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Reproductive Health Experiences of Syrian Refugees Residing in Jordan

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ABSTRACT

Background & Aims: In 2016, 28% of Syrian women residing in Amman experienced at least one unplanned pregnancy, and 17% did not access antenatal care for pregnancy. This study aimed to elucidate the imminent need for greater accessibility to comprehensive sexual and reproductive healthcare among Syrian refuges residing in Jordan.

Methods: This ethnographic case study was conducted in 2017 in order to understand the reproductive health experiences of 21 male and female Syrian refugees residing in Amman. Participants were selected based on purposive sampling. Study interviews examined the experiences of participants regarding their pregnancy outcomes, influencing factors for their reproductive decisions, and gaps in sexual and reproductive healthcare in Amman.

Results: Participants indicated great SRH need specifically related to their education on contraceptive methods. Participants confirmed that reproductive health services in Syria were more accessible, affordable, and comprehensive compared to health services in Jordan. The greatest contributors to gaps in care for participants were financial constraints and apathy regarding refugee welfare among providers in Jordanian public facilities. All study participants placed great value on family and reproduction. The most commonly used methods of contraception among participants were the oral contraceptive pill (OCP) and coitus interruptus. Over 75% of participants began trying to conceive right after marriage.

Conclusion: Increases in access to comprehensive sexual and reproductive healthcare among refugees in low-resource, humanitarian settings is a healthcare priority. Study findings can influence the policies affecting family planning and reproductive health mechanisms provided to refugees in Jordan and other crisis and humanitarian settings.

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Introduction

In 2015, the United Nations declared the Syrian crisis as the worst humanitarian crisis of the 21 century (1). Jordan hosts 660,935 registered Syrian refugees, which are only a fraction of the total number of Syrian refugees in the country that is estimated to be 1.8 million, or one in every eight individuals in Jordan (2, 3, 4) (Figure 1). In total, 75% of Syrian refugees are women and children, and 716,492 of them are women of reproductive age (5).

Many Syrians are (illegally) smuggled into Jordan for various reasons, such as lack of any identification, lack of mobility, and captured by the police; therefore, they are not registered by

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the United Nations Refugee Agency (6). Majority of Syrian refugee communities in Jordan (approximately 80%) are located in non-camp settings, specifically in cities close to the northern border of Jordan and Syria, including Mafraq, Irbid, and Amman (Figure 1). However, given Jordan's small size and limited economic resources, already burdened health infrastructure, and diminished water supply, the country does not have the required capacity to meet the needs of refugee populations it has welcomed through its borders.

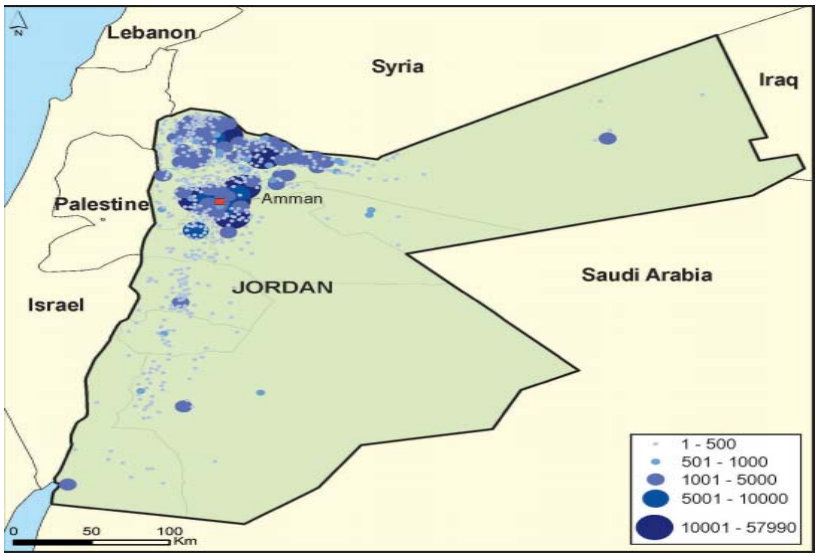

Figure 1. Location of Refugees in Jordan in 2017. Source: Map modified from UNHCR (2017)

