Exploring Syrian refugees' access to emergency contraception in Jordan

Thesis

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Abstract

As of April 2019, there were over 650,000 Syrian refugees residing in Jordan. A combination of economic, social, and moral imperatives related to the Syrian civil war have led to a threefold increase in early marriage rates. Syrian women and girls, particularly those who marry under the age of 18, are at significant risk of sexual and gender-based violence and unwanted pregnancy. In this context, emergency contraception could play a significant role in supporting Syrian refugees prevent pregnancy. In 2016-2017 we conducted six focus group discussions with Syrian women and girls. We conducted 100 structured interviews with pharmacists in different areas of the country regarding EC provision practices. We also interviewed 13 key informants about available sexual and reproductive health services, including EC, and conducting six focus group discussions with Syrian child brides. We audio-recorded and translated all discussions from Arabic to English and conducted content and thematic analyses using deductive and inductive techniques. Most women and girls became pregnant during the first six months of their marriage, face pressure to become pregnant repeatedly, and experience or had experienced physical and sexual violence. None of the women knew of EC but all expressed curiosity and excitement about this method of pregnancy prevention. Our findings suggest that Syrian women and girls in early marriages have significant unmet contraceptive needs. Child brides, specifically those under the age of 15, reported rarely using any type of contraception, largely due to familial pressures to prove fertility. As a result of this research we undertook a multipronged initiative to respond to the sexual and reproductive health, as well as psychosocial needs, of Syrian child brides.

Résumé

Depuis avril 2019, il y avait plus de 650,000 refugiés syriens habitant en Jordanie. Une combinaison d'impératifs économiques, sociales, et morales reliés à la guerre civile syrienne ont triplé le taux de mariages précoces. Les filles et femmes syriennes, en particulier celles qui se marient sous l'âge de 18 ans, ont un risque plus important de vivre la violence sexuelle et sexiste et de grossesses non-désirées. Dans ce contexte, la contraception d'urgence (CU) peut jouer un rôle important afin de prévenir les grossesses non-désirées chez les réfugiées syriennes. Entre les années 2016-2017 nous avons mené six entretiens collectifs avec des filles et femmes syriennes. Nous avons mené 100 entretiens directifs avec des pharmaciens situés au travers le pays, concernant les pratiques de provision de la CU. Nous avons aussi mené 13 entretiens avec des informateurs clés concernant l'accès aux soins de santé sexuelles et reproductives, incluant la CU, ainsi que six entretiens collectifs avec des enfants mariés syriennes. Nous avons enregistré l'audio et traduis toutes les discussions de l'arabe à l'anglais suivis par une analyse thématique employant des approches déductives et inductives. La majorité des filles et femmes ont tombé enceintes pendant les premiers six mois de leur mariage, sont sous pression pour tomber enceinte plusieurs fois, et subissent ou ont déjà subi de la violence physique et sexuelle. Aucune des femmes avaient des connaissances préalables de la CU mais chacune d'elles ont exprimé de la curiosité et de l'excitation envers cette méthode de prévenir la grossesse. Nos données nous suggèrent que les filles et femmes syriennes en mariages précoces ont des besoins de contraceptions qui ne sont pas satisfaits. Les enfants mariés, surtout celles sous l'âge de 15 ans, ont signalé qu'elles utilisent rarement une méthode de contraception, surtout en raison de la pression familiale afin de prouver la fertilité.

À la suite de cette recherche, nous avons mené une initiative afin de répondre aux besoins de santé sexuelles et reproductives, ainsi que les besoins psychologiques, des enfants mariés syriennes.

