The researcher and advisor analyzed the transcripts independently and identified
common themes. These themes were compared to create a comprehensive list, each of which were supported by direct quotes.

**Quantitative:** Survey data was analyzed in SAS online. Composite scores were calculated for the EPDS and ISEL, as well as along the three subscales of appraisal support, belonging support, and tangible support within the ISEL. Descriptive statistics of the composite scores, as well as the sociodemographic variables were computed (Table 1). Correlations were computed between composite EDPS and ISEL scores and ISEL subscale scores and EDPS (Table 2). Correlations were also computed between EDPS composite scores and various sociodemographic factors, and between ISEL composite and subscale scores and various sociodemographic factors (Table 3).

**Obstacles and Adjustments**

The most prominent obstacle that arose during this research project was difficulty identifying and recruiting participants. The initial intention of the study was to recruit mothers who had given birth to a child in Jordan and were currently in the postpartum period, so that they could be screened for postpartum depression while also reflecting on the ways that giving birth in Jordan had affected the support systems they had and their overall experience with pregnancy and childbirth. However, it was difficult to locate mothers through community-based organizations who had recently delivered, and thus, the sample widened to include any Syrian refugee mothers living in Amman, Jordan. However, this complicated the ability to ask them about their experiences delivering a child in Jordan, as not all of them had delivered in Jordan. Thus, mothers were asked to recall any symptoms of postpartum depression they had following their first birth. However, this resulted in some mothers recalling their experiences delivering in Jordan, while other mothers who had only given birth in Syria were asked to recall their symptoms after delivering their first child in Syria. During interviews, mothers who had given
birth in Jordan spoke to those experiences, and mothers who had not given birth in Jordan spoke about their experiences raising children in Jordan.

The widening of the sample also introduced challenges associated with measuring postpartum depression. While the EPDS asks mothers to “check the answer that comes closest to how [they] have felt in the past 7 days” because they “are pregnant or have recently had a baby,” most of the study’s participants were not pregnant, nor had recently had a baby. Thus, they were instructed to recall their symptoms following their first delivery, as they would have experienced them in a 7-day period. Thus, the EPDS was used to measure past occurrences based on recall, while the ISEL was used to measure current social support. As a result, there was a time difference between the social support and PPD symptoms reported. Thus, the scope of the study became to assess the associations between previous PPD and current social support or social support and recall of PPD, and social support and sociodemographic variables, in Syrian refugee mothers living in Amman, Jordan.

**Ethical Considerations**

As ought to be done in all studies, but even more so in this study because participants were members of traditionally vulnerable populations, precautions were taken to ensure that their rights were protected. Informed consent forms explicitly included the fact that their participation in the study was completely voluntary, and that they had the right to discontinue participation at any time. In addition, the translator communicated information on the consent form verbally to each participant prior to filling out the consent forms.

In order to protect participants’ privacy, surveys and interviews were conducted in private rooms so that other people in the locality could neither view participants’ responses to questionnaires, nor hear their answers to interview questions. However, the focus group was
conducted among four women who knew each other very well and were comfortable in that setting. In addition, names and other identifying information were not collected from participants.

**Findings**

**Findings from Qualitative Data**

Upon analysis of interviews, several recurring themes emerged: many mothers expressed the feeling of having all responsibilities on them alone in Jordan; many of the women interviewed experience less freedom of movement in Jordan as compared to Syria: this was negative for the mother's happiness, negative for their kids if they had unmet needs as a result and positive for their kids if they spent more time with their mother; some mothers have more freedom of movement in Jordan, but see it as greater responsibility rather than more freedom; mothers got assistance from Jordanian doctors in terms of childbirth and raising children and some mothers receive help from Jordanian men; many mothers cited bettering financial coverage as a way to support them as mothers and allow them to access better medical care and educational improvements including decreasing violence or psychosocial support for their kids to learn how to deal with violence; their legal status as refugees appeared to take a toll on mothers’ psychological health; childrens’ ages were implicated in the amount of opportunities they were afforded; the situation and available services seem to be improving. Elaboration on each of these themes follows.

**Perceived Change in Social Support**

*In Syria:* Every mother stressed the importance of parents and family members in assisting with the care of their children and supporting them as mothers when they lived in Syria. This included
the husband, mother, mother-in-law, and other family members both from the immediate and extended families of the woman who gave birth and of her in-laws.

In Jordan: Many mothers expressed the feeling of having all responsibilities on them alone in Jordan.

“Previously in Syria, I was partly responsible. But here I am responsible for the whole house, I’m the one who’s feeding everyone, I’m the one who’s working; if someone needs healthcare, I’m the one who will take him to the hospital or doctor.”

Many mothers only got assistance from Jordanians pertaining to childbirth or raising children in the form of medical care from Jordanian doctors. However, some mothers receive help from Jordanian men.

“A lot of men live nearby and they give good advice. They help us with financial aid in case we have any medical cases for our kids. Sometimes if we face any problems at the school with Jordanians, they just go with us to the school and help us to solve these types of problems.

Between Syrians, some mothers lived together in the same building and would constantly help each other do daily activities and raise their children.

“We are like one family in this building.”

Other mothers were supported by the few family members who traveled with them to Jordan.

Freedom of Movement

Three of the women interviewed experience less freedom of movement in Jordan as compared to Syria due to security issues, lack of available childcare, and increased responsibilities. This was negative for the mother's happiness as some felt trapped, unsafe, and limited in their abilities to carry out necessary responsibilities.

“Here you are in prison. Your children will not go outside of the building.”

Mothers also felt unsafe, and avoided going outside in Jordan.
“It’s totally different. Even my social activities and going out by myself in Jordan and Syria. Before in Syria I used to go, I’m so familiar with the places [...] In Jordan no, now I just ask my husband to bring things from the market home.”

This was negative for the children of the women if they had unmet needs as a result of their mothers’ restricted movement; however, this was positive for kids if they spent more time with their mother. If lack of freedom of movement inhibited mothers from meeting their children’s needs, it took a toll on the mother’s psychological well-being.

“If your children are comfortable, you will be comfortable. It will be sad if your children are not comfortable.”

On the other hand, some mothers have more freedom of movement in Jordan, but view it as a source of more responsibility rather than a freedom.

“It’s not a freedom, it’s just a freedom that makes you tired. In Syria, it was very different. Our husbands used to bring everything [...] Here we took both roles - for the mother and the father, so things are hard.”

The legal status of refugees drains significant amounts of their psychological health

A few mothers cited a lack of financial coverage and poor healthcare facilities due to their legal status as refugees. One mother had a very unpleasant experience after having a cesarean section at a public hospital.

“I was in a very bad governmental hospital and one day just suffering from the pregnancy and experiencing pain, and they didn’t even ask me if I wanted to give birth naturally or cesarean.”

She explained that this experience was directly related to her refugee status and the coverage that was provided to her within that status.

“If I was in a private hospital it would be even better. I was in a public hospital because it was organized by the UNHCR. But if we paid by ourselves, even they would treat us way better.”

This poor care as a result of her legal status and coverage took a serious toll on her psychological health.
“I was depressed after my first birth because my medical situation was so bad. It was all about my medical condition.”

