



Baseline Study: Documenting Knowledge, Attitudes and Practices of Iraqi Refugees and the Status of Family Planning Services in UNHCR's Operations in Amman, Jordan

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This report is one of a series of five reports documenting baseline findings and recommendations to improve family planning programming for refugees in Djibouti, Jordan, Kenya, Malaysia and Uganda. The reports have similar objectives, literature reviews, methodology and limitations sections. The studies can be found at <http://www.womensrefugeecommission.org/reports>.

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ACRONYMS AND ABBREVIATIONS

CDC	Centers for Disease Control and Prevention
ECC	Exceptional care committee
FP	Family planning
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
IAWG	Inter-agency Working Group (IAWG) on Reproductive Health in Crises
IFH	Institute for Family Health
IRD	International Relief and Development
IUD	Intrauterine device
JHAS	Jordan Health Aid Society
MOH	Ministry of Health
NGO	Nongovernmental organizations
OB/GYN	Obstetrician/Gynecologist
RH	Reproductive health
STI	Sexually transmitted infection
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
WRA	Women of reproductive age
WRC	Women's Refugee Commission
WHO	World Health Organization

EXECUTIVE SUMMARY

This report addresses a family planning (FP) study undertaken by the United Nations High Commissioner (UNHCR), the Women's Refugee Commission (WRC) and the Centers for Disease Control and Prevention (CDC) among Iraqi refugees in Amman, Jordan in June-July, 2011. It documents the knowledge, beliefs, perceptions and practices of refugees, as well as the state of service provision to improve programming and subsequently increase uptake of good quality FP services among Iraqi women, men and adolescents.

KEY FINDINGS

Knowledge of FP and the benefits of child spacing was found to be high among adult Iraqi refugees living in Amman. However, there is a dearth of reproductive health (RH) knowledge among adolescents (ages 15 to 19), which appears to be in large part due to cultural norms that prohibit sex among people who are unmarried. In addition, very few respondents had heard of emergency contraception or female condoms.

FP education and most methods are available to the Iraqi refugee community through government public health centres; yet, the calculated contraceptive prevalence for modern methods, at 21.4%, remains low among women of reproductive age (WRA). In addition, the data show that approximately 40-41% of women are accessing FP from pharmacies, followed by 27% from health facilities. The most commonly used FP method reported was withdrawal. In addition, oral contraceptive pills and intrauterine devices (IUDs) were found to be utilized within the Iraqi community. There is very limited use of injectable contraceptives and implants. Low uptake of modern methods may be related to lack of availability at the health facility level, as reflected by the observation that the two health facilities which serve the largest number of Iraqi refugees in Amman do not provide any modern FP services.

The following recommendations are the result of two months of qualitative and quantitative data collection, which include a household survey, clinic assessments, focus group discussions and in-depth interviews.

KEY RECOMMENDATIONS

The following recommendations are based on the quantitative and qualitative findings of this study:

IMMEDIATE RECOMMENDATIONS

1. **International Relief and Development (IRD) should engage its community-based health workers (CBHWs) to inform the refugee community about the benefits of FP and on where and how to access modern FP services.** It would be beneficial to increase the number of Iraqi health workers who can provide information and education to the Iraqi community at the household level, specifically about the benefits of FP, where to obtain FP and which methods are available at each clinic.
2. **UNHCR should work with its implementing partners and affiliated health facilities to provide education on all FP methods and work to improve referral services.** Even though it is against Caritas' and the Italian Hospital's mission to provide modern FP, they should at a minimum provide education on traditional methods, which are the most commonly used methods within the Iraqi community. In addition, if they cannot provide modern FP methods or education, they should provide referrals to other clinics if their clients want and ask about modern methods.

Education about emergency contraception and long-term methods such as implants and injectables should be further emphasized.

3. **The Ministry of Health (MOH) and UNHCR should support in-service training on standard precautions and ensure a monitoring and evaluation system is established in all facilities to ensure infection control measures are followed, especially at the government public health centres.** Regular in-service trainings should be implemented and a monitoring and evaluation system established to ensure infection control measures. If UNHCR continues to refer and encourage refugees to utilise public health centres, UNHCR should work to ensure refugees are receiving good care at public health facilities through regular monitoring and evaluation. Monitoring and evaluation procedures should involve patient satisfaction surveys, patient focus groups and regular facility assessments.
4. **The MOH and UNHCR should ensure consistency of method availability at all public health centres.** All government public health centres should have the same methods and staff capacity to provide methods. During the study's facility assessments, only one of seven public health centres visited had implants. Implants are available from the MOH and should be accessible in all clinics, and appropriate staff training should be provided.

LONG-TERM RECOMMENDATIONS

5. **The MOH should increase the capacity of nurses and midwives to insert IUDs by expanding public policy and training opportunities.** It is MOH policy that only physicians can insert IUDs. Considering many health facilities reported being understaffed, it would be beneficial to increase the capacity of staff available. Survey data showed that IUDs were the most commonly used modern method among Iraqi refugees. Therefore, interest exists in the method and access should be encouraged.

INTRODUCTION

According to the Jordanian government, an estimated 450,000 to 500,000 Iraqis resided in Jordan as of May 2007;¹ 32,421 are registered with the UNHCR.² The greatest influx of refugees since the start of the Iraqi war in 2003 occurred in 2006 and 2007. The majority of refugees live in urban areas (specifically in Amman). They are not official residents of Jordan; rather, the Kingdom of Jordan considers them to be guests.

While UNHCR has focused on emergency obstetric care, gender-based violence and HIV/AIDS in the past several years, FP activities have not been given sufficient attention to ensure adequate access for refugees and other persons of concern. Previous studies and reports have shown that FP coverage in Amman among Iraqi refugees has been low and RH has not been made a priority.

Access to FP services is a human right³ and neglecting FP can have serious health consequences. Providing access to safe, effective contraceptives can reduce unwanted pregnancies, unsafe abortion and maternal death and disability. It also provides women and girls the autonomy to determine the number and spacing of their children, access educational and livelihoods opportunities, and manage scarce resources more effectively.

The Statement on Family Planning for Women and Girls as a Life-Saving Intervention in Humanitarian Settings,⁴ developed by the WRC on behalf of partners and endorsed by the steering committee of the Inter-agency Working Group (IAWG) on Reproductive Health in Crises in May 2010 outlines existing standards on providing contraceptives from the onset of an emergency and throughout protracted crises and recovery. It further describes methods of service delivery and provides recommendations for governments, donors and implementing agencies.