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Abbreviations and acronyms

CPR	Contraceptive prevalence rate
CRHC	Cambridge Reproductive Health Consultants
DHS	Demographic and Health Survey
DoS	Department of Statistics
EC	Emergency contraception
ECP	Emergency contraceptive pill
FCPS	Family and Child Protection Society
FGD	Focus group discussion
GBV	Gender-based violence
HPC	Higher Population Council
HSD	Health Service Delivery
IAFM	Inter-agency field manual
IAWG	Inter-agency working group on reproductive health in crises
ICEC	International Consortium for Emergency Contraception
IDI	In-depth interview
IDP	Internally displaced person
IFH	Institute for Family Health
IPV	Intimate partner violence
IUD	Intra-uterine device
JAFPP	Jordanian Association for Family Planning and Protection
JPFHS	Jordan Population and Family Health Survey
KI	Key informant
KII	Key informant interview
MENA	Middle East and North Africa
MISP	Minimum initial service package
MoH	Ministry of Health
NGO	Non-governmental organization
NPS	National Population Strategy
NSRHFP	National Strategy for Reproductive Health and Family Planning
OCPs	Oral contraceptive pills
RH Kits	Inter-Agency Reproductive Health Kits
RMS	Royal Medical Services
SC	Steering Committee
SDGs	Sustainable Development Gaols

SGBV	Sexual and gender-based violence
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TFR	Total fertility rate
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
UNRWA	United National Relief and Works Agency
WASH	Water, sanitation and hygiene
WHO	World Health Organization

Chapter 1: Introduction

Access to sexual and reproductive health (SRH) services has been identified as a global priority and a fundamental pillar of human rights (WHO, 2019). Sexual and reproductive health includes increasing access to quality services, eliminating preventable maternal and neonatal morbidity and mortality, undertaking efforts to address sexually transmitted infections (STIs) and cervical cancer, addressing violence against women and girls, and meeting the needs of adolescents (WHO, 2019). Lack of access to SRH services puts women and girls at increased risk of unintended pregnancy, reproductive morbidities, and death (Barot, 2015). Furthermore, war, conflict, and emergencies have been associated with the disruption of vital SRH services; prolonged emergencies and humanitarian crises have also been associated with weakened health systems (Alnuaimi, Kassab, Ali, Mohammad, & Shattnawi, 2017).

The world is currently witnessing the largest refugee crisis since World War II. As of 2018, the United Nations High Commissioner on Refugees (UNHCR) reported that there were 68.5 million forcibly displaced people worldwide (UNHCR, 2019). Approximately 25.4 million of these displaced persons were refugees, 75% of whom were women and children (UNHCR, 2018). Reports from humanitarian organizations and researchers demonstrate that access to SRH services – including antenatal care, emergency obstetric care, and pregnancy prevention services – become scarce during crises. Therefore, many women face barriers to accessing adequate SRH services, which increases the risk of unintended pregnancy and unsafe delivery (Krause et al., 2015a; Samari, 2017; UN Women, 2013). Displaced populations are also at an increased risk of unintended pregnancy secondary to sexual violence, exploitation, and an exposure to the remunerative sex industry, in addition to experiencing a disruption in

contraceptive services in general (WHO, 2016). Although the SRH needs of displaced individuals have increased, funding for such programming has decreased over the last few years (UNFPA, 2019). Consequently, both host country governments and international organizations have had to do more with less. These overarching global dynamics also characterizes the Syrian refugee crisis (Fink, Helm, Belknap, & Johnson-Agbakwu, 2014).

The Syrian refugee crisis

Since 2011, the Syrian civil war has resulted in the displacement of more than 11 million people to both neighboring countries and within Syria (European Union, 2019); approximately 12.5 million Syrian require humanitarian assistance (UNHCR, 2019b). More than one million people from Syrian currently reside in Jordan (Balsari, Abisaab, Hamill, & Leaning, 2015), including approximately 650,000 people registered with the United Nations High Commissioner for Refugees (UNHCR, 2019) and as many as 700,000 unregistered individuals who are unable to return to Syria (UNHCR, 2017). In 2016, approximately one in five people living in Jordan had fled from Syria; women of reproductive age comprise about half of this population (Jordan Times, 2016). The overwhelming majority of Syrian refugees in Jordan are scattered across the country; indeed, only 22% live in refugee camps (UNHCR, 2019a). As a result, Syrians who live in these disparate communities must rely on local health care services. Evidence suggests that these populations have less access to and/or more difficulty navigating these services than their Jordanian counterparts (Gavlak & Nations, 2013). The influx of refugees has placed an unsustainable strain on an already weak infrastructure in Jordan. Consequently, organizations

have been unable to meet the social service demands of both refugees and local residents (UN Women, 2013).