In 2015, rapid assessments that took place in camps in Jordan revealed that 23%, 28%, and 17% of Syrian female refugees were unaware of reproductive health services, experienced unintended pregnancies, and did not have access to antenatal care, respectively (7). Syrian refugees residing in Jordan were deprived of contraceptives (8). In 2015, almost 44% of all Syrian females in Jordan who married were between the ages of 13 and 17, while 33% of Syrian females in Syria who married in 2010 were within that age range (9).

Based on the findings of previous studies, females who marry at a young age or before the age of 18 tend to have more children and heavily rely on traditional values and methods in their reproductive choices (10). In addition, these females, their spouses, and their families often possess limited reproductive health knowledge, which results in dire consequences regarding future obstetric outcomes, long-term health, and financial circumstances. Literature on reproductive health needs among males in the Arab World, specifically, is very limited. However, poverty serves as a predictor for limited RPH knowledge in both males and females.

According to a statement made by the Inter-Agency Working Group in 2010, comprehensive family planning can prevent up to 32% of maternal deaths and nearly 10% of newborn deaths (11). Based on the review of related literature, Syrian males and females who live in Jordan in disadvantaged, urban areas outside of camp settings would greatly benefit from improved access to information on the possible advantages of delayed pregnancies, birth spacing, a limited number of children, and available family planning methods and services (8).

Based on the review of the related literature until July 2020, no case study has been conducted on reproductive health experiences among Syrian refugees residing in Amman, Jordan in a qualitative, narrative-style interview format.

The present study attempted to answer the three following questions as they pertain to Syrian refugees residing in urban settings in

Amman, Jordan:
1. What sexual and reproductive health services are provided for this population?
2. What challenges does this population face regarding access to comprehensive sexual and reproductive health services?
3. What are the fertility intentions and perceptions of parenthood among this population?
In asking these questions, the research team sought to understand, in a qualitative and narrative format, the gaps in reproductive and sexual healthcare among a vulnerable population in a humanitarian setting. Today, research on refugee sexual and reproductive health is often conducted using survey methods and lacks urban refugee perspectives.

It is the goal of this study to contribute to the currently limited pool of research and dialogue on reproductive health services provided for Syrian refugees in Jordan. This study aimed to provide refugee aid organizations as well as the Jordanian government with evidence-based research that elucidates the need for sexual and reproductive health (SRH) education and services in order to bridge the undeniable family planning gaps that exist in crisis and humanitarian settings.

This study hoped to fill this gap in knowledge with pertinent and honest stories that could better inform the care that the refugee, displaced, and stateless individuals justly deserve to receive.

Materials and Methods

This ethnographic case study was employed in order to gain in-depth insights into the challenges facing Syrian males and females who seek sexual and reproductive healthcare. This approach was inspired by Drs. Baxter and Jack who stated that a case study is a valuable method for health science researchers to develop theories, evaluate programs, and create interventions in their study (12). The ethnographic qualitative interviews in this study allowed participants to provide the real-life context of their reproductive health experiences. This elaborate context contributed to the richness of the collected data. The ethnographic element of this study also led to its novelty, as there have been a limited number of studies conducted hitherto which gave a comprehensive and detailed overview of the lives of Syrian refugees residing in urban settings.

The study participants consisted of 15 Syrian females and 6 Syrian males. Two primary districts in Amman were visited in order to conduct study interviews. Participants were selected with the help of the Jordanian Hashemite Fund for Human Development (JOHUD) and through a purposive sampling method. The inclusion criteria consisted of 1) married status, 2) at least 18 years of age, 3) willingness to participate in the study, 4) residency in Jordan for at least the last year, and 5) Syrian nationality. All the study procedures were approved by the ethical review boards at Duke University, the University of Jordan, and JOHUD.