Mothers cited major obstacles associated with giving birth to and raising children in Jordan. Many of these major obstacles were related to their status. One mother stated that when she arrived,

“the situation was so bad [...] it affected my children. I leave them at the house and I will go and work. And the essential things I couldn’t provide them...the essential needs. I was not taking care of them. I was working for long hours.”

Her status was related to her low salary and lack of childcare services, which prevented her from providing for her kids; she also stated that her lack of freedom associated with her status affected her perception of her life.

“In Syria you had your own house, you had your own land. Here you are in prison.”

Other mothers stated that their biggest challenges raising children in Jordan as refugees was

“everything. The idea of raising them by itself is hard. Education. Healthcare. Everything. We are responsible for everything.”

Their access to education and healthcare are directly related to their status as refugees.

**Issues related to the child's age**

One mother mentioned that resources are limited for refugees and older children are given fewer opportunities. In addition, having older children above the age of 12 or 14 can limit the ability of mothers to be placed in housing accommodations. The weight of responsibility is also heavier on older children.

“The eldest brother, he will play the role of a father. So he will be 14 and he is the one who will take care of them all.”

**Improving Situation and Resilience**

The situation now appears to be generally better than it was in the past, and accommodations and services seem to be getting better. One mother said the situation in Zaatari Camp has improved.
“The situation was so bad. Before 7 years, the situation was so bad. But here there is improvement.”

She also stated that her own financial situation improved.

“My children wanted to eat something and I could not bring it to them because I do not have money. After my situation improved, we became better.”

Thus, the experiences of Syrian refugees in Jordan appear to be improving on both institutional and personal levels. Despite the improvements they suggested, several women mentioned that they are doing the best that they can with the resources they have.

“The bad education level, even such kind of problems, we can’t solve them. But at the same time we try as much as we can just to make it better” and “I adapt with the environment directly. Where you will put me, I will live.”

Ideal Support Systems

While the interviewees expressed high levels of resilience, they had several suggestions to improve the support they receive. Many mothers cited bettering financial coverage and support as a way to support them as mothers. This coverage would then allow them to access better medical care. They also would like educational improvements, including decreasing violence or psychological support for their kids to learn how to deal with violence. Mothers also wanted follow-ups from their medical care providers following procedures. Some mothers also wanted to have men who were willing to help them carry out activities that they either feel unsafe or unable to do alone.

“I want a trustworthy man that will be beside me and help me. You need a man. In the end, the man is not like the woman.”

However, it was clear that mothers felt that their family was their main support system in Syria and that their families could not be replaced.

“We depend on parents, and there are no parents here.”

Findings from Quantitative Data:
In our sample, the mean score on the EPDS was 14.9 and the mean score on the ISEL was 33.6. All mothers migrated to Jordan between 2012 and 2016, with an average age of 34.6 years during migration. The women’s average age at marriage was 19.2 years old and the average number of children mothers had was 2.5. Mothers had lived in an average of 2.4 places in Jordan, with a range from 1 to 4 places, and mothers who gave birth in Jordan did so at an average age of 23.8 years old (Table 1).

Social Support and Depression

There were no statistically significant correlations between PPD and either total social support or each of the three subscales of social support: appraisal support, belonging support, or tangible support. The Pearson correlation coefficients between PPD and each of the social support measures were: 0.50, 0.48, 0.44, and 0.38, respectively (Table 2).

Sociodemographic Variables and Social Support

Significant or marginally significant correlations were found between social support and sociodemographic variables, including age at marriage and number of locations lived in Jordan (Table 3). Older age at marriage and moving more within Jordan were both associated with less social support. Marital status, contact with child caretakers, and employment status were all measured nominally, and thus were compared through an ANOVA and t-tests. An ANOVA was computed to compare the amount of reported PPD and social support by mothers with different marital statuses. There were significant differences in total and tangible social support when compared along marital status, with married women reporting more social support than both widowed or divorced mothers. In addition, staying in contact with child caretakers was marginally associated with lower perceived belonging support.

Sociodemographic Variables and Depression
No statistically significant correlations were found between PPD and the continuous sociodemographic variables (Table 3). In addition, no differences in PPD scores were found between differences in nominally measured sociodemographic variables, as measured by an ANOVA and t-tests (Table 3).

**Discussion and Conclusions**

Generally, the qualitative findings were consistent with previous literature on postpartum depression in Syrian refugees. This included the fact that mothers who were interviewed consistently cited family members as constituting important support networks during childbirth and childrearing, consistent with another Canadian study in which Syrian refugee women cited their strong family support around birth as a reason why they believed Syrian women experience less PPD than other women, and that giving birth in Canada without female family members would be challenging (Ahmed, Bowen & Feng, 2017). The perceived change in social support from Syria to Jordan, with a concentration of responsibilities onto mothers was consistent with previous literature (El-Khani, Ulph, Peters & Calam, 2016). The theme of a lack of freedom of movement associated with being a refugee hindering the ability of mothers to provide for their children was also consistent with previous literature; this hindered ability has been associated with helplessness due to difficulty fulfilling traditional roles as a wife and mother (Nahas, Hillege & Amashe, 1999). However, interestingly, some mothers did not view freedom of movement as a freedom, but rather as a burden. This highlights the need to evaluate and deconstruct underlying assumptions researchers make about the experiences and value systems held by participants. Legal status taking a toll on mothers’ psychological well-being has also been found in previous research (Stevenson et al, 2018). However, our research also found issues related to children’s ages and evidence of an improving situation and resilience of mothers. The
exploratory analysis of which support networks mothers would like is a new development within
the literature on social support for Syrian refugee mothers in Jordan. One interesting finding was
the request of a mother for, and the fact that several mothers are currently getting support from,
trustworthy men they have come to know in Jordan in relation to everyday activities and raising
their children. This is a support mechanism that is often overlooked in literature on the issue, and
is an important avenue to develop when designing strategies to increase social support, especially
for divorced or widowed mothers.

From the quantitative data, there was a fairly strong though not statistically significant
correlation between social support and postpartum depression. This lack of statistical
significance could be due to the very small sample size. It is notable, however, that the social
support and postpartum depression risk were positively correlated, indicating that with more
social support, mothers also reported more symptoms of postpartum depression. This is
inconsistent with general research on postpartum depression and social support, in which social
support is a protective factor against depression (Lu, 2012; Ugarriza, Brown, Chang-Martinez,
2007) and less social support is associated with greater PPD symptoms (Collins, Zimmerman &
Howard, 2010; Morikawa et al, 2015; Nahas, Hillege & Amashe, 1999; WTO, 2001). However,
this is consistent with a study of refugee women in Canada, in which greater social support was
associated with greater depression in some cases (O’Mahony, Donnelly, Raffin & Este, 2012).
However, our study was complicated by the fact that mothers recalled postpartum depression
symptoms and reported current levels of perceived social support, in which a strong, but not
significant positive correlation was found between recalled PPD and current social support. This
is contrary to what is expected, as previous research has shown that when people perceive greater
social support, they recall negative personal events with less emotional weight (Rami, 2013).
Thus, we would expect mothers who perceive greater current social support to recall fewer PPD symptoms. This point requires further investigation and clarification. Due to the limited sample size, it is not possible to draw generalizable conclusions from this study. However, this result suggests that there may be an atypical relationship between social support and postpartum depression in refugee mothers. The amount of recall associated with remembering depression after childbirth introduces challenges related to the reliability of the data. People tend to overestimate their negative emotions when recalling them; this effect is more pronounced in people with depression at the time of reporting (Urban, Charles, Levine, Almeida, 2018). This appears to have happened in our sample, as the lowest reported score on the EPDS was 10, indicating that 100% of our sample recalled PPD symptoms extreme enough to be at risk of depression. This number could be skewed due to the small sample size, yet by any means, is extremely high.