Syrian refugee women in Jordan have significant unmet SRH needs (Krause et al., 2015b). Several recent studies indicate that high rates of sexual violence and early and forced marriage, low contraceptive use, and high rates of unintended pregnancy characterize the experiences of both camp- and urban-based refugees in this Jordan (JCAP, 2016; Khawaja, 2004; Krause et al., 2015b; Samari, 2017; Sami et al., 2014). Internally displaced people and refugees' circumstances result in significant financial and security burdens which families attempt to mitigate by marrying their daughters (Sahbani, Al-Khateeb, & Hikmat, 2016). Moreover, husbands are often the decision-makers for their wives, specifically regarding family planning; therefore, women often lack the autonomy to access comprehensive reproductive health services (Clark et al., 2017; Sahbani et al., 2016). Despite efforts to increase access to comprehensive sexual and reproductive health services within the community through awareness campaigns and family planning programing, women and girls' choices remain limited (Sahbani et al., 2016). Although research on abortion among Syrian refugees is virtually non-existent, media reports suggest that Syrian women living in Jordan lack access to safe services (Al-Jazeera, 2017). Sexual and reproductive health is difficult to address in this context due to strong social norms and customs that negatively impact the uptake of SRH services (Dabash & Roudi-Fahimi, 2008).

Setting the context: Jordan

The sociodemographic profile of Jordan has changed significantly in recent years due to the large influx of refugees from neighboring countries. Given that Jordan is a small, upper-middle income country with limited natural resources, the large influx of refugees has strongly impacted Jordan's already weak infrastructure (UNWomen & REACH, 2017). Results from the 2015 Census suggest the population of Jordan is 9.5 million; the majority of the population (63%) live in the central governorates of Amman, Balqa, Zarqa and Madaba, the northern governorates are home to 28% of the population, and the remaining 9% reside in the south (map provided as Appendix A).

Jordan's annual population growth rate of 2.4% per year is influenced by the migration of refugees from neighboring countries, particularly Iraq and Syria (Department of Jordanian Statistics, 2015). Jordan hosts the second-highest proportion of refugees worldwide, with one in every three people in Jordan being a refugee. Details from the 2015 Census indicate that 130,911 Iraqi refugees, 636,270 Egyptian labor workers, and 634,182 Palestinians with no national identification number reside in urban areas in Jordan (Department of Statistics, 2015).

The Jordan Population and Family Health Survey (JPFHS) of 2017-2018, carried out by the Department of Statistics (DoS) and included Syrian refugees for the first time, provides data on fertility, mortality, contraception, and maternal and child health. Findings from the JPFHS suggest that the total fertility rate (TFR) in Jordan has declined significantly in less than two generations, from 7.4 children per woman in 1976 to 3.8 children per woman in 2009 (Jordan Population and Health Survey, 2002; Jordan Population and Health Survey, 2013). However, from 2002 to 2012 the rate effectively stagnated, declining from 3.7 to 3.5 (Jordan Population

and Health Survey, 2013). According to the findings of the JPFHS, Jordan, despite the influx of refugees in 2011, witnessed another remarkable drop in TFR, from 3.5 to 2.7 between 2012 and 2017 (Jordan Population and Health Survey, 2018). However, this same survey indicated that the TFR among Syrians was approximately 4.2 (Jordan Population and Health Survey, 2018).

Sexual and reproductive health in Jordan

Jordan has had a long-standing national commitment to family planning demonstrated by the development of a series of family planning strategies and action plans. Over the past 25 years, Jordan has enacted policies, laws, and regulations that contribute positively to the development of the country by increasing the national commitment to SRH and family planning programs. The first of these policies was enacted in 1993, followed by the National Population Strategy (NPS) in March 1996, which was formulated by the National Population Commission and endorsed by the Cabinet of Ministers. In 2000, a task force of national specialists revised, amended, and updated the NPS, taking into account recommendations from various studies and surveys. The Strategy goals include "achiev[ing] a total fertility rate of 2.9 by 2010, 2.5 by 2015, and lower than that by 2020" and "[increasing] the Contraceptive Prevalence Rate (CPR) in general and for modern methods in particular" (Higher Population Council, 2013).