UNHCR intends to document knowledge, beliefs, perceptions and practices of refugees, as well as the quality of services provided to Iraqi refugees living in Amman, in order to improve programming and subsequently increase uptake of FP services among women, men and adolescents. The study is one of several conducted for a global overview of baseline findings. The UNHCR-Jordan office will use the findings and recommendations from this baseline study to inform and improve FP programming.

¹ Fafo, Jordania Department of Statistics, UNFPA (2007). Iraqis in Jordan: Their Numbers and Characteristics. Available online at www.unhcr.org, accessed 15 August 2011.

² UNHCR Regional Data Analysis Group (2011). April 2011 Statistical Report on UNHCR Registered Iraqis and Non-Iraqis. Available at: http://reliefweb.int/sites/reliefweb.int/files/resources/Full_Report_576.pdf.

³ Under international law, universal access to family planning is a human right. According to Article 16(1) of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), all individuals and couples have the “right to decide on the number, spacing and timing of children”. The Programme of Action from the 1994 International Conference on Population and Development also notes the right of couples and individuals, “to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so” (Article 7.3). Moreover, General Comment No. 14, para. 12 of the Committee on Economic, Social and Cultural Rights states that the right to the highest attainable standard of health includes the “right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning”.

⁴ Inter-agency Working Group on RH in Crises (2010). A Statement on Family Planning for Women and Girls as a Life-saving Intervention in Humanitarian Settings. Available online at <http://www.iawg.net/fpstatement.html>, accessed 15 August 2011.

OBJECTIVES

Goal

To document knowledge, beliefs, perceptions and practices of refugees, as well as the state of service provision in the select UNHCR operation to improve programming and subsequently increase uptake of FP services among women, men and adolescents.

Objectives

- To increase baseline information to guide policy and planning.
- To improve quality of services through training and guiding health and community providers, and improving infrastructure as required.
- To adapt programmes according to barriers, beliefs, fears and perceptions, in terms of information, education and communication efforts, and service delivery.
- To expand access through a broader choice of contraceptive methods, community-based distribution and linkages with national programmes or other in-country initiatives as appropriate.

Study Question

This study aimed to answer the primary question: What are the barriers and challenges at the community and health facility levels that hinder increased uptake of contraceptives among the select refugee communities, and what are the practical ways that the challenges can be addressed?

LITERATURE REVIEW

In May 2007, the Jordanian government commissioned a study in order to assess the size and household characteristics of the Iraqi community residing in Jordan. The study included a household survey in which 3,439 households were interviewed. Information was gathered on demographics, household living conditions, economic and livelihood conditions and access to education and health care. The study found that the majority of refugees live in urban areas, specifically in Amman. About one in five households is headed by a female and those households are more often among the poorer households. Economic hardships and inability to find work were cited by other studies and reports as factors for Iraqi refugees entering into prostitution.⁵

Previous studies have shown that Iraqis residing in Jordan encounter difficulties when trying to access FP services. A 2009 study conducted by Johns Hopkins University, the World Health Organization (WHO) and UNICEF reported that 58% of current pregnancies were unplanned, while 24% of married WRA reported a current need for contraception. The study also found that among married WRA who were menstruating, 39.8% were using a FP method (this includes traditional and modern methods). Study participants cited cost and not knowing where to seek care as two predominant barriers to accessing RH services.⁶

The WRC undertook three field missions to Jordan from 2007 to 2009. The initial findings in 2007 showed limited attention to RH by humanitarian responders, with a lack of funding for RH as a

⁵ Fafo, Jordania Department of Statistics, UNFPA (2007). Iraqis in Jordan: Their Numbers and Characteristics. Available online at www.unhcr.org, accessed 15 August 2011.

⁶ WHO, UNICEF JHU Bloomberg School of Public Health (2009). *The Health Status of the Iraqi Population in Jordan*. Available in PDF: http://www.unicef.org/jordan/jo_children_HealthStatusofIraqisinJordan2009en.pdf.

predominant barrier to services for Iraqi refugees in Jordan. In addition, a lack of baseline information about Iraqis residing in Jordan was noted as a challenge by implementing agencies in proving to donors that RH was a priority. In 2008, the WRC noted that the humanitarian response showed increased attention to maternal and newborn health services and the problem of domestic violence. By 2009, most objectives of the Minimum Initial Service Package (MISP)⁷ for RH had gained attention by humanitarian workers. However, many practitioners with whom the WRC met agreed that there was still an unmet need for FP. While it was noted that the MOH had made FP available through primary health care, the WRC also received reports that Iraqi refugees did not know about these services and that the quality of FP counseling techniques could be improved.⁸

In order to support greater health care access for refugees, UNHCR has formed partnerships with nongovernmental organizations (NGOs) and government health care facilities. Primary health care services in Amman are available to refugees through UNHCR's two implementing partner clinics: Caritas in Hashimi and the Jordanian Health Aid Society (JHAS) in central Amman. In addition to partnerships with implementing partners, UNHCR reached an agreement with the Ministry of Planning and International Cooperation in 2007 to make primary health care services available to all Iraqis regardless of their UNHCR registration or legal status in the country, at the same rate as an uninsured Jordanian.⁹

UNHCR is currently working to encourage refugees to use government health services, especially at the primary health care level. In efforts to encourage refugees to use government health facilities, implementing partner clinics started charging a nominal fee of two Jordanian dollars (JD) for each consultation beginning in March 2010, a rate slightly higher than at government public health centres.¹⁰

Secondary health care services are offered through the Caritas-affiliated Italian Hospital. Tertiary health care services are available to UNHCR-registered refugees by referral from Caritas. If the estimated cost of the treatment is more than JD 1,000 per person per year, the case must be approved by the UNHCR exceptional care committee (ECC) before the referral takes place.¹¹

Hospital-based births are available at the Caritas-affiliated Italian Hospital. Delivery services for Iraqi refugees are available at governmental hospitals only with a referral from Caritas (in which case Caritas will cover the fees). Emergency obstetric care is provided free of charge up to JD 1,000 per person/per year at the Caritas-affiliated hospitals and all governmental hospitals; however, if emergency obstetric care exceeds JD 1,000, prior approval from UNHCR through Caritas is required.¹²

Many of UNHCR's operational partners have programmes aimed at improving RH within the refugee community. Information about ongoing projects, future programmes and inter-agency collaboration are discussed on a monthly basis during the RH Sub-Group Meeting that includes UNHCR, the United Nations Population Fund (UNFPA), IRD, Institute for Family Health (IFH), JHAS, MOH, WHO and International Medical Corps.¹³

⁷ The Sphere Project, *Humanitarian Charter and Minimum Standards in Disaster Response*, 2004 Edition, 288 – 290.