Because mothers recalled depression during their first birth, while the social support questionnaire measured current social support, conclusions cannot be drawn about the association between cross-sectionally measured social support and postpartum depression risk. In addition, because the data was not collected longitudinally, no conclusions can be made regarding the directionality of any associations between social support and postpartum depression. Instead, conclusions can be drawn about the associations between social support and recall of postpartum depression, sociodemographic factors and perceived social support, and sociodemographic factors and recall of postpartum depression. Along these three avenues of conclusions, there were only statistically significant negative correlations between marital status and total social support and tangible support, as well as between the number of places participants had lived in Jordan and total social support. We found that widowed women
reported significantly less social support than married women; this is similar to results found in previous research in which PPD was associated with poor quality of current intimate relationship(s) (Garza, 2018; Boyce, 2003). While these were the only statistically significant results, there were also other strong correlations which did not reach statistical significance, most likely due to the small sample size. However, again, due to the limited sample size, generalizable conclusions cannot be drawn. Rather, these sociodemographic factors may be avenues for further investigation into ways to create comprehensive social support networks for refugee mothers.

Strengths and Limitations

One of the strengths of this study is the fact that it utilized a mixed-methods approach, allowing for conclusions to be drawn both through statistical significance based on directional hypotheses based on previous research and through qualitative analysis of exploratory interviews. Another strength of the study is that it included Syrian refugee participants who are living in a developing country, as there are limited studies that focus on this population.

At the same time, this study had several limitations. The sample size in the study was very small and at the same time diverse in terms of experiences, which made it difficult to draw both specific conclusions and generalizable conclusions. In addition, the EPDS was used in ways which it was not necessarily designed for, to measure postpartum depression based on recall, rather than currently. At the same time as mothers recalled depression during their first birth at an earlier time point, they reported current levels of perceived social support. This hindered the ability to draw conclusions about the association between perceived social support and postpartum depression risk. In addition, participants were recruited from community-based organizations which included housing for women. This led to sampling bias, in which only mothers receiving extensive support were interviewed, and did not include mothers who either
came to Jordan more recently and were still living in refugee camps, or who had connections in Jordan and were living in more stable housing conditions outside of these community-based organizations.

**Recommendations for Further Research**

Further research should use larger sample sizes to verify whether there is a positive or negative correlation between perceived social support and postpartum depression in Syrian refugee mothers. They should also recruit mothers who are currently in the postpartum period and have given birth in Jordan, in order to generate cross-sectional data at a single time point and to include reporting of a birth that occurred after migration and thus, after social support networks were potentially lost. By including larger and more precise samples, future studies can specifically investigate the ways that changing social support networks resulting from migration are related to postpartum depression, and to strengthen the statistical significance and generalizability of the results.

Future studies should also examine Syrian refugee mothers’ opinions on how to best fill the gap in their social support systems that their families previously filled in Syria. It was clear that leaving their families behind or losing them had concentrated a lot of responsibility solely onto mothers, which had previously been diffused among other family members. While many understandably appeared to have perspectives that family support networks are irreplaceable, it could be very valuable to look into supports that could mimic how families previously supported mothers, without suggesting that families can be replaced.

**Implications**

This study has implications for the understanding of the relationship between social support and postpartum depression in refugee communities, in which greater perceived social
support could be associated with less psychological well-being, or recall of greater postpartum depressive symptoms, though this result needs verification. This study also has implications for the development of social support networks for refugee mothers, especially in developing and/or neighboring countries to regions of conflict, in which focus should be placed on re-diffusing responsibility that is concentrated on refugee mothers through both institutional and personal means, advocating for greater freedom of movement, support of legal structures which provide mothers with adequate financial support and provide their children with opportunities regardless of age, and guard their psychological well-being.

Conclusions

In situations in which social support of Syrian refugee mothers is being assessed, this study suggests that it could be important to evaluate their support in light of demographic factors such as their marital status, age of marriage, and the amount they have moved within the host country, and that there are several avenues of support which refugee mothers would like to have improved. However, the nature of the relationship between social support and postpartum depression risk, as well as the directionality of that relationship, requires further clarification.
### Tables

#### Table 1. Descriptive Statistics

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Std Dev</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total PPD</td>
<td>14.9</td>
<td>2.6</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>Total social support</td>
<td>33.6</td>
<td>7.1</td>
<td>24</td>
<td>45</td>
</tr>
<tr>
<td>Year of migration</td>
<td>2013</td>
<td>1.1</td>
<td>2012</td>
<td>2016</td>
</tr>
<tr>
<td>Age at migration</td>
<td>34.6</td>
<td>9.4</td>
<td>20</td>
<td>51</td>
</tr>
<tr>
<td>Number of children</td>
<td>2.5</td>
<td>1.3</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Number of places lived in Jordan</td>
<td>2.4</td>
<td>1.1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Age at birth of first child born in Jordan</td>
<td>23.8</td>
<td>6.5</td>
<td>16</td>
<td>33</td>
</tr>
<tr>
<td>Number of institutions used for childcare</td>
<td>0.5</td>
<td>0.7</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Age at marriage</td>
<td>19.2</td>
<td>5.5</td>
<td>14</td>
<td>30</td>
</tr>
</tbody>
</table>

#### Table 2. Pearson’s correlation coefficients between PPD and Social Support

<table>
<thead>
<tr>
<th></th>
<th>Total Social Support</th>
<th>Appraisal Support</th>
<th>Belonging Support</th>
<th>Tangible Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total PPD</td>
<td>0.50</td>
<td>0.48</td>
<td>0.44</td>
<td>0.38</td>
</tr>
</tbody>
</table>
### Table 3. Pearson’s correlation coefficients, F values and t values between Demographic Variables and PPD and Social Support

<table>
<thead>
<tr>
<th></th>
<th>Total PPD</th>
<th>Total Social Support</th>
<th>Appraisal Support</th>
<th>Belonging Support</th>
<th>Tangible Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Children</td>
<td>0.13</td>
<td>0.04</td>
<td>-0.10</td>
<td>0.27</td>
<td>-0.19</td>
</tr>
<tr>
<td>Marital Status</td>
<td>(2.09)</td>
<td>(6.15**)</td>
<td>(3.12)</td>
<td>(2.67)</td>
<td>(9.00**)</td>
</tr>
<tr>
<td>Age at Marriage</td>
<td>-0.25</td>
<td>-0.71*</td>
<td>-0.73*</td>
<td>-0.74*</td>
<td>0.05</td>
</tr>
<tr>
<td>Number of Locations Lived in Jordan</td>
<td>-0.28</td>
<td>-0.71**</td>
<td>-0.67*</td>
<td>-0.67*</td>
<td>-0.45</td>
</tr>
<tr>
<td>Number of child caretakers in Jordan</td>
<td>0.13</td>
<td>0.00</td>
<td>0.18</td>
<td>0.17</td>
<td>-0.42</td>
</tr>
<tr>
<td>Length of time of childcare assistance</td>
<td>-0.79</td>
<td>-0.11</td>
<td>0.17</td>
<td>-0.28</td>
<td>-0.10</td>
</tr>
<tr>
<td>Whether or not still in contact with child caretakers (0=not in contact)</td>
<td>(-0.66)</td>
<td>(-1.68)</td>
<td>(-0.69)</td>
<td>(-3.00*)</td>
<td>(-1.31)</td>
</tr>
<tr>
<td>Employment Status (0=unemployed)</td>
<td>(-1.33)</td>
<td>(-1.32)</td>
<td>(-1.65)</td>
<td>(-0.75)</td>
<td>(-1.07)</td>
</tr>
<tr>
<td>Household Income</td>
<td>-0.06</td>
<td>0.11</td>
<td>0.14</td>
<td>0.28</td>
<td>-0.30</td>
</tr>
</tbody>
</table>