In 2003, the Higher Population Council (HPC) launched its first stand-alone five-year Reproductive Health Action Plan followed by a second five-year Reproductive Health Action Plan in 2008 (Higher Population Council, 2003; Higher Population Council, 2008). These Plans set the stage for the most recent National Strategy for Reproductive Health and Family Planning (NSRHFP) from 2013 to 2018 (Higher Population Council, 2013).

In Jordan, many organizations currently provide SRH services for both Jordanian and Syrian refugee women. The Ministry of Health (MoH) is the largest entity in Jordan that provides SRH services (Higher Population Council, 2015). The MoH currently provides 41% of all contraceptive methods in Jordan through affiliated hospitals and health centers (Higher Population Council, 2015). As of February 2016, Syrian refugee women were able to access contraception free of charge (Higher Population Council, 2016). Further, the MoH provides modern contraceptive methods to other medical service providers, including the Royal Medical Services (RMS) and non-governmental and private sector entities such as the Jordanian Association for Family Planning and Protection (JAFPP), the United Nations Relief and Works Agency (UNRWA), University Hospitals, and a number of clinics and pharmacies (Higher Population Council, 2015). As the private sector provides 55.4% of all contraceptive services, it plays a large role in the provision of SRH in Jordan (Higher Population Council, 2013). Finally, the Institute for Family Health (IFH) is the largest provider for SRH services for Syrian refugees in Jordan(Higher Population Council, 2016). Given that IFH is funded through the United Nations Population Fund (UNFPA), they have been able to provide free SRH services since the onset of the Syrian refugee crisis for those residing in urban areas of Jordan.

Trends in contraceptive use

According to the JPFHS the most commonly known method of modern contraception in Jordan is the intra-uterine device (IUD), with 98% of women and 84% of men reporting familiarity (Jordan Population and Health Survey, 2018). It is therefore unsurprising that the IUD is the most widely adopted method by married women (21%), with no significant discrepancy

between Jordanian and Syrian women. However, according to the 2012 Demographic and Health Survey (DHS), 36% of women were unaware of the type of IUD they were using (Jordan Population and Health Survey, 2013). Although significantly less popular, oral contraceptive pills (OCPs) (8%) and the male condom (5%) are the most commonly used modern contraceptive methods after the IUD (Jordan Population and Health Survey, 2018).

Compared to other countries in the region, women residing in Jordan are more likely to use a "traditional" family planning method. In 2012, 19% of women in Jordan reported using a traditional method compared to 2% in Egypt, 8% in Tunisia, 11% in Morocco, and 15% in Syria (Haub, Kaneda, & Reference Bureau, 2012). Withdrawal is the most popular traditional method (19% of married women) – and the most popular contraceptive method after the IUD – followed by periodic abstinence (1% of married women) (Jordan Population and Health Survey, 2018). Withdrawal is most commonly used among women aged 15-19 (7.2%) and 20-24 years (11.6%), particularly in rural areas (17% rural versus 13% urban) (Population & Survey, 2013). Though traditional method use decreased in 2017 (14%), this rate remains perplexing considering the wide variety of modern contraceptive methods available in Jordan (Population & Survey, 2013).

Unmet need for contraception among women in Jordan increased from 12% in 2012 to 14% in 2017, with Syrian women reporting the highest rate of unmet need at 18.6% (Jordan Population and Health Survey, 2018). The total demand for contraception in Jordan is 67% among married women; 49% of women do not want any additional children and 18% want to delay pregnancy for at least two years (Jordan Population and Health Survey, 2018). However, only 57% of the total demand for family planning is being met by modern contraceptive

methods (Jordan Population and Health Survey, 2018). Despite a series of national action plans and concerted public sector efforts, the gap is significant; one third of all pregnancies in Jordan are unintended (Mawajdeh, 2007).