⁸ Women's Refugee Commission (2009). Internal, unpublished country report. *Progress and Gaps: Reproductive Health Among Iraqi Refugee Woman and Youth in Jordan*.

⁹ UNHCR (2011). Unpublished report. *Guidelines UNHCR-Supported Health Service in Jordan*.

¹⁰ Ibid.

¹¹ Ibid.

¹² Ibid.

¹³ United Nations (2011). *Reproductive Health Sub-Group April 26, 2011 Meeting Notes*.

Currently, IRD conducts home visits for health education, assessment and referrals to UNHCR's implementing partners and MOH clinics. In addition to IRD, UNHCR's operational partner, the IFH, conducts awareness sessions and home visits while also providing RH services at its clinic in Amman.¹⁴

METHODOLOGY

Household Survey Methodology

The household survey was undertaken in 15 districts within Amman, Jordan. The objective of the survey was to assess RH measures among the registered Iraqi refugee population. The survey included questions assessing safe motherhood, FP, and marriage and live-in partnerships. Seven hundred registered Iraqi refugee households were sampled. The inclusion criteria for the sample was as follows: the household must be registered with UNHCR as an Iraqi refugee household; each household must contain at least one WRA (defined as 15-49 years old); and the household must be located within Amman. A simple random sample was generated from UNHCR's proGres Registration Database. As UNHCR does not typically store data by household (instead, it is by individual or case), a list of all women meeting the sample criteria was produced. This generated a list of 7,230 Iraqi women and 177 non-Iraqis (non-Iraqis are not necessarily recognized by UNHCR as refugees or asylum seekers, but are married to recognised persons of concern and were therefore included in the sample). From this list, the women were grouped into households based on those who had the same registered family name, address and phone number. This process produced a list of 6,879 households that contained one or more women who met the sampling criteria. Taking into consideration incorrect or disconnected phones numbers, a random selection of 700 households that included the head of household phone numbers was then produced from this list using Microsoft Access.

The survey tool used was an adaptation of CDC's *Reproductive Health Assessment Toolkit for Conflict-Affected Women*.¹⁵ The survey was translated from English to Arabic and then back-translated in order to ensure accuracy of the final Arabic tool. The survey was revised for cultural appropriateness and phrasing by the UNHCR-Jordan office and further adjustments were made after it was pilot-tested in 30 refugee households.

The survey team consisted of five female interviewers and one supervisor, all of whom had prior survey experience. The team was selected by UNHCR's operational partner, IRD. All interviewers worked as outreach volunteers for IRD. The interviewers were familiar with the Iraqi refugee community and were Iraqi refugees themselves. The team underwent a five-day training that included a review of the survey and survey questions; interviewing techniques; explanation of participants' rights and confidentiality; and RH terminology.

Data collection took place from 26 June to 14 July 2011. All households were initially telephoned and informed of the survey and its purpose. If the household member agreed to participate, the respondent was asked about the number of women between 15 and 49 years old currently residing in the household. All WRA were listed for that household and one woman was selected using a locator form that included a random selection table. The interviewer then visited the household and explained to the selected woman her rights as a participant and informed her that her name would not be recorded or connected with her responses. If she agreed to participate, she was then interviewed in her house

¹⁴ Ibid.

¹⁵ Center for Disease Control and Prevention. (2009). *Reproductive Health Assessment Toolkit for Conflict-Affected Women*. Available as a PDF document: <http://www.cdc.gov/reproductivehealth/refugee/PDF/AppendixC.pdf>.

within a private space. Households were telephoned up to five times before they were excluded from the sample. If the selected woman refused to participate, the entire household was listed as a refusal and no other woman in the household was asked to be interviewed.

During survey implementation, the study coordinator and survey team supervisor reviewed the completed surveys for daily completion. Any errors made on the surveys were discussed with the interviewer. Survey quality assurance and training was continuous throughout the implementation period. Data were entered during and after the survey period, solely by the study coordinator. Data were entered using the CSPro software. Data were cleaned and analysis was conducted using the software, CSPro and SPSS. Reported percentages were weighted to account for random sampling at the population level and at the household level.

Health Facility Assessment Methodology

Seven health facilities were assessed. These were selected by UNHCR-Jordan's assistant public health officer and included a balance of primary, secondary and tertiary facilities. The seven facilities were two MOH primary public centres, two UNHCR-implementing partner primary and secondary care clinics, one MOH public hospital, one private NGO hospital and one private NGO family health facility. A project manager was interviewed at each facility, along with direct providers of RH services.

An existing UNHCR health facility assessment tool was adapted by UNHCR, the WRC and the study's FP expert. Two tools were developed; one for the staff in charge and one for other staff and consultation observations. The tools were translated into Arabic and back-translated into English to ensure accuracy. Facility assessments were conducted by the in-country study coordinator with the assistance of an interpreter who translated the questions and responses. Notes were taken in English by the study coordinator.

Focus Group Discussion Methodology

Twelve focus groups were conducted for this study. These were: three groups of married and unmarried women aged 20-49 years; three groups of married and unmarried men aged 20-49 years; three groups of unmarried girls aged 15-19 years; and three groups of unmarried boys aged 15-19 years. All focus group participants were Iraqi refugees.

Focus group participants were selected by IRD. All participants were beneficiaries of IRD's programmes, services and trainings. Participants were selected from three different regions of Amman (Hashimi, Jabal Al Hussein and Jabal Al Nasir) to ensure diversity. Male focus groups were facilitated by a male and female focus groups were facilitated by a female in order to provide a culturally appropriate atmosphere to discuss RH matters. In addition to a facilitator, a note taker was present at each discussion and all discussions were recorded. Participants were read a consent form that presented the purpose of the study and informed them of their rights as participants. All participants agreed to the recording of the discussions. Discussion recordings were deleted after analysis.

Focus group facilitators and note takers were part of UNHCR-Jordan's field and community service staff. Three facilitators, all of whom were highly experienced and trained in focus group facilitation, conducted the discussions. The WRC provided topic guides, which were translated into Arabic and back-translated into English to ensure accuracy. The topic guides covered participants' experiences with FP services and community attitudes towards the use of FP services. Separate topic guides were used for adults and adolescents groups.