* = marginally significant, p<.10; **=significant, p<.05
Parenthesis indicate F or t values; ANOVA was used for marital status and t-tests were used for contact with child caretakers and employment status
References


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Appendices

Appendix A - Demographic Survey: English

Demographics Questionnaire

1. In what year did you come to Jordan? How old were you when you arrived?
   Year: __________ Age: __________

2. Who did you come with to Jordan?
   □ Alone □ With mother □ With father □ With sister(s) □ With brother(s)
   □ With husband □ With friend(s)

3. How many children do you have?
   □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ more than 10

4. What is your marital status?
   □ Married □ Never been married □ Divorced □ Widowed □ Other: __________

5. If you have been or are married, how old were you when you got married?
   __________

6. Which of your children were born in Jordan?
   Total number: __________
   Respective birth orders: __________

7. How old were you when you gave birth to your first child in Jordan?
   Age: __________

8. Where have you lived in Jordan, and for how long in each locality?
   Location 1: __________ Number of Years: __________
   Location 2: __________ Number of Years: __________
   Location 3: __________ Number of Years: __________
   Location 4: __________ Number of Years: __________

9. Where were you living when you gave birth to your children in Jordan?
   Child number: __________ Location: __________
   Child number: __________ Location: __________
   Child number: __________ Location: __________
   Child number: __________ Location: __________

10. Where do you live in Jordan now?

11. When you gave birth in Jordan, who helped you care for your child after he/she was born?
    □ No one □ Mother □ Father □ Sister(s) □ Brother(s)
    □ Husband □ Friend(s) □ Other: __________

12. How long did those people help you care for your children?
    □ 1 day □ 1 week □ 1 month □ 1-3 months □ 3-6 months
    □ 6-12 months □ more than 1 year □ Other: __________

13. Are you still in contact with those people?
    □ Yes □ No
14. If you had given birth in Syria, who would have helped you care for your children?
   □ No one □ Mother □ Father □ Sister(s) □ Brother(s)
   □ Husband □ Friend(s) □ Other: ____________

15. How long would those people have helped you care for your children?
   □ 1 day □ 1 week □ 1 month □ 1-3 months □ 3-6 months
   □ 6-12 months □ more than 1 year □ Other: ____________

16. What institutions did you use to help you care for your children?
   □ Myself □ Nanny/Babysitter □ School □ Family □ Friends
   □ Other: ____________

17. Do you have health insurance?
   □ Yes □ No

18. What is your employment status?
   □ Employed □ Unemployed

19. What is your household income per month?

20. Have you ever been diagnosed with a mental illness?
   □ Yes □ No
   a. If yes, which disorder(s)?

21. Did you ever feel depressed or very sad after giving birth?
   □ Yes □ No
   a. If yes, after which children?
      □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Other: _____
   b. If yes, where were you living when you had the sadness/depression?

22. Do you think that sadness or depression was related to having a new baby?
   □ Yes □ No

23. Do you think that sadness or depression was related to living in Jordan, rather than Syria?
   □ Yes □ No

24. Did you ever smoke?
   □ Yes □ No
   a. If yes, how many packs per day?
      □ Less than 1 □ 1 □ 1-2 □ 2 or more
   b. If yes, when did you quit?
      □ I still smoke □ less than 1 year ago □ less than 5 years ago
      □ more than 5 years ago
25. Did you ever drink alcohol?
   ☐ Yes ☐ No
   a. If yes, how many drinks per day?
      ☐ I do not drink every day ☐ 1 ☐ 1-2 ☐ 2 or more
   b. If yes, when did you stop drinking?
      ☐ I still drink ☐ less than 1 year ago ☐ less than 5 years ago
      ☐ more than 5 years ago
26. Did you ever use any other substances?
   ☐ Yes ☐ No
   a. If yes, which ones?
   ____________________________________________________________
   b. If yes, how often?
      ☐ Multiple times per day ☐ Once per day ☐ Once per week
      ☐ Twice per month ☐ Once per month ☐ A few times per year
      ☐ Other: ____________
27. Have you ever been diagnosed with a chronic health condition?
   ☐ Yes ☐ No
   a. If yes, which condition?
   ____________________________________________________________
   b. If yes, when were you diagnosed?
      Year: ____________
28. Do you regularly take any medications?
   ☐ Yes ☐ No
   a. If yes, which ones?
   ____________________________________________________________
## Appendix B - Demographic Survey: Arabic

البيانات الديموغرافية

1. في أي عام أتيت إلى الأردن؟ كم كان عمرك عندما وصلت؟
   
   السنة: ___________ عمر: ___________

2. مع من أتيت إلى الأردن؟
   
   □ وحدي □ مع الأم □ مع الأب □ مع الأخ، الأخوات □ مع الأخ، الأخوات □ مع الزوج □ مع الأصدقاء