Emergency contraception in Jordan

One contraceptive method that is markedly absent in Jordan is the dedicated emergency contraceptive pill (ECP). Emergency contraceptives are medications or devices that are used post-coitally to prevent pregnancy (Trussell, Rodríguez, & Ellertson, 1999; WHO, 2017). Emergency contraception (EC) can be provided to prevent pregnancy up to 120 hours after unprotected and/or under-protected intercourse (WHO, 2017). ECPs are safe and effective, and potentially lifesaving, especially in contexts where abortion is legally restricted, or otherwise inaccessible, as women facing an unplanned pregnancy are at a higher risk of death, illness, or disability due to complications from an unsafe abortion or childbirth.

Currently, 147 countries have registered at least one dedicated progestin-only EC product (International Consortium for Emergency Contraception, 2019). However, a dedicated progestin-only emergency contraceptive pill (ECP) is still not registered in Jordan (International Consortium for Emergency Contraception, 2019). This is surprising given the availability of a broad range of contraceptive methods and that surrounding countries, including Egypt, Iraq, Lebanon, and Saudi Arabia have a registered product (International Consortium for Emergency Contraception, 2019).

The Inter-Agency Field Manual (IAFM), is the guide for humanitarian actors to support the delivery of reproductive health services in humanitarian and emergency settings (IAWG,

2010). A fundamental component of the IAFM is the minimum initial service package (MISP), a set of lifesaving SRH interventions that should be implemented at the onset of a humanitarian emergency. One of the objectives of the MISP is to prevent sexual violence and respond to the needs of survivors (IAFM, 2018). Priority activities include the clinical management of rape, which includes provision of emergency contraception to survivors who present within 120 hours of the assault. Indeed, provision of EC to survivors of sexual violence has long been a part of the humanitarian standards (IAFM, 2010; UNHCR 1999). As of 2018, humanitarian stakeholders need to offer EC to all women as part of the new MISP objective to prevent unplanned pregnancy (IAFM, 2018). Therefore, according to the global guidelines, in Jordan, progestin-only EC should be available to all refugee women and girls (IAWG, 2018).

Gender-based violence (GBV)

A 1998 study conducted by Belbeisi and colleagues suggested that one in four women residing in Jordan experience violence within their marriage (Nasser, Belbeisi, & Atiyat, 1998). More recent studies focusing on intimate partner violence (IPV) have shown that one in three women experience physical violence from their husbands and/or his family during their marriage. This number increases to one in two for women who live in refugee camps (Spencer, Shahrouri, Halasa, Khalaf, & Clark, 2014). Studies in Jordan have found that women who experience IPV are at heightened risk of unintended pregnancy (Clark, Hill, Jabbar, & Silverman, 2009). Refugee and displaced populations residing in Jordan appear to have compounded risks for unintended pregnancy and are at greater risk of GBV, in general, and early and forced marriage, in particular.

UNICEF defines early marriage as marriage before the age of 18 (UNICEF, 2014). In Jordan, the legal age of marriage is 18 for boys and 16 for girls. However, the legal system allows for the marriage of girls and boys 15-18 years according to specific criteria issued by the Chief Justice (Clark et al., 2017). Legislators made a change to Personal Status Law No. 36, Article 5-13 in 2010. Under "Conditions of Marriage", the law now states that a marriage cannot be legally registered if a child is under the age of 15 (UNICEF, 2014). Exceptions to this law are made in cases of pregnancy, but registration of the marriage is suspended until the girl turns 15 (UNICEF, 2014). Therefore, marriages for those between the ages of 15-17 must be permitted by a judge from the Shari'a court (The Save the Children Fund, 2014). Such approval may only occur, in theory, under specific circumstances, including: non-disruption of education for both parties, a religious and economically stable groom, and a consenting bride with permission from a male guardian (Kabbani, 2017). If all requirements have been met, the Shari'a court judge must provide the necessary documentation describing reasons for the exception (The Save the Children Fund, 2014).

Syrian refugees residing in Jordan tend to marry at an earlier age than Jordanians due to the circumstances surrounding their displacement (UNICEF, 2014). According to the annual report of the Chief Justice Department, the percentage of married Syrian refugee girls aged 15-19 was 34% in 2017, more than double the percentage of Jordanian girls (13%) (Higher Population Council, 2016). In 2016, Syrian refugees between the ages of 25-49 reported an overall median age of first marriage as 20 years for women and 25 years for men (Higher population council, 2016).