In-depth Interview Methodology

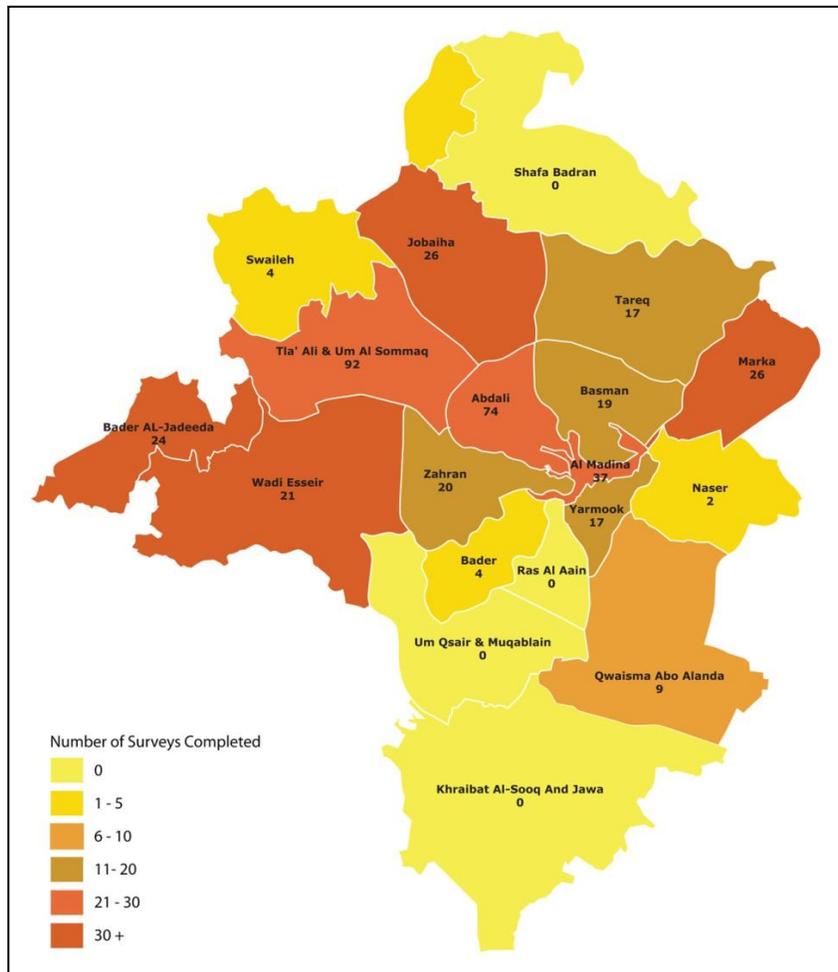
Three in-depth interviews with community key informants were conducted at the onset of the study. Key informants were identified by UNHCR-Jordan and included two community health volunteers and one community Imam. An interview guide was developed by UNHCR and the WRC. Interviews were conducted by the in-country study coordinator with an interpreter who translated the questions and responses. Notes were taken in English by the study coordinator.

PRESENTATION OF FINDINGS

Household Survey

The household survey was conducted between 26 June and 14 July, 2011. Of the 700 sampled households, 410 interviews were completed. However, three surveys with unmarried adolescents were not included in the data analysis because the mother of the participant refused to leave the room. Therefore, it is assumed that answers given by the participant may not have been reflective of the respondent herself. The 407 households that were included in the data analysis were spread throughout 15 government districts in Amman. There was a 58.1% response rate after reaching 700 households in total. This distribution is presented in Figure 1.

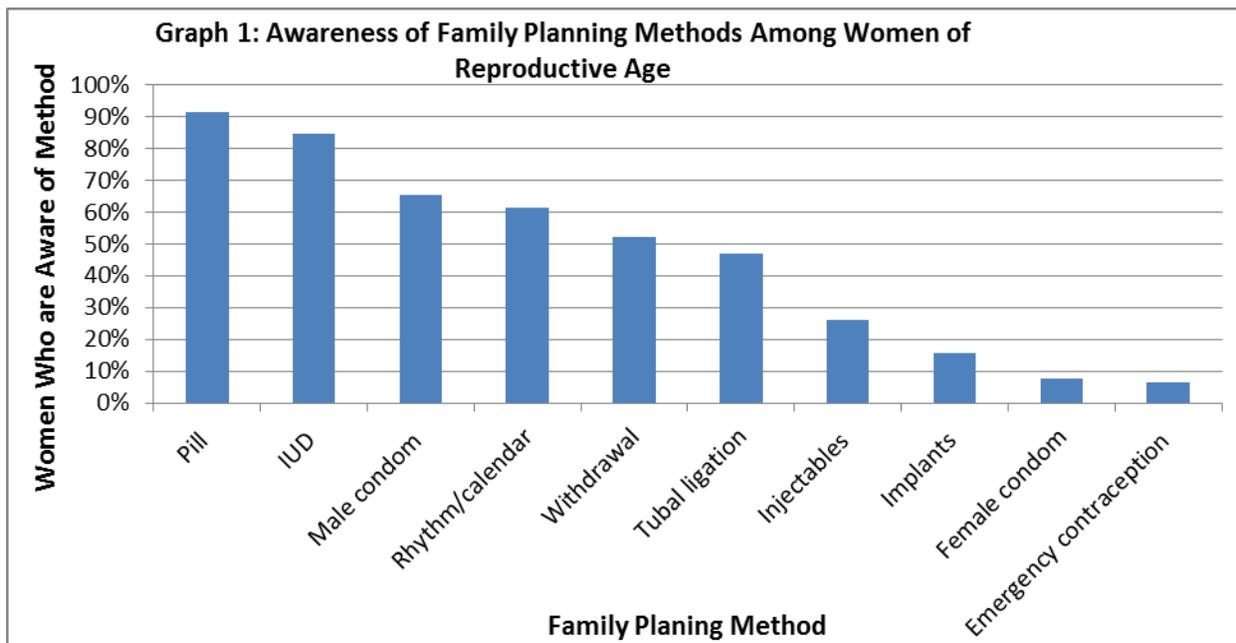
Figure 1: Distribution of Surveyed Households within Amman



Out of the 407 households, 14.8% of the respondents were between the ages of 15 and 19, 32.2% were between 20 and 29 years old, 25.4% were between 30 and 39 years old and 27.5% were between 40 and 49 years old.

To assess awareness of FP methods, respondents were asked whether they had ever heard of a particular method. The majority of respondents had heard of the pill (91.5%), IUD (84.7%), male condom (65.4%), rhythm/calendar (61.4%) and withdrawal (52.3%) methods. However, few respondents had ever heard of the female condom (7.7%) or emergency contraception (6.4%). See Graph 1 for the complete breakdown of findings.