3. كم عدد الأطفال لديك؟ ___________

4. ما هي حالتك الزوجية؟
   
   □ متزوج □ أعزب □ مطلق □ أرمل □ أخرى: ___________

5. إذا كنت متزوجًا أو تزوجت سابقاً، كم كان عمرك عندما تزوجت؟ ___________

6. أي من أطفالك ولدوا في الأردن؟
   
   العدد الإجمالي: ___________
   
   ترتيب الولادات: ___________

7. كم كان عمرك عندما أنجبت طفلك الأول في الأردن؟ ___________

8. أين كنت تعيش في الأردن، وكم المدة التي قضيتها في كل مكان؟
   
   الموقع 1: ___________ عدد السنوات: ___________
   
   الموقع 2: ___________ عدد السنوات: ___________
   
   الموقع 3: ___________ عدد السنوات: ___________
   
   الموقع 4: ___________ عدد السنوات: ___________

9. أين كنت تعيش عندما أنجبت أطفالك في الأردن؟
   
   رقم الطفل 1: ___________ الموقع: ___________
   
   رقم الطفل 2: ___________ الموقع: ___________
   
   رقم الطفل 3: ___________ الموقع: ___________
   
   رقم الطفل 4: ___________ الموقع: ___________
<table>
<thead>
<tr>
<th>رقم الطفل:</th>
<th>الموضع:</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. أمين تعيش في الأردن الآن؟</td>
<td></td>
</tr>
<tr>
<td>11. عندما أنجبت في الأردن، من الذي ساعدك على رعاية طفلك؟ لا أحد □ الأم □ الأب □ الأخت □ الزوج □ الأصدقاء □ أخرى:</td>
<td></td>
</tr>
<tr>
<td>12. إلى من ساعدك هؤلاء الأشخاص في رعاية أطفالك؟ يوم واحد □ أسبوع واحد □ شهر واحد □ 1-3 أشهر □ 3-6 أشهر □ 6-12 أشهر □ أكثر من سنة □ أخرى:</td>
<td></td>
</tr>
<tr>
<td>13. هل زارت على اتصال بهؤلاء الناس؟ نعم □ لا</td>
<td></td>
</tr>
<tr>
<td>14. إذا كنت قد أنجبت في سوريا، فمن كان سيساعدك على رعاية أطفالك؟ لا أحد □ الأم □ الأب □ الأخت □ الزوج □ الأصدقاء □ أخرى:</td>
<td></td>
</tr>
<tr>
<td>15. كم من الوقت قد ساعدك هؤلاء الناس في رعاية أطفالك؟ يوم واحد □ أسبوع واحد □ شهر واحد □ 1-3 أشهر □ 3-6 أشهر □ 6-12 أشهر □ أكثر من سنة □ أخرى:</td>
<td></td>
</tr>
<tr>
<td>16. ما هي الجهات التي استخدمتها لمساعدتك في رعاية أطفالك؟ نفسي □ مربية / جلية أطفال □ مدرسة □ عائلة □ أصدقاء □ أخرى:</td>
<td></td>
</tr>
<tr>
<td>17. هل لديك تأمين صحي؟ نعم □ لا</td>
<td></td>
</tr>
<tr>
<td>18. ما هو وضعك الوظيفي؟ موظف □ عاطل عن العمل</td>
<td></td>
</tr>
<tr>
<td>19. ما هو دخل أسرتك في الشهر؟</td>
<td></td>
</tr>
<tr>
<td>20. هل سبق أن تم تشخيصك بمرض عقلي؟ نعم □ لا</td>
<td></td>
</tr>
</tbody>
</table>
1. إذا كانت الإجابة بنعم، ما هو التشخيص؟

2. إذا كانت الإجابة بنعم، متى تم تشخيصه؟ عام: ______

3. هل زلت تعاني من المرض؟ □ نعم □ لا

4. هل شعرت بالاكتئاب أو الحزن الشديد بعد الولادة؟ □ نعم □ لا

5. إذا كانت الإجابة بنعم، بعد ولادة أي طفل حصل ذلك؟

6. إذا كانت الإجابة بنعم، فإن كنت تعيش عندما كان لديك الحزن / الاكتئاب؟

7. هل تعتقد أن الحزن أو الاكتئاب مرتبط بانجاب مولود جديد؟ □ نعم □ لا

8. هل تعتقد أن الحزن أو الاكتئاب كان مرتبطاً بالحياة في الأردن، وليس سوريا؟ □ نعم □ لا

9. هل سبق لك التدخين؟ □ نعم □ لا

10. إذا كانت الإجابة بنعم، فكم عدد الباكيتات في اليوم؟ □ أقل من 1 □ 1-2 □ 2 أو أكثر

11. إذا كانت الإجابة بنعم، متى تركت التدخين؟

12. ما زلت أدخن □ منذ أقل من سنة □ أقل من 5 سنوات مضت □ منذ أكثر من 5 سنوات

13. هل شربت الكحول؟ □ نعم □ لا

14. إذا كانت الإجابة بنعم، فكم عدد المشروبات يوميًا؟ □ لا أشرب الكحول كل يوم □ 1-2 □ 2 أو أكثر

15. إذا كانت الإجابة بنعم، متى توقفت عن الشرب؟
ما زلت أدخن □ منذ أقل من سنة □ أقل من 5 سنوات مضت □ منذ أكثر من 5 سنوات □

26. هل سبق لك استخدام أي مواد أخرى؟

نعم □ لا □

ا. إذا كانت الإجابة بنعم، أي منها؟

ب. إذا كان نعم، كم مرة؟

عدد مرات في اليوم □ مرة واحدة في اليوم □ مرة واحدة في الأسبوع □ مرتين في الشهر □ مرة واحدة في الشهر □ عدة مرات في السنة □ أخرى: __________________________

27. هل سبق أن تم تشخيص حالتك الصحية بمرض مزمن؟

نعم □ لا □

ا. إذا كانت الإجابة بنعم، ما هو التشخيص؟

ب. إذا كانت الإجابة بنعم، متى تم تشخيصك؟ عام: __________________________

28. هل تتناول بانتظام أي أدوية؟

نعم □ لا □

ا. إذا كانت الإجابة بنعم، أي منها؟____________________
Appendix C - Social Support Scale: English

Instructions: This scale is made up of a list of statements each of which may or may not be true about you. For each statement circle "definitely true" if you are sure it is true about you and "probably true" if you think it is true but are not absolutely certain. Similarly, you should circle "definitely false" if you are sure the statement is false and "probably false" if you think it is false but are not absolutely certain.

1. If I wanted to go on a trip for a day (for example, to the country or mountains), I would have a hard time finding someone to go with me.

   1. definitely false  2. probably false  3. probably true  4. definitely true

2. I feel that there is no one I can share my most private worries and fears with.

   1. definitely false  2. probably false  3. probably true  4. definitely true

3. If I were sick, I could easily find someone to help me with my daily chores.

   1. definitely false  2. probably false  3. probably true  4. definitely true

4. There is someone I can turn to for advice about handling problems with my family.

   1. definitely false  2. probably false  3. probably true  4. definitely true

5. If I decide one afternoon that I would like to go to a movie that evening, I could easily find someone to go with me.

   1. definitely false  2. probably false  3. probably true  4. definitely true

6. When I need suggestions on how to deal with a personal problem, I know someone I can turn to.

   1. definitely false  2. probably false  3. probably true  4. definitely true

7. I don’t often get invited to do things with others.

   1. definitely false  2. probably false  3. probably true  4. definitely true

8. If I had to go out of town for a few weeks, it would be difficult to find someone who would look after my house or apartment (the plants, pets, garden, etc.).

   1. definitely false  2. probably false  3. probably true  4. definitely true

9. If I wanted to have lunch with someone, I could easily find someone to join me.

   1. definitely false  2. probably false  3. probably true  4. definitely true
10. If I was stranded 10 miles from home, there is someone I could call who could come and get me.

1. definitely false  2. probably false  3. probably true  4. definitely true

11. If a family crisis arose, it would be difficult to find someone who could give me good advice about how to handle it.

1. definitely false  2. probably false  3. probably true  4. definitely true

12. If I needed some help in moving to a new house or apartment, I would have a hard time finding someone to help me.

1. definitely false  2. probably false  3. probably true  4. definitely true

Self Report Measures for Love and Compassion Research: Social Support
التعليمات: يتكون هذا المقياس من قائمة من العبارات التي قد تكون أو لا تكون صحيحة حولك. يرجى اختيار الخيار الذي يناسبك:

1. إذا أردت الذهاب في رحلة ليوم واحد (على سبيل المثال، إلى البلد أو الجبال) ، فسوف أجد صعوبة في العثور على شخص يذهب معي.

بالتأكيد خطاً 2. ربما خطأ 3. ربما صحيح 4. بالتأكيد صحيح

2. أشعر أنه لا يوجد أحد يمكنني مشاركة مخاوفي ومخاوفه الخاصة.