Early marriage is associated with high teenage childbearing rates. Indeed, teenage childbearing is more common in Mafraq (13%) than in other areas of the country (7%) and Mafraq has the highest rate of early marriage (Jordan Population and Health Survey, 2018). Education is a major protector against teenage pregnancies, exemplified by the fact that women who are more educated and wealthier have lower teenage pregnancy rates (UNICEF, 2016). In Jordan overall, 27% of girls who were married under the age of 18 with elementary-level education had begun childbearing compared to 8% of women with preparatory education and 4% of women with a secondary education (Jordan Population and Health Survey, 2018). Thirteen percent of women aged 15-19 from the lowest wealth quintile have begun childbearing, compared to only 4% of women in the middle quintile (Jordan Population and Health Survey, 2018). Adverse maternal outcomes associated with teenage pregnancy include preterm delivery, anemia, miscarriage, still births, and postpartum infection (Swan, 2018).

Study rationale

My supervisor, Dr. Angel M. Foster, has been conducting SRH research in Jordan for more than 20 years. Over the last seven years, Dr. Foster has partnered with a local research organization (TRY Center) on a series of projects related to SRH and GBV policies, services, and programming. A number of these projects have focused specifically on addressing the needs of Syrian refugees. In 2016-2017, I spent a year in Jordan as a Fellow with Cambridge Reproductive Health Consultants (CRHC) and contributed to several of these projects. One, which the HPC commissioned, sought to understand better the increasing rates of child marriage in Jordan. We

conducted a multi-methods study dedicated to exploring the economic, social, and political dynamics surrounding child marriage in Jordan.

The findings from this study indicated that there was a tremendous need to focus on efforts to both prevent and respond to early marriage among Syrian refugees, particularly those living outside of the camps. This formative research also indicated that there was a need to develop more response SRH systems and services and that emergency contraception could play a promising role. Informed by these findings, we successfully applied for funding from UN Women to undertake a two-year interventional study. One component of this initiative was dedicated to identifying and addressing the comprehensive sexual and reproductive health needs of Syrian refugee child brides in both camp- and urban-based settings in Jordan. This component of the project serves as the basis of my thesis.

Research questions and objectives

Through this overarching multi-phased interventional study we aimed to explore the dynamics shaping early marriage among Syrian refugees in Jordan. We sought to develop, implement, monitor, and evaluate educational and SRH initiatives to respond to the needs of child brides and improve their overall wellbeing. Our overarching research question was: Can we develop an educational and SRH initiative that responds to the complex psychosocial needs of Syrian child brides residing in Jordan? Over a two-year period, we conducted fieldwork in the UNHCR-operated Al-Za'atari refugee camp, Mafraq, Irbid, and Amman.

Although I was involved with all components of the project, my thesis project specifically focused on Syrian refugees' knowledge of and access to EC. My primary research

questions were: 1) What is the current availability, accessibility, and acceptability of EC among Syrian refugees living in Jordan? and 2) Can EC be incorporated into an educational and SRH initiative that responds to the complex psychosocial needs of Syrian child brides?

Given the context, this multi-methods study aimed to:

1. Explore key stakeholders' knowledge of and attitudes toward EC and their perception of need among Syrian refugees;
2. Explore Syrian child brides' knowledge of, attitudes toward, and experiences with EC; and
3. Identify, implement, and evaluate strategies for improving Syrian child brides' access to EC.

Thesis outline

I have chosen to write a thesis-by-articles consisting of six chapters.

1. Chapter 1: The first chapter contains an introduction with background information on the project and the local SRH context in Jordan. This section concludes with the study rationale, the research questions and objectives, and an outline of the thesis.
2. Chapter 2: The second chapter provides information on the methods. Specifically, I provide detailed information about the study sites, methods of data collection, and analytical approach. I conclude this chapter with a statement of contributions.
3. Chapter 3: The third chapter presents the first manuscript. Entitled, *Emergency contraception in Jordan: Assessing retail pharmacists' awareness, opinions and perceptions of need*, we have submitted this article to *Contraception*.
4. Chapter 4: The fourth chapter presents the second manuscript. This article focuses on Syrian refugee child brides' knowledge of and attitudes towards emergency contraception.