Respondents who reported hearing of a method were then asked whether they had ever been instructed on how to use the method and if they had ever used the method themselves (see Table 1). Between 20% and 33% of respondents had ever used the pill (30.1%), IUD (21.6%), male condom (20.8%), rhythm/calendar (21.4%) or withdrawal (32.2%) methods. Very few or no women had ever used the female condom (0.2%), emergency contraception (0.6%), implants (0%), injections (2.6%) or tubal ligation (2.4%).



*Percentages may add up to greater than 100%.

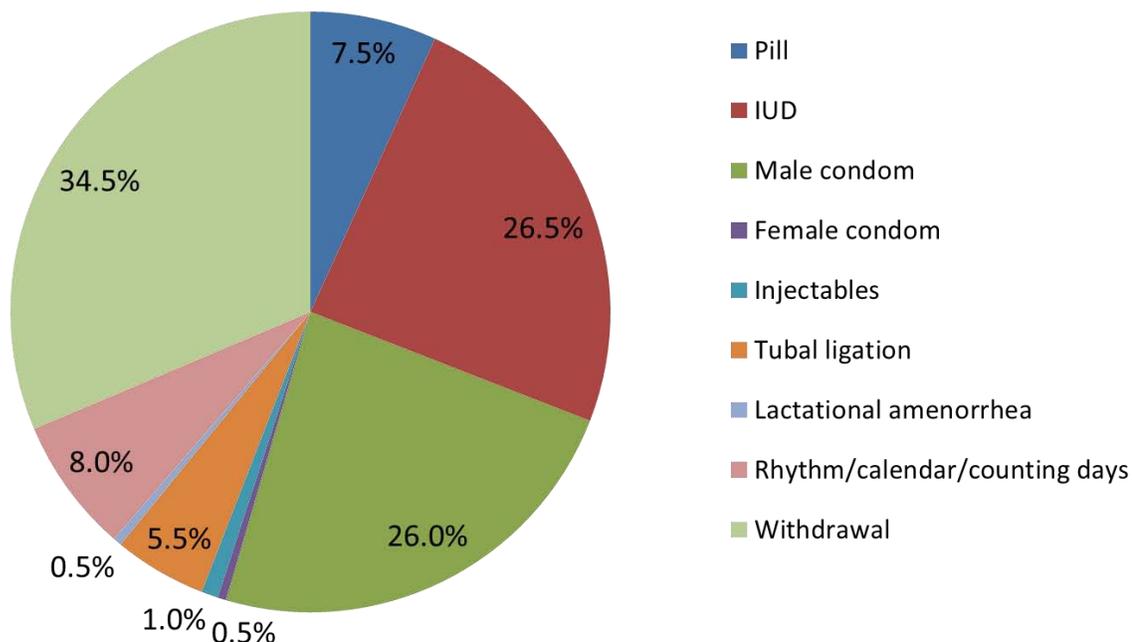
TABLE 1: PROPORTION OF WOMEN WHO HAVE BEEN INSTRUCTED HOW TO USE OR HAVE EVER USED FAMILY PLANNING METHODS AMONG WOMEN OF REPRODUCTIVE AGE* IN AMMAN, JORDAN 2011. {N = 407}

Method	Instructed how to use method % (n) women	Ever used % (n) women
Pill	61.2% (257)	30.1% (132)
IUD	55.9% (236)	21.6% (99)
Male condom	47.3% (208)	20.8% (99)
Female condom	6.1% (29)	0.2% (1)
Implants	9.8% (42)	0% (0)
Injectables	17.4% (79)	2.6% (13)
Emergency contraception	5.6% (25)	0.6% (4)
Tubal ligation	34.3% (147)	2.4% (8)
Rhythm/calendar/counting days	49% (208)	21.4% (97)
Withdrawal	47.7% (215)	32.2% (146)

*Percentages may add up to more than 100% as respondent may give more than one response.

The proportion of respondents who reported ever using any FP method was 54.8%, while the proportion of respondents who reported currently using any FP method was 31.9%. Currently, the most commonly used method is withdrawal (34.5%), followed by the IUD (26.5%) and the male condom.

Figure 2: Family planning method being used among women who are currently using any family planning method



Among respondents who are currently using any FP method, 21.4% are using a modern FP method (modern FP methods include the pill, IUD, male and female condoms, implants, injectables, emergency hormonal contraception, tubal ligation and vasectomy). Of those respondents who are using a modern method, 40.3% obtained their method from the pharmacy, followed by 26.9% who obtained their method at public health centres and 14.2% at a hospital.

Health Facility Assessments

In total, seven health facilities were visited within Amman, including UNHCR’s implementing partner facilities (Caritas and JHAS). Neither Caritas nor JHAS clinic had FP methods available. Caritas follows a Catholic mission and therefore does not promote or provide referrals for modern FP. Traditional FP methods, such as withdrawal and the rhythm/calendar methods, were not promoted in the clinic because they were perceived by the health staff to have low efficacy. JHAS does not provide methods at its clinic but the agency provides FP counseling, verbal referrals to government clinics and hospitals for FP services and it also provides education materials, such as pamphlets, on a wide variety of methods. Standard precautions for infection prevention were followed at both clinics.

Two government public health facilities were assessed during this study, one in Hashimi and one in Sahab. Both clinics were providing modern FP methods, such as condoms, pills, injections and IUDs. Sahab clinic also had implants available and had trained staff in implant insertion, but at the time of visit it had not started offering the method. Hashimi did not provide implants as an FP option because implants were not yet made available to Hashimi by the MOH. Both clinics were making verbal referrals

to public hospitals for tubal ligation if the method was requested by the client. A visit to the Hashimi public centre showed that the facility was overcrowded and standard precautions and general hygienic procedures were not being adhered to, such as the changing of bed sheets after each patient. This was also the case at Sahab. Both clinics reported being understaffed.

Two hospitals were also visited; one government public hospital, Al Bashir, and one private/NGO hospital, the Italian Hospital. All temporary and long-acting contraceptive methods were available at Al-Bashir Hospital except for the female condom, which was reported as not being available in Jordan. Al-Bashir had brand-new FP counseling rooms and the staff had extensive training in modern FP methods. In addition, Al-Bashir received adequate scores in its capacity to meet infection prevention standards and in its quality of care.