بالتأكيد خطأ 2. ربما خطأ 3. ربما صحيح 4. بالتأكيد صحيح

3. إذا كنت مريضًا، يمكنني بسهولة أن أجد شخصًا يساعدني في الأعمال اليومية.

بالتأكيد خطأ 2. ربما خطأ 3. ربما صحيح 4. بالتأكيد صحيح

4. هناك شخص يمكن أن أتوجه إليه للحصول على المشورة بشأن التعامل مع المشاكل مع عائلتي.

بالتأكيد خطأ 2. ربما خطأ 3. ربما صحيح 4. بالتأكيد صحيح

5. إذا قررت في الذهاب إلى فيلم أو مشوار ما ، يمكن أن أجد شخصًا يذهب معني بسهولة.

بالتأكيد خطأ 2. ربما خطأ 3. ربما صحيح 4. بالتأكيد صحيح

6. عندما أحتاج إلى اقتراحات حول كيفية التعامل مع مشكلة شخصية ، فأنى أعرف شخصًا يمكنني اللجوء إليه.

بالتأكيد خطأ 2. ربما خطأ 3. ربما صحيح 4. بالتأكيد صحيح

7. لا ألقى دعوة غالبًا للقيام بالأشياء مع الآخرين.

بالتأكيد خطأ 2. ربما خطأ 3. ربما صحيح 4. بالتأكيد صحيح

8. إذا اضطررت إلى الخروج من المدينة لبضعة أسابيع، فسيكون من الصعب العثور على شخص يعتني بمنزلي أو شقيتي (النباتات، الحيوانات الأليفة، الحديقة، وما إلى ذلك).

بالتأكيد خطأ 2. ربما خطأ 3. ربما صحيح 4. بالتأكيد صحيح

9. إذا أردت تناول الغداء مع شخص ما، فإليكاني بسهولة العثور على شخص ينضم إلي.

بالتأكيد خطأ 2. ربما خطأ 3. ربما صحيح 4. بالتأكيد صحيح

Appendix D - Social Support Scale: Arabic
10. إذا أقطعت بي السبل على بعد أميال من المنزل، فهناك شخص يمكنني الاتصال به ويمكن أن يأتي لي.

1. بالتأكيد صحيح. 2. ربما خاطأ. 3. ربما صحيح. بالتأكيد صحيح.

11. إذا نشأت أزمة عائلية، سيكون من الصعب العثور على شخص يمكنه إعطائي نصيحة جيدة حول كيفية معالجتها.

1. بالتأكيد خاطأ. 2. ربما خاطأ. 3. ربما صحيح. بالتأكيد صحيح.

12. إذا كنت بحاجة إلى بعض المساعدة في الانتقال إلى منزل أو شقة جديدة، أجد صعوبة في العثور على شخص يساعدني.

1. بالتأكيد خاطأ. 2. ربما خاطأ. 3. ربما صحيح. بالتأكيد صحيح.
Appendix E - Postpartum Depression Scale: English

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example, already completed.

I have felt happy:
☐ Yes, all the time
☒ Yes, most of the time  This would mean: “I have felt happy most of the time” during the past week.
☐ No, not very often  Please complete the other questions in the same way.
☐ No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   ☐ As much as I always could
   ☐ Not quite so much now
   ☐ Definitely not so much now
   ☐ Not at all

2. I have looked forward with enjoyment to things
   ☐ As much as I ever did
   ☐ Rather less than I used to
   ☐ Definitely less than I used to
   ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   ☐ Yes, most of the time
   ☐ Yes, some of the time
   ☐ Not very often
   ☐ No, never

4. I have been anxious or worried for no good reason
   ☐ No, not at all
   ☐ Hardly ever
   ☐ Yes, sometimes
   ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   ☐ Yes, quite a lot
   ☐ Yes, sometimes
   ☐ No, not much
   ☐ No, not at all

*6 Things have been getting on top of me
   ☐ Yes, most of the time I haven’t been able
to cope at all
   ☐ Yes, sometimes I haven’t been coping as well
as usual
   ☐ No, most of the time I have coped quite well
   ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   ☐ Yes, most of the time
   ☐ Yes, sometimes
   ☐ Not very often
   ☐ No, not at all

*8 I have felt sad or miserable
   ☐ Yes, most of the time
   ☐ Yes, quite often
   ☐ Not very often
   ☐ No, not at all

*9 I have been so unhappy that I have been crying
   ☐ Yes, most of the time
   ☐ Yes, quite often
   ○ Only occasionally
   ☐ No, never

*10 The thought of harming myself has occurred to me
   ☐ Yes, quite often
   ☐ Sometimes
   ☐ Hardly ever
   ☐ Never

Administered/Reviewed by ___________________________  Date ___________________________


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Appendix F - Postpartum Depression Scale: Arabic

التعليمات (Instructions)

قد شعرت بأنني سعيدة
نعم كل الأوقات
نعم معظم الأوقات
لا، ليس في أحوال كثيرة
لا، إذا

هذا يعني: "قد شعرت بأنني سعيدة معظم الوقت خلال الأسبوع الماضي".

يرجى أن تكتب الأسئلة الأخرى بالطريقة ذاتها.

خلال الأسبوع (In the Past 7 days) الماضى (إدراج أن تسمع خطأ تحت أحد الأجوبة التالية):

1. لقد كنت أشعر بالمرض والتعب والشعور العام.
   1. المشاعر السلبية، وشعرت أن نبضات القلب تزداد.
   2. المشاعر السلبية، وشعرت أن أحلام المرح تزداد.
   3. المشاعر السلبية، وشعرت أن أحلام المرح تزداد.
   4. المشاعر السلبية، وشعرت أن أحلام المرح تزداد.
   5. المشاعر السلبية، وشعرت أن أحلام المرح تزداد.

2. لقد كنت سعيدًا في الأسابيع الماضية.
   1. المشاعر السلبية، وشعرت أن نبضات القلب تزداد.
   2. المشاعر السلبية، وشعرت أن أحلام المرح تزداد.
   3. المشاعر السلبية، وشعرت أن أحلام المرح تزداد.
   4. المشاعر السلبية، وشعرت أن أحلام المرح تزداد.
   5. المشاعر السلبية، وشعرت أن أحلام المرح تزداد.

3. لقد كنت سعيدًا في الأسابيع الماضية.
   1. المشاعر السلبية، وشعرت أن نبضات القلب تزداد.
   2. المشاعر السلبية، وشعرت أن أحلام المرح تزداد.
   3. المشاعر السلبية، وشعرت أن أحلام المرح تزداد.
   4. المشاعر السلبية، وشعرت أن أحلام المرح تزداد.
   5. المشاعر السلبية، وشعرت أن أحلام المرح تزداد.

4. لقد كنت سعيدًا في الأسابيع الماضية.
   1. المشاعر السلبية، وشعرت أن نبضات القلب تزداد.
   2. المشاعر السلبية، وشعرت أن أحلام المرح تزداد.
   3. المشاعر السلبية، وشعرت أن أحلام المرح تزداد.
   4. المشاعر السلبية، وشعرت أن أحلام المرح تزداد.
   5. المشاعر السلبية، وشعرت أن أحلام المرح تزداد.