The study translator explained the purpose and procedures of the study to each participant and demonstrated that they are voluntary participants and can withdraw from the study at any time. Afterward, the participants gave their written and oral informed consent for participation. It should be noted that their oral consent was recorded with a tape recorder. To adhere to the standards of the Institutional Review Board at Duke University and the University of Jordan, each subject was interviewed separately to maintain their privacy and rights as research participants. Two of 21 participants were illiterate; therefore, instead of signing the consent form, their consent was obtained orally after the content of the consent form was explained for them in detail. The participants were reassured that they could withdraw from the study at any point if they felt uncomfortable and that this would in no way affect their access to services at JOHUD in the future.

The required data for this study were collected through face-to-face and semi-structured interviews. During these interviews, researchers listened to participants' narratives surrounding their lives in Jordan and in their homeland; participants also divulged how the environmental factors in these settings impacted their perceptions of parenthood and reproductive decisions. The interviews started with demographic information.

After demographic information was obtained, participants were asked questions from the

semi-structured interview guide. Study interviews were carried out primarily by the researcher and one translator. The translator had the greatest interaction with the participants, asking each interview question in Arabic, and then translating participants' responses directly afterward into English for the researcher to record.

The interviews contained three main themes, namely reproductive health, pregnancy outcomes, and family planning decision-making. At the beginning of each interview, participants were asked about their life experiences in Syria, their migration journeys to Jordan, and how their contemporary life in Jordan compares to life in Syria.

Questions then explored birthing experiences among participants, the quality of care in private vs. public vs. teaching hospitals, treatment of healthcare providers, and any complications they faced while giving birth. In this section of the interview guide, the participants were asked about the services they are currently receiving and received in the past. Paralleling questions from the previous section, participants were asked to describe and compare the services offered to them in Jordan versus those in Syria.

These questions also gave participants an opportunity to share their perspectives on contraceptive methods. Furthermore, they were asked if their partners respected their reproductive health decisions. In this section of the interview guide, study subjects were asked to describe motherhood and fatherhood from their own perspective. Afterwards, they were asked that if they could start their life over again, would they have done anything differently. The interview ended with questions about the future.

Some questions on the interview guide were different for males and females, specifically questions regarding contraceptive methods, ideas of motherhood/fatherhood, and birth experiences. During study interviews, the interviewer took notes and also recorded subjects' answers to ensure that all interview content was recorded. After the data collection, the interviews were analyzed in order to identify important and recurring themes. Moreover, study interviews were transcribed in real-time since the interview content was translated during each interview.

The research team continued to conduct interviews until data saturation was reached, i.e., when the participants began to repeat the same information and revealed no new information. After the interview of the 13th female participant, the responses became repetitive, particularly regarding sentiments about public versus private health facilities, financial constraints, and the desires of male partners to conceive a son instead of a daughter. Nevertheless, in order to ensure that no new information was presented, the research team conducted two additional interviews with females which did not reveal any new information. For this reason, the research team concluded the study after the interview with the 15th female participant.

After the interviews were transcribed, they were reviewed, entered into Microsoft Word, and uploaded onto NVivo software (version 11). Afterward, notes were taken both on printed copies of interviews and on NVivo software. Themes were extracted after reading study transcripts to find the meaning within the data.

The principal researcher of the study (M.P.) and her mentor (R.S.) analyzed findings through the use of NVivo software, which is a computer-assisted qualitative data analysis software (CAQDAS). According to the theories of Feng and Behar-Horenstein, in order to analyze open-ended responses from semi-structured, qualitative interviews, the researchers used qualitative methods to code, organize, and coherently divide the study data into categories or themes to gain an innate understanding of the data (15).

The CAQDAS helped study researchers to successfully categorize the collected data and to minimize their inevitable and implicit biases that could unduly impact the data analysis, particularly when open-ended questions are employed like the present study (15). Study researchers also used NVivo software to generate codes, which encompassed the main themes of the data.