This article also outlines Syrian child brides' experiences with sexual and gender-based violence and SRH services. We have submitted this article to *Critical Public Health.*

5. Chapter 5: The fifth chapter presents the third manuscript. This article focuses on an educational and family planning intervention with a cohort of Syrian refugee girls in Irbid. We have formatted this article for submission to *Sexual and Reproductive Health Matters.* We will submit the article to the journal once the other articles have been accepted as these manuscripts build on each other.
6. Chapter 6: The final chapter of the thesis integrates the findings. I begin by discussing the findings from the initial needs assessments and describe how these results informed the overall intervention. Although a full evaluation of the overall initiative is underway and beyond the scope of this thesis project, in the final chapter I offer some recommendations for scaling-up the intervention. I conclude this chapter with reflections on my positionality and how this may have impacted the research. The final chapter is followed by a complete bibliography as well as appendices.

Chapter 2: Methods

We collected primary research for this thesis from the fall of 2016 through the spring of 2019. My fieldwork required significant periods of residence in Jordan and I collected data through the country. I describe here the primary sites of my fieldwork: Amman, Mafraq and the Al-Za'atari refugee camp, and Irbid. The larger project team identified these fields sites as priorities given the concentration of Syrian refugees and the location of local partners. However, as part of my initial assessment on the availability of emergency contraception in retail pharmacies, I also conducted research in other governorates (see Appendix A).

Primary field sites: Amman, Mafraq and Al-Za'atari, and Irbid

Estimates based on the Department of Statistics of Jordan indicate Jordan's population had grown to around 10.3 million in 2018 (Department of Statistics, 2018). Amman, the country's centrally-located capital, is the country's economic, political, and cultural center. With a population of over 4.3 million, and voted the most expensive city in the Arab world (Aljadid, 2018), Amman currently hosts the largest Syrian refugee population in Jordan (Department of Statistics, 2015; UNHCR, 2019b). UNHCR estimates that 29% of registered Syrian refugees (about 196,068 people) currently live in the governorate of Amman (UNHCR, 2019b). Given that there are over 700,000 unregistered Syrian refugees in Jordan, this number is likely significantly higher. Many refugees are currently residing in low socio-economic neighborhoods, specifically East Amman, which is known for having cheaper rent and living necessities (such as food, electricity and water) than other areas. UNHCR estimates that more than half of Syrian refugees

residing in urban areas in Amman are currently living below the poverty line; the majority live under the abject poverty line (UNHCR, 2016).

Mafraq governorate is situated in northern Jordan and shares its borders with Syria. According to the 2015 census, over 540,000 individuals reside in Mafraq, 77,215 of whom are registered refugees in its urban and rural areas (Department of Statistics, 2015). As is the case in Amman, the number of refugees in Mafraq is likely underestimated due to the number of unregistered individuals residing there. The resettlement of refugees in Mafraq, one of the most impoverished governorates in Jordan, has created significant strain on the existing healthcare and educational infrastructure, leading to conflict between the refugee and host communities (Tiltnes, Zhang, & Pedersen, 2017). To the north of Mafraq, approximately 10 kilometers from the Syrian border, is Al-Za'atari refugee camp – the largest Syrian refugee camp in the world, currently hosting over 80,000 Syrian refugees (UNHCR, 2019a). Al-Za'atari, the fourth largest city in Jordan, receives support from the Jordanian government and a network of 26 international agencies (Xu & Maitland, 2015). Lead by UNHCR, Al-Za'atari refugee camp was established in July 2012 and is known for its strong infrastructure; 90% of households have access to electricity, water, and shower spaces within their individual shelters (UNHCR, 2019a).