The Italian Hospital is an affiliate of Caritas and also abides by a Catholic mission. As a result, modern FP methods were not available at the Italian Hospital. In addition, there was a weak verbal referral system for modern FP services available at other facilities. An obstetrician/gynecologist (OB/GYN) at the Italian Hospital reported that patients received FP counseling only if they asked. However, a midwife at the Italian Hospital reported that staff offer some FP counseling and provide verbal referrals.

The IFH part of the Noor Al Hussein Foundation was also assessed. The clinic provides comprehensive FP services that include counseling, provision of short- and long-term methods and a verbal referral system for methods not available at the clinic, such as tubal ligation. The clinic received adequate scores in its quality of service and capacity to meet infection prevention standards.

Qualitative Findings

In all, 107 men, women, girls and boys participated in the 12 focus group discussions. Three focus groups were conducted for women aged 20-49 years and included 32 women in total (24 married, five unmarried, two divorced and one widowed). Three focus groups were conducted for men aged 20-49 years and included 27 men in total (22 married and five unmarried). Three focus groups were conducted for boys and included 21 boys aged between 15 and 21 years and three focus groups were conducted for girls and included 27 girls aged between 15 and 20 years.

Adult Focus Group Findings

Number of Children. Most groups agreed that three or four children was the typical number of children a woman should have, and while there may be an agreement between a husband and wife, it is mainly the husband's decision. All groups mentioned a difficult financial state and insecurity about the future as the predominant factors taken into account when deciding the number of children.

Knowledge of FP and Child Spacing. Knowledge regarding FP methods and their availability was widespread throughout the adult groups. Most groups reported that FP services were free and available, but there was some discussion that accessing FP services was not easy. As reported in one of the male groups: "It is available but not so easily obtained. Our community is in need of more advice, guidance and more centres that can provide this kind of information and methods."¹⁶

In addition, both female and male adult groups recognised the benefits of child spacing, such as the recovery of the woman and providing time to care for each child. As reported in one of the male groups

¹⁶ Focus group discussion with men, Amman, Jordan, 19 July 2011.

when asked whether they have heard of child spacing: “Yes we have heard of it, and it is best to space children by two to three years for the health and well-being of the woman.”¹⁷

Social and financial factors were also given as benefits to spacing children. In addition, most groups thought two to three years was the appropriate spacing period.

Community Attitudes about Using Contraceptives. There were mixed opinions about the community’s perceptions on using modern contraceptives. Some participants felt the community had negative attitudes towards using contraceptives. As one woman stated: “Some war-inflicted communities like Iraq tend to prefer more births as many people died in the war.”¹⁸

However, some participants disregarded any negative perceptions while countering that the current financial and security situation was leading the community to accept the use of contraceptives. As one woman reported: “I don’t agree. The current state of affairs doesn’t help: there’s no safety, a man can disappear any day, leaving the woman alone to care for the children with no income and end up living in poor conditions.”¹⁹

When asked how the community feels about contraceptive use among the unmarried and adolescents, all groups rejected the idea. As stated in one of the female groups: “That concept is refused by the Iraqi community entirely, for women, men or adolescents.”²⁰

Adolescent Focus Group Findings

Reproductive and Sexual Health. There was general consensus in all adolescent groups (boys and girls aged 15-19 years) that if they had a problem concerning their reproductive or sexual health they would seek the advice of either their mother (for girls) or their father (for boys). When asked whether adolescents their age were having sex, there was agreement within all groups that some adolescents in the community were sexually active but that it was very rare. A participant in one female group said: “Girls sometimes use boys for gifts and telephone calls to enjoy themselves and then provide ‘rude’ favors in return.”²¹

However, in general it was agreed that within the Iraqi community, sex among adolescents was rare and occurred more commonly outside of the Iraqi community. “Certain schools, it happens more than others, mostly the students aren’t Iraqi.”²²

Sexual activity among adolescents was widely referred to as “wrong,” “shameful” and “bad for a girl’s reputation.” When asked how the community perceives an unmarried girl who is pregnant, it was overwhelming agreed that this is strongly condemned by the community. Some group members described an unmarried girl being pregnant as “a disaster” and that it would “ruin” the family. In all groups it was said that an unmarried girl would be at risk of death (honor killing) if she became pregnant or that she would be forced to marry the male that impregnated her. As stated in one of the boys’ groups: “Her family or tribe would be marred and put to shame; they would need to have her killed or [she would be] forced to marry the partner to redeem their honor.”²³

¹⁷ Ibid.

¹⁸ Focus group discussion with women, Amman, Jordan, 18 July 2011.

¹⁹ Ibid.

²⁰ Ibid.

²¹ Focus group discussion with adolescent girls, Amman, Jordan, 12 July 2011.

²² Focus group discussion with adolescent girls, Amman, Jordan, 19 July 2011.

²³ Focus group discussion with adolescent boys, Amman, Jordan, 12 July 2011.

Knowledge of FP Methods and STIs. Knowledge of FP methods was very low in all adolescent groups. Most groups could not name more than one contraceptive method and could not name any advantages to using contraceptives. In addition, knowledge of how to prevent STIs was low, as most groups could not offer any ways to prevent STIs besides not having sex.

DISCUSSION

As shown through the survey findings, lack of access and opposition to use among married adults were not found to be significant barriers to using modern FP methods. (Data on usage of FP by adolescents are limited and it is thus hard to make an accurate inference.) These findings are also supported by the focus group discussions in which most participants agreed that FP methods were available and free. Although UNHCR and its implementing partners encourage refugees to use the government health centres for FP services, it was found that a large percentage of households continue to obtain modern methods for cost at pharmacies instead of from the government health centres. Additionally, when asked where the best place to obtain the methods, very few survey respondents identified the public health centres. This may indicate a service problem at the clinics themselves. As reported in focus group discussions and during in-depth interviews with key informants, problems reported with public health centres were long waiting times and a provider bias against Iraqis. Facility assessments further identified problematic sanitation practices, overcrowded conditions and a lack of staff.

Focus group participants reported that even though methods are available and free they are not easy to obtain. This may be due to the fact that UNHCR's implementing partners do not offer any methods at their clinics and if a patient would like a method, they must go to another source. Because most Iraqis are not residents of Jordan and cannot legally work, they have limited financial resources. Transportation costs incurred in traveling to different health facilities to obtain methods may be a barrier for some refugees. In addition, refugees may not be receiving referral information on where to obtain methods. Caritas sees significantly more patients than UNHCR's other implementing partner clinic, JHAS, but, while JHAS provides FP counseling and referrals, Caritas does not. In fact, Caritas and the Italian Hospital report seeing the most refugees of any UNHCR-affiliated facility; yet, neither facility routinely provides any FP services.