After the two researchers coded the collected data, they informally compared their respective codes and concluded that their codes overlap. The only difference between their coding

included a separate code for midwifery that was generated by M.P. since five participants mentioned the use of a midwife. Further information on midwifery and participants' experiences using midwives is mentioned in the latter part of the results section.

Results

Mean ages of female and male participants were 33 and 45 years, respectively. Mean ages of marriage were 19 and 29 among females and males, respectively. Study participants migrated between the years of 2012 and 2016, and came from cities in Syria, including Damascus, Daraa, Hama, and Homs. It is noteworthy that the majority of the participants (15) came from Homs, Syria. On average, participants earned roughly 179 JD (252 USD) per month. None of the participants owned a house in Jordan, while all of them owned houses in Syria. Five participants were not currently working or received money from the UN. Reported occupations included porter, carpenter, house cleaner, and water deliverer. Some participants who could not find jobs received financial assistance from their extended family members. Participants' level of education ranged from fourth grade to third year of college for Syrian females and no education to Ph.D. for Syrian males. Participants' number of children ranged from three to seven and the average number of children was four and three for Syrian females and males, respectively.

Study codes primarily included migration experiences and trauma, contraceptive methods, level of education (primary, secondary, college, and post-college as sub-codes), satisfaction with reproductive health services (satisfied and not satisfied as sub-codes), comparison of healthcare standards in health facilities of Jordan with those of Syria, influential factors on reproductive decisions, and economic circumstances/hardships. These themes served as the preliminary interview codes created in NVivo that were further elaborated through the formulation of code descriptions/definitions and were applied to each interview in the software. Additional codes were created in the software, such as female entrepreneurship, interpretations of parenthood, healthcare service experiences in both public and private hospitals, causes of migration, and unintended pregnancy.

Selection and Access to Contraceptives

In Jordan, only married women have access to contraceptives, which are free in the Ministry of Health (MOH) centers. Many of the participants in this study visited the Noor al Hussein Center, a public health facility, in order to access reproductive health services and contraceptives. No participants mentioned any issues regarding the access to contraceptives since they was free, and MOH centers were always within a 6-10-mile radius of their homes.

Contraceptive methods mentioned by participants included no contraception at all coupled with or without coitus interruptus; pills; the injection method; and the intrauterine device (IUD). Many participants used at least one of these methods and at most all of them. The most common method used by female subjects was the use of pills, while the least common method was injection, which was mentioned only by one Syrian female. Female participants who chose the pill stated they made this choice because it helped them to have a regular period. However, others did not choose the pill because it caused mood swings, anxiety, and weight gain, and it was also ineffective. The women who did not select IUD stated reasons for this, including bleeding, previous experience of pregnancy despite using it, difficulty in insertion after C-section, and unwillingness to put a foreign object inside one's body, which also applied to other implantable contraceptive methods.

In addition, some women mentioned using contraceptives in Syria; however, they decided not to use these methods in Jordan since they did not trust the health facilities in Jordan and were dependent on lactation as a perceived method of contraception. Two participants stated that they never used contraception at all in their lives.

"I never used any contraception. All the birth spacing was natural. After the last child, I used the IUD, but it didn't work; it fell out. So, because of this, no contraception. I am now taking a chance and if I get pregnant, it'll be God's will (quote from a 43-year-old Syrian female)."

Another Syrian female had not used contraception at all before the birth of her sixth

child. Female participants stated that their decisions to use certain contraceptive method(s) often stemmed from the guidance of their family members and friends. In fact, the majority of participants used contraceptives under the influence of friends and family rather than guidance from clinicians. Moreover, female participants stated that their husbands supported their decisions to use whatever method they chose, and male participants confirmed this point by stating that their wife chose her contraceptive method on her own, or with the help of friends/medical staff.