5. لقد كنت سعيدًا في الأسابيع الماضية.
   1. المشاعر السلبية، وشعرت أن نبضات القلب تزداد.
   2. المشاعر السلبية، وشعرت أن أحلام المرح تزداد.
   3. المشاعر السلبية، وشعرت أن أحلام المرح تزداد.
   4. المشاعر السلبية، وشعرت أن أحلام المرح تزداد.
   5. المشاعر السلبية، وشعرت أن أحلام المرح تزداد.
McGill University Press

Edinburgh

The Edinburgh Postnatal Depression Scale

Administered/Reviewed by

Date (yyyy-Mon-dd)

Score

Alberta Health Services collects information about you in accordance with Section 20 of the Health Information Act (HIA) for the purpose of providing you health services, determining your eligibility for health services, or to carry out any other purpose authorized by the HIA. Your information will be collected directly from you, except in the limited circumstances where we are authorized by the HIA to indirectly collect such information. If you have any questions about this collection, please ask your care provider or contact Maureen Devolin, Director, Healthy Children and Families telephone 403-943-6704.

Appendix G - Interview Guide: English

1. Can you describe the ways people in Syria help each other after they give birth to a child?

2. In Syria, do they do anything specifically if it is a woman’s first child?

3. Can you describe the ways that people in Jordan have helped you after you gave birth to a child here?

4. If you have more than one child in Jordan, how did the help you received from others differ based on where you were living at the time?

5. What are the main differences between how people help new mothers in Syria and in Jordan?
6. How does your freedom of movement differ between Syria and Jordan? What are the reasons for those differences? Do you think those differences impacted your ability to be the best mother you could be?

7. What were the biggest challenges you faced when having a child in Jordan?

8. What are aspects of support that you would have liked to have as a new mother, regardless of if you were in Syria or Jordan or any other part of the world?

9. Do you feel that you received those aspects of support here in Jordan?
   a. If so, which ones?
   b. If not, which ones were missing?
10. Do you think having a child in Jordan versus in Syria affected any sadness of depression you had after giving birth? Why?

11. If you were to have another child here in Jordan, what would an ideal support system look like for you?

12. How do you think that support system can be created as ideally as possible?
Appendix H - Interview Guide: Arabic

1. هل يمكنك وصف الطرق التي تساعد بها الناس في سوريا بعضهم البعض بعد ولادة طفل؟

2. في سوريا، هل يفعلون أي شيء على وجه التحديد إذا كان الطفل الأول للمرأة؟

3. هل يمكنك وصف الطرق التي تساعد بها الناس في الأردن بعد أن أنجبت طفلًا هنا؟

4. إذا كان لديك أكثر من طفل واحد في الأردن، كيف تختلف المساعدة التي تلقينها من الأخرين بناءً على المكان الذي كنت تعيش فيه في ذلك الوقت؟

5. ما هي الاختلافات الرئيسية بين كيفية مساعدة الناس للأميات الحدود في سوريا والأردن؟

6. كيف تختلف حرية التنقل بين سوريا والأردن؟ ما هي أسباب هذه الاختلافات؟ هل تعتقد أن هذه الاختلافات أثرت على قدرتك على أن تكون أفضل أم يمكنك أن تكون؟

7. ما هي أكبر التحديات التي واجهتك عند إنجاب طفل في الأردن؟

8. ما هي جوانب الدعم التي كنت ترغبين في الحصول عليها كأم جديدة، بغض النظر عما إذا كنت في سوريا أو الأردن أو أي جزء آخر من العالم؟

9. هل تشعر أنك تلقينت هذه الجوانب من الدعم هنا في الأردن؟

10. إذا كان الأمر كذلك، ما هي؟ - إذا لم يكن كذلك، أي منها مفقود؟ هل تعتقد أن وجود طفل في الأردن مقارنة مع وجوده في سوريا أثر على الانتباذ بعد الولادة؟ لماذا؟

11. إذا كنت تستجيبين طفل آخر هنا في الأردن، فما هو شكل نظام الدعم المتالي بالنسبة لك؟

12. كيف تعتقد أن نظام الدعم يمكن أن يكون مثالياً بقدر الإمكان؟
PARTICIPANT INFORMED CONSENT

Title of the Study: Syrian Refugee Mothers in Jordan: Social Support and Postpartum Depression

Researcher Name: Marya Rana

My name is Marya Rana and I am a student with the SIT program in Amman, Jordan called Refugees, Health and Humanitarian Action.

I would like to invite you to participate in a study that I am conducting as part of the SIT Study Abroad program in Amman, Jordan. Your participation is voluntary. Please read the information below, and ask questions about anything you do not understand before deciding whether to participate. If you decide to participate, you will be asked to sign this form and you will be given a copy of this form.

PURPOSE OF THE STUDY
The purpose of this study is to assess current modes of social support utilized by Syrian refugee mothers who gave birth to their first child in Jordan and to determine if they associate lack of social support with postpartum depressive experiences.

The purpose is also to determine whether those mothers express a desire for more extensive support, and if so, to identify the characteristics of the support they would like to have, in order to advise future projects to guide further development of current systems or to facilitate the design of new networks.

STUDY PROCEDURES
Your participation will consist of filling out a survey, which will require approximately 30 minutes of your time, and potentially also participating in a one-hour interview. The interview will take place in a private setting such as your house. You will be audio recorded during the interview, but no photographs or video recordings will be taken. If you do not want to be audio recorded, you can still participate in this research study.

POTENTIAL RISKS AND DISCOMFORTS
There may be slight and brief psychological discomfort when reporting instances of depression, if applicable. However, there are no significant foreseeable risks to participating in this study and no penalties should you choose not to participate; participation is voluntary. During the interview you have the right not to answer any questions or to discontinue participation at any time.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY
Because one of the purposes of this study is to determine if Syrian refugee mothers express a desire for more extensive support, and if so, to identify the characteristics of the support they
would like to have, I hope that this research will be used to further develop support networks for Syrian refugee mothers.

**CONFIDENTIALITY**
Any identifiable information obtained in connection with this study will remain confidential. I will keep the data on a password-protected computer which only I have access to. The audio will be transcribed and translated by a translator who will not be provided with any of the participants’ identifiable information. In order to do this, each participant will be given a number by me, and all other parties involved in any aspect of the study will only be given the participants’ numerical identification.

All audio recordings, transcriptions, and translated transcriptions will be deleted by December 20, 2019 from all devices except one master device and backup drive. They will remain on that master device which is password-protected and only I have access to.

When the results of the research are published or discussed in conferences, no identifiable information will be used. In the event that names are required, pseudonyms (fake names) will be used.

**PARTICIPATION AND WITHDRAWAL**
Your participation is voluntary. Your refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study.

“**I have read the above and I understand its contents and I agree to participate in the study. I acknowledge that I am 18 years of age or older.”***

Participant’s signature ______________________________________ Date __________

Translator’s signature ______________________________________ Date __________

Researcher’s signature ______________________________________ Date __________
Consent to Quote from Interview
I may wish to quote from the interview with you either in the presentations or articles resulting from this work. A pseudonym (fake name) will be used in order to protect your identity.

Initial one of the following to indicate your choice:
_____ (initial) I agree to allow you to quote from my interview
_____ (initial) I do not agree to allow you to quote from my interview

Consent to Audio-Record Interview
I may wish to record the interview with you in order to refer back to it during my analysis of the data gathered.