A study conducted in 2009 found that among married women of reproductive age who were menstruating, 39.8% were using a FP method.²⁴ The study also reported that the most commonly used methods were the hormonal pill (34.7%) and IUD (34.7%).²⁵ The current study found that of the 267 women who reported ever being married, 54.8% were currently using any FP method. Withdrawal was reported as the most commonly used FP method (34.5%), followed by the IUD (26.5%).

Reasons for preference of withdrawal over a modern method are not clear. Personal and partner opposition and lack of access were not reported by survey participants as barriers to modern methods. In addition, religious opposition was not cited as a barrier to modern methods. During an in-depth interview with a Muslim religious leader, no religious opposition was mentioned to the use of modern FP methods and, in fact, they were encouraged. Problems accessing modern methods at the facility level may prove to be a barrier considering many facilities serving refugees do not provide modern methods.

²⁴ WHO, UNICEF JHU Bloomberg School of Public Health, (2009). *The Health Status of the Iraqi Population in Jordan*. Available in PDF: http://www.unicef.org/jordan/jo_children_HealthStatusofIraqisinJordan2009en.pdf.

²⁵ Ibid., p.25.

Government health facilities are the only facilities that provide modern methods to refugees at no cost; however, there was reported hesitation among refugees about accessing the government health facilities.

An interest in long-acting methods appears to exist, as reflected in the high use of IUDs. However, the prevalence of other long-acting methods is low. There was no reported current use of implants, and only 1% of respondents were currently using injectables, while only 5.5% reported having a tubal ligation. Low implant usage may be related to the lack of implant availability at the health facilities. Only one of the seven clinics visited offered implants as a method. Injectables were offered at the public clinics but were not reported as being readily used by survey respondents. This may be due to a lack of knowledge of the method and its availability, as only 25.9% of all survey respondents had even heard of injectables.

LIMITATIONS

It is possible that sexual activity and FP use went unreported among unmarried women because of strong cultural beliefs that those who are unmarried should not be sexually active. In order to help facilitate a confidential environment in which participants would feel comfortable answering sensitive questions, interviewers received training in confidentiality practices and interviewing techniques. Additionally, interviews took place in a private room in each household.

Because asking the unmarried and adolescents about FP and sexuality was considered extremely sensitive and taboo, interviewers expressed concern over asking questions about sexual activity and FP to adolescents and unmarried woman. This may have imposed an interviewer bias in surveys with unmarried or adolescent girls. Hesitation among the interviewers over asking sensitive questions was dealt with by prefacing sensitive questions with part of the informed consent that stated all questions were voluntary and the respondent's identity would be kept confidential. In addition, interviewers informed participants that this was a health survey and all questions were being asked of all participants regardless of marital status and age. This strategy of prefacing sensitive questions with part of the informed consent helped to mediate objections by the interviewers. However, it is still possible that interviewers may have appeared uncomfortable when asking unmarried women and adolescents certain questions and in return making such participants feel uncomfortable reporting sexual activity and FP use.

Due to instability and lack of work opportunities, some refugees in Jordan move locations and change phone numbers frequently. This proved a challenge when trying to contact and locate all households randomly selected by UNHCR. Difficulty in reaching selected households due to incorrect or disconnected phones numbers was a predominant reason some selected households could not be interviewed. Therefore, the original 500 household sample had to be increased to 700 households in order to complete over 400 interviews.

With regard to the focus group discussions, facilitators were skilled and highly experienced in facilitating focus group discussions. However, facilitators were neither Iraqi nor refugees themselves. This may have limited the comfort of the participants when discussing a sensitive topic. In order to help counter unfamiliarity with the facilitator, focus group discussions took place at community-based centres that were familiar to the participants. Also, facilitators were the same sex as the focus group participants. This appeared to be very important in encouraging open discussion and participation.

APPENDICES

APPENDIX I: HOUSEHOLD SURVEY DATA TABLES

Method	% (n) women*
Pill	91.5% (379)
IUD	84.7% (354)
Male condom	65.4% (281)
Female condom	7.7% (38)
Implants	15.6% (66)
Injectables	25.9% (111)
Emergency contraception	6.4% (28)
Tubal ligation	47% (201)
Rhythm/calendar/counting days	61.4% (260)
Withdrawal	52.3% (234)

*Percentages may add up to greater than 100% as respondent may give more than 1 response.

Method	Health Centre % (n) women	Private clinic % (n) women	Market % (n) women	Friends/ relatives % (n) women	Pharmacy % (n) women	Don't Know % (n) women
Pill	5.5% (24)	2.9% (13)	0.2% (1)	0.2% (1)	75.2% (310)	6.9% (27)
IUD	18.4% (73)	50.7% (210)	0.0% (0)	0.0% (0)	3.5% (19)	11.6% (47)
Male condom	3.9% (17)	1.0% (5)	0.0% (0)	0.2% (1)	48.8% (211)	11.4% (47)
Female condom	0.3% (1)	0.6% (3)	0.0% (0)	0.0% (0)	4.3% (24)	2.3% (10)
Implants	3.4% (16)	4.8% (19)	0.0% (0)	0.2% (1)	3.1% (14)	3.9% (14)
Injectables	8.1% (29)	2.7% (15)	0.0% (0)	0.0% (0)	8.1% (36)	6.6% (29)
Emergency contraception	1.1% (4)	0.5% (2)	0.0% (0)	0.0% (0)	2.7% (16)	2.1% (7)
Tubal ligation	12.7% (54)	14.5% (60)	0.0% (0)	0.0% (0)	0.2% (1)	10.5% (47)

*Modern family planning methods include the pill, IUD, male and female condoms, implants, injectables, emergency hormonal contraception (EC), tubal ligation and vasectomy.

[†]Percentages may add up to more than 100% as respondent may give more than 1 response.