Only two participants mentioned that a male in the household influenced their contraceptive choice. A female participant stated:

"In Syria, he (her husband) didn't want me to use the IUD. He didn't support me. He said you're going to put a strange thing in your body?" (Quote from a 33-year-old Syrian female).

Satisfaction with Services in Jordan

A total of four participants mentioned that they underwent enduring labor complications, including hypertension while giving birth, high levels of physical and psychological stress while in labor, and infections. According to the collected data, three participants experienced miscarriages and one participant had an abortion.

Participants preferred private hospitals to public ones since private facilities were better able to provide them with adequate time and attention, staff treated them with more respect and less discrimination, and there were fewer instances of complications and medical mistakes in private facilities.

While many women gave birth in private hospitals, they went to public facilities for their antenatal care and postnatal care since these services were cheaper at public facilities. At a public facility, each antenatal care (ANC) and postnatal care (PNC) cost less than 5 JD (7 USD), and several participants mentioned that these services were free for them. In a private facility, the cost of ANC and PNC visits start at 10 JD (14 USD) and can increase to approximately 80 JD (112 USD) depending on the facility and whether or not a family has insurance. One Syrian male mentioned that his wife did not receive any antenatal care or postnatal care at all.

Participants also mentioned that having connections and nepotism correlated with receiving better services at both public and private facilities. They explained that private hospitals in Jordan are very expensive, while they are cheaper in Syria. Many Syrian participants also stated that the public facilities in Syria are much cleaner and less crowded than those in Jordan and their staff are much more professional and qualified. Therefore, participants highlighted using both public and private facilities in Syria to give birth without mentioning a drastic distinction between the two. However, according to them, there was a considerable difference between public and private facilities in Jordan.

Four participants gave birth at home with a midwife and one participant gave birth in a private facility with a midwife.

"I had my third child at home with a midwife. So hard, I didn't like the midwife. My in-laws insisted that I have a baby at home. When the in-laws intervene, they make trouble. The baby was born and each time we carried him, he was hurt, seemed he had a fracture." (Quote from a 38-year-old Syrian female).

Family Planning Decision-Making

"To be a mother is the utmost thing a woman looks for. It's the delight of a woman's life. In our culture, a wife has to bear children. If she gets married and has no children, everyone wants to know why you don't have kids. It's expected to do this in our culture." (Quote from a 42-year-old Syrian female).

Regarding the strong sentiment in the quote above, all participants revealed the importance of having children, pointing to widespread societal and cultural expectations surrounding building a family in the Middle East. All participants had at least three children, and many, as previously mentioned, had four, five, and six children.

On average, couples started trying to have children right after they were married. In addition, the common suggested time for birth spacing by more than half of the participants was two years. The factors that influenced birth spacing decisions included the mother's recovery after a previous birth, breastfeeding, Quranic guidance, and the psychological development of the child. Reasons for longer

birth spacing than desired, such as five to eight years, included issues like migration, experimentation with contraceptives, health complications, and/or unintended pregnancy.

Reasons for having more children according to the participants were religious beliefs, interference of in-laws, parents, and familial interference, influence of the spouse, need for a sibling for the previous child, desire for a son, mother's desire for a daughter, and one's own personal desire. The most salient reason for not having more children and unintended pregnancies was related to finances.

All participants made decisions regarding family planning with their spouses. However, there was one exception to this among participants, as one male participant stated:
"She wanted two and I wanted ten. We compromised. But if she only wanted one kid, that would have been a big problem." (Quoted by a 42-year-old Syrian man).

Four Syrian females stated that they were not in agreement with their husbands regarding family planning decisions.

"I'm not very fond of having children. I wanted to stop after the girl (first child) but my husband didn't let me. My husband likes children, but I don't. Even now, he wants me to have more children but I don't want to. He's insisting on a brother for my son, just one more. But I'm saying no, so then no more children." (Quote from a 26-year-old Syrian female).

A Syrian woman shared this information when asked how many children she imagined she'd have at the beginning of her marriage.