Initial one of the following to indicate your choice:
_____ (initial) I agree to allow you to record my interview
_____ (initial) I do not agree to allow you to record my interview

Consent to Play Audio-Recorded Interview in Public
I may wish to play your recorded interview in a conference or classroom presentation. In the event that it is played, a pseudonym (fake name) will be used in order to protect your identity.

Initial one of the following to indicate your choice:
_____ (initial) I agree to allow you to play the recording in a public setting
_____ (initial) I do not agree to allow you to play the recording in a public setting

RESEARCHER’S CONTACT INFORMATION
If you have any questions or want to get more information about this study, please contact me at maryazrana@gmail.com or my advisor at l.dardas@ju.edu.jo.

RIGHTS OF RESEARCH PARTICIPANT – IRB CONTACT INFORMATION
In an endeavor to uphold the ethical standards of all SIT proposals, this study has been reviewed and approved by an SIT Study Abroad Local Review Board or SIT Institutional Review Board. If you have questions, concerns, or complaints about your rights as a research participant or the research in general and are unable to contact the researcher please contact the Institutional Review Board at:

School for International Training
Institutional Review Board
1 Kipling Road, PO Box 676
Brattleboro, VT 05302-0676 USA
irb@sit.edu
802-258-3132
نموذج الموافقة المستنيرة

عنوان الدراسة: الأهمات اللاجئات السوريات في الأردن: الدعم الاجتماعي واكتتاب ما بعد الولادة

اسم الباحثة: ماريا رانا

اسمي ماريا رنا وأنا طالبة في برنامج SIT في عمان، الأردن وأدرست مساق في مؤسسة التعلم الأمريكية في الأردن: دراسات عامه حول الصحة وتنمية المجتمع.

أود أن أدعوكم للمشاركة في دراسة أخرى بجزء من برنامج الدراسة عن بعد في عمان، الأردن. مشاركتكم طوعية.

يرجى قراءة المعلومات أدناه، وطورح أسئلة حول أي شيء لا تفهمه قبل قبول المشاركة. إذا قررت المشاركة، سيطلب منك التوقع على هذا النموذج وستحصل على نسخة من هذا النموذج.

الهدف من الدراسة: الهدف من هذه الدراسة هو تقييم أنشطة الدعم الاجتماعي الحالية التي تستخدمها الأمهات اللاجئات السوريات اللائي ولدن طفلهن الأول في الأردن وتحديد ما إذا كان هناك علاقة بين نفس الدعم الاجتماعي والاكتتاب ما بعد الولادة.

الهدف من هذه الدراسة أيضًا هو تحديد ما إذا كانت تلك الأمهات تعرب عن رغبتهم في الحصول على دعم أكثر شمولًا.

وإذا كان الأمر كذلك، تحدث خصائص الدعم الذي يرغبون في الحصول عليه، من أجل إبداء المشورة للمشاريع المستقبلية لتوجيه مزيد من التطوير للاستراتيجية الحالية أو تسهيل تصميم شبكات دعم جديدة.

إجراءات الدراسة: ستتألف مشاركتكم من مهل الاستبيان، والذي سيطلب حوالي 30 دقيقة من وقتكم، وربما تشارك أيضًا في مقابلة مدنها ساعة واحدة. ستتم مقابلاتك في مكان خاص مثل منزلك. سيتم عمل تسجيل صوتي أثناء المقابلة، ولكن لن يتم التقاط صور فوتوغرافية أو تسجيلات فيديو. إذا كنت لا ترغب في التسجيل الصوتي، فلا يزال بإمكانك المشاركة في هذه الدراسة البحثية.

المخاطر المحتملة: قد يكون هناك إزعاج نفسي طفيف وجيز عند الإبلاغ عن حالات الاكتتاب، ان وجدت. ومع ذلك، لا توجد مخاطر كبيرة ملحوظة على المشاركة في هذه الدراسة. لا توجد غرامات إذا اختبرت عدم المشاركة; المشاركة طوعية. خلال المقابلة، يحق لك عدم الإجابة عن أي أسئلة أو التوقف عن المشاركة في أي وقت.
الفوائد المحتملة للمشاركين و/أو المجتمع: لأن أحد غرض هذه الدراسة هو تحديد ما إذا كانت أمهات اللاجئات السوريات

يعبر عن رغبتهم في الحصول على دعم أكثر شمولًا، وتحديد خصائص الدعم الذي يقدمه، أمل أن يتم استخدام هذا

البحث لتطوير شبكات الدعم لأمهات اللاجئات السوريات.

سرية المعلومات: إن أي معلومات يتم الحصول عليها فيما يتعلق بهذه الدراسة ستبقى سرية. سأحتفظ بالبيانات الموجودة

على جهاز كمبيوتر محمي بكلمة مرور يمكنني أنا فقط من الوصول إليه. سيتم تخزين الصوت وترجمته بواسطة مترجم لن يتم

تزويد أي من معلومات تعريف المشاركين. من أجل القيام بذلك، سيتم منح كل مشارك رقمًا من قبلي، وسيتم منح جميع

المشاركين في الدراسة فقط رقمًا رفقيًا.

سيتم حذف جميع النسجات الصوتية والنسج المترجمة بحلول 20 ديسمبر 2019 من جميع الأجهزة باستثناء جهاز رئيسي

واحد ومحرك أقراص احتياطي. سيقوم على هذا الجهاز الرئيسي المحمي بكلمة مرور وفقط يمكنني الوصول إليها.

عندما يتم نشر نتائج البحث أو مناقشتها في المؤتمرات، فإن يتم استخدام معلومات محددة. في حالة طلب الأسماء، سيتم

استخدام أسماء مستعارًا.

المشاركة والانسحاب: يمكنك طلبية. لن يتضمن رفضك للمشاركة أي عقوبة أو خسارة في المزايا التي يحق لك

الحصول عليها. يمكنني سحب موافتك في أي وقت ووقف المشاركة دون عقوبة. لا يجوز التنازل عن أي مطالبات أو حقوق

أو تعويضات قانونية بسبب مشاركتك في هذه الدراسة البحثية.

"لقد قرأت ما ورد أعلاه وأتفق به. أوافق على المشاركة في الدراسة. أقر بأن عمري 18 عامًا أو أكبر.

التاريخ:

توقيع المشكـّــــكـار

التاريخ:

توقيع الباحثة

توقيع المترجم

الموافقة على الاقتباس من المقابلة

قد أقتبس من المقابلة ممكّن في العروض التقديمية أو المقالات الناتجة عن هذا العمل. سيتم استخدام اسم مستعار لحماية

هويتك.

يرجى اختيار مما يلي للإشارة إلى اختيارك:

أوافق على السماح لك بالاقتباس من مقابلتي
Social Support & Postpartum Depression: Syrian Refugees

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No agreement on the satisfaction to record the voice

The agreement on recording

If you do not wish to provide the data, please provide the evidence of this. If you have any questions, please refer to your advisor:

Agreement on recording

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If you do not wish to provide the data, please provide the evidence of this. If you have any questions, please refer to your advisor:

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- Confidentiality of data provided for the research: If you feel that any question or need more information, contact us by l.dardas@ju.edu.jo or our consultant on maryazrana@gmail.com.

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