TABLE 4: MAIN PROBLEM REPORTED WITH USING SPECIFIC FAMILY PLANNING METHODS AMONG WOMEN WHO HAVE EVER HEARD OF THAT METHOD IN AMMAN, JORDAN 2011 {N = WOMEN WHO HAVE HEARD OF METHOD}

Method	Lack of access % (n) women	Opposition to use % (n) women	Method-related % (n) women	No problem % (n) women
Pill (N=379)	0.0% (0)	0.9% (2)	44.1% (165)	12.9% (49)
IUD (N=354)	0.0% (0)	0.0% (0)	37.5% (144)	16.5% (61)
Male condom (N=281)	0.0% (0)	6.4% (21)	12.8% (39)	33% (93)
Female condom (N=38)	0.0% (0)	0.0% (0)	23% (9)	14.6% (6)
Implants (N=66)	0.0% (0)	0.0% (0)	23.7% (19)	11.3% (6)
Injectables (N=111)	0.0% (0)	0.6% (1)	28.6% (32)	11.% (14)
Emergency contraception (N=40)	0.0% (0)	0.0% (0)	25% (7)	15% (5)
Tubal ligation (N=201)	0.0% (0)	0.3% (1)	16.4% (35)	38.7% (72)
Rhythm/calendar/counting days (N=260)	0.0% (0)	0.3% (1)	36.2% (103)	32% (85)
Withdrawal (N=234)	0.0% (0)	6.8% (15)	16% (45)	51.1% (113)

TABLE 5: DEMOGRAPHIC CHARACTERISTICS OF WOMEN WHO ARE CURRENTLY USING ANY FAMILY PLANNING METHOD IN AMMAN, JORDAN 2011 {N = 150}

Characteristic	% (n) women
Age	
15-24	6.57% (11)
25-34	28.28% (50)
35-49	65.15% (87)
Relationship Status	
Living with a husband/partner	96.46% (143)
Not living with husband/partner	3.54% (5)
Total pregnancies	
0	2.02% (4)
1-2	26.77% (44)
3-4	48.48% (73)
>4	22.73% (27)
Sexually active in last 30 days	
Yes	87.88% (133)
No	8.08% (9)

TABLE 6: FAMILY PLANNING METHOD BEING USED AMONG WOMEN WHO ARE CURRENTLY USING ANY FAMILY PLANNING METHOD IN AMMAN, JORDAN 2011 {N=150}

Method	% (n) women*
Pill	7.5% (12)
IUD	26.5% (42)
Male condom	26% (37)
Female condom	0.5% (1)
Implants	0% (0)
Injectables	1% (1)
Emergency contraception	0% (0)
Tubal ligation	5.5% (6)
Vasectomy	0% (0)
Lactational amenorrhea	0.5% (1)
Rhythm/calendar/counting days	8.0% (11)
Withdrawal	34.5% (51)
Periodic abstinence	0% (0)

*Percentages may add up to greater than 100% as respondent may give more than 1 response.

TABLE 7: LOCATION WHERE FAMILY PLANNING METHOD WAS LAST OBTAINED AMONG WOMEN WHO ARE CURRENTLY USING A MODERN FAMILY PLANNING METHOD IN AMMAN, JORDAN 2011 {N=98}

Method	% (n) women
Health Center	26.9% (24)
Hospital	14.2% (15)
Supermarket/Market	0% (0)
Pharmacy	40.3% (41)

*Modern methods include the pill, IUD, female and male condoms, implants, injectables, emergency hormonal contraception (EC), tubal ligation and vasectomy.

TABLE 8: BARRIERS TO FAMILY PLANNING AMONG WOMEN WHO ARE AT RISK FOR PREGNANCY, DESIRE TO STOP OR DELAY CHILDBEARING AND ARE NOT USING FAMILY PLANNING IN AMMAN, JORDAN 2011 {N=112}

Barriers to family planning	% (n) women*
Fertility-related reasons	93% (101)
Opposition to use	5.9% (7)
Method-related reasons	2.2% (4)
Lack of access	1.1% (2)
Other	1.6% (1)

*Percentages may add up to more than 100% as respondent may give more than 1 response.

TABLE 9: DEMOGRAPHIC CHARACTERISTICS OF WOMEN WHO REPORTED BARRIERS TO FAMILY PLANNING AMONG WOMEN WHO ARE AT RISK FOR PREGNANCY, DESIRE TO STOP OR DELAY CHILDBEARING AND ARE NOT USING FAMILY PLANNING IN AMMAN, JORDAN 2011 {N=112}				
Characteristic	Fertility-related % (n) women	Opposition to use % (n) women	Method related % (n) women	Lack of access % (n) women
Age				
15-24	49.71%(44)	54.55% (3)	25% (1)	0.0% (0)
25-34	33.53%(36)	18.18% (2)	50% (2)	0.0% (0)
35-49	16.76%(21)	27.27% (2)	25% (1)	100% (2)
Relationship Status				
Living with a husband/partner	13.87%(18)	9.09% (1)	75% (3)	50% (1)
Not living with a husband/partner	86.13%(83)	90.91% (6)	0.0% (0)	50% (1)
Total pregnancies				
0	73.99%(66)	63.64% (4)	25% (1)	0.0% (0)
1-2	13.87 (19)	0.0% (0)	50% (2)	50% (1)
3-4	6.94% (11)	18.18% (1)	25% (1)	0.0% (0)
>4	5.20% (5)	18.18% (2)	0.0% (0)	50% (1)
Sexually active in last 30 days				
Yes	10.4% (15)	9.09% (1)	75% (3)	50% (1)
No	87.86%(84)	90.91% (6)	25% (1)	50% (1)

KEY INDICATOR FP-E: PROPORTION OF WOMEN WHO ARE NOT CURRENTLY USING A FAMILY PLANNING METHOD, BUT PLAN TO IN THE NEXT 12 MONTHS IN AMMAN, JORDAN 2011 {N=407}	
Indicator	% (n) women
Future intent to use family planning in next 12 months	14.9% (42)

APPENDIX II: HEALTH FACILITY ASSESSMENT SUMMARY

Facility Assessment Indicators								
Topic	Indicator	Caritas	JHAS	Italian Hospital	Al Bashir	Sahab	IFH	Hashimi
Staffing	# of doctors or clinical officers providing any FP method	1	1	0	38	2	2	2
	# of midwives, nurse-midwives or nurses providing any FP method	0	1	0	4	4	1	6
Training	Proportion of doctors or clinical officers trained in FP among all doctors and clinical officers providing FP	2	1	0	38	1	1	1
	Proportion of midwives, nurse-midwives or nurses trained in FP among all midwives, nurse-midwives or nurses providing FP	0	1	0	4	1	1	1
Method Mix	# of temporary methods available	0	1	0	6	5	6	5
	# of long-acting methods available	0	0	0	2	2	1	1
	# of permanent methods available	0	0	0	1	0	0	0
	# of traditional methods promoted	0	2	0	2	2	2	2
	Is EC available?	No	No	No	Yes	No	Yes	No
Relative Score of Quality Measure	Score (Out of 15)	12	12	5	13	13	14	12
Capacity to meet infection prevention standards	Score (Out of 15)	12	15	15	15	15	15	12