Five Syrian women stated that if they could live their lives over again, they would have had fewer children than the number they have now. Two Syrian males stated that if they could have lived their lives over again, they would have had more children. Lastly, a total of 11 participants mentioned having at least one unintended pregnancy.

Discussion

Confirming the results of Cherri et al and DeJongJ et al, this study revealed the long-term benefits of family planning and spacing births on reproductive health outcomes and overall health outcomes, particularly among refugees under heightened economic stress (16, 17).

Findings related to factors impacting selection and access to contraceptives among study participants are consistent with those identified in other settings (18). Finlayson and Downe show that refugee populations outside of camps live under considerable financial stress. Although sexual and reproductive health services are available in public and private sectors of Jordan, costs remain a substantial factor in care-seeking decisions and locations among our study population. Without the legal right to work and sustainable livelihood opportunities, the ability to access essential maternal health services will remain a challenge (19).

Paralleling the results of previous studies (14, 8, 7), this study also revealed the limited reproductive health knowledge among Syrians, who often stated that they were not using contraceptives while lactating since they thought it would prevent them from becoming pregnant. This nonfactual information was often what led to unintended pregnancies and further strained financial circumstances.

Similar to findings from the UNHCR, study participants, as well as other urban refugees in Jordan, identified the scarcity of female doctors, distance to clinics, and high costs for private clinics and transport as obstacles to obtaining care, further contributing to their dissatisfaction with services in both public and private health facilities (20).

Study participants possessed mixed views on contraception, with some using natural methods, like coitus interruptus, or no contraceptive at all, and others using modern methods such as the OCP. In her 2019 article, Pierce concludes similar information on a group of urban refugees residing in Amman. Paralleling our findings, 42% of participants in Pierce's study sample used modern methods, 15% used traditional methods, and 25% didn't use any methods at all (21).

It should be noted that this study only focused on participants residing in Amman due to limited time and resources; the study was not expanded to the North of Jordan where many refugees live. In addition, the study's small sample size makes it impossible to generalize the conclusions of this study to the total Syrian refugee population residing in Jordan. The study took place during the month of Ramadan, which

could have negatively impacted the number of participants recruited, as well as their responses during interviews.

Furthermore, due to the study translator's schedule in the last two weeks of data collection, the study researcher, although highly advanced in Arabic, conducted the last five interviews on her own without the help of a translator. This could have led to a misunderstanding participant responses. Lastly, it is worth mentioning that the translator was female, which could have impacted male participants' comfort level sharing intimate information about their sexual and reproductive health.

This study revealed the dire need for comprehensive reproductive and sexual health education and information to be disseminated among refugee communities in humanitarian settings, and in lower-income settings in Jordan. It would be beneficial for future research to administrate interventions to assess the feasibility of an educational program that addresses family planning and contraceptive mechanisms among refugees first arriving to Jordan. In this regard, healthcare providers should be trained on how to inform their patients about these topics.

Many interventional studies in the past have created sexual and reproductive health education programs in refugee camp settings where refugees are confined to one area. Selection of this type of setting is likely to create fewer logistical barriers and less anticipated loss to follow-up among participants, compared to urban settings. Despite the ample barriers that would accompany urban refugee settings and study recruitment, this type of intervention is necessary.

This study could have also benefited from interviewing couples, instead of non-couple males and females. However, this is challenging to accomplish since males are often busy and less comfortable speaking about sexual and reproductive health.

Conclusion

It is necessary to create policies that encourage refugee married couples residing in Jordan to participate in a reproductive health education program, either in Zaatari when they first arrive to Jordan or when they move into urban communities, in order to decrease the number of children born in a country that can neither provide the proper resources for them to flourish nor promise them a secure future. Reproductive health education programs that highlight the importance of contraception, antenatal and postnatal visits among intrapartum and postpartum women, prevention of unsafe labor, and healthy family planning decision making with one's spouse, would also prevent health complications provoked by many sexual and reproductive health issues.

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Conflicts of interest

Authors declared no conflicts of interest.

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