Irbid governorate is also located in the north of Jordan near the border with Syria, adjacent to Mafraq. With a population of over 660,000, Irbid is the second largest city in Jordan, and hosts the third-largest number of refugees, at 140,091 people (Department of Statistics, 2015). The highest refugee population densities are in the central city of Irbid, Ramtha, and the villages of Rorrah and Nu'ayma. The population of Irbid, both host and refugee communities, face similar challenges to those who reside in Mafraq, including tensions that have been

exacerbated by a rapid increase in housing costs after 2013 (REACH, 2014). Income-generating opportunities are limited given that the Irbid economy primarily relies on the service sector; therefore, approximately 60% of refugees currently live under the poverty line, in contrast with 14.7%of its non-refugee residents (REACH,2014).

Study design

My thesis project contained two components: a multi-methods needs assessment and a pilot intervention with 10 Syrian child brides in Irbid, Jordan. I detail the data collection for each component of the project separately below.

Data collection methods: Needs assessment and baseline research

From the fall of 2016 through early 2018 we conducted a multi-pronged needs assessment and baseline research related to emergency contraception, early marriage, and the SRH needs of child brides in Jordan. We modeled our approach to the needs assessment after the standards developed by the UNFPA (United Nations Population Fund, 2010) and previous assessments with refugee and displaced populations conducted by Dr. Foster's research group (Hobstetter, Sietstra, Walsh, Leigh, & Foster, 2015; Sheehy, Aung, Sietstra, & Foster, 2016; Nara, Banura, Foster, 2019). Our assessment consisted of four distinct components: 1) Collection and review of peer-reviewed articles and grey literature, including reports, organizational data, and patient logs from the Institute for Family Health (IFH); 2) Structured interviews with retail pharmacists; 3) Focus group discussions (FGDs) with women and girls who married before the age of 18; and 4) Interviews with key informants. The multi-methods needs

assessment informed the pilot intervention as well as the larger intervention funded by UNWomen.

Collecting and reviewing existing data

The first component of our needs assessment and baseline research consisted of conducting an in-depth review of published and un-published literature on SRH issues in Jordan, with a specific lens on Syrian refugees. We requested data from government bodies, such as the Ministry of Health, and both international and national non-governmental organizations (NGOs), and the Institute for Family Health in particular. IFH, the largest provider of SRH services to Syrian refugees in Jordan, permitted us to review patient logbooks and conduct a chart review. Consequently, we were able to understand better the SRH needs of Syrian refugees who seek patient care through IFH clinics as well as existing sexual and gender-based violence (SGBV) services and referral systems. Throughout this process, we built relationships with a number of key stakeholders. These relationships facilitated the development and implementation of our intervention and brought us into contact with potential study participants.

Conducting structured interviews with retail pharmacists

The private sector provides 54% of all contraceptive services in Jordan (Higher Population Council, 2015) and anecdotal evidence suggests that a large portion of the population seeks health care services through pharmacies, as most medications (with the exception of narcotics and misoprostol) are available directly from pharmacists without a

prescription. Given the significant role pharmacists play in health care service delivery in Jordan, we conducted 100 structured in-person interviews with retail pharmacists working in both independently owned and "chain" pharmacies. We purposively conducted these interviews in seven urban and rural areas across Jordan in order to gauge perceptions of pharmacists working in different socio-economic and demographic areas. We began each of our interviews by collecting general demographic data on the pharmacists and their level of training surrounding sexual and reproductive health. We proceeded to explore pharmacists' knowledge of and attitudes toward different modalities of EC (including dedicated progestin-only pills and post-coital use of OCPs, also known as the Yuzpe method). We further queried pharmacists' perceptions of the need for this method of contraception. Finally, we explored participants' support for a dedicated progestin-only EC product in Jordan including whether they would be willing to stock the product and provide it to women, if registered. I conducted all interviews in Arabic (with some English, depending on the preference of the pharmacist) and took notes during and memoed immediately after each interaction. These interviews all took place in the fall of 2016.

Facilitating focus group discussions with displaced Syrian women and girls

In 2017, we facilitated six FGDs with women and girls between the ages of 12 and 45, two in Al-Za'atari refugee camp and four in urban areas across Jordan. Each FGD included 5-12 Syrian refugee women and girls who were married before the age of 18. In order to create a comfortable environment for our participants, we divided the participants into two age groups: 12-24 and 25-45. We recruited our participants through local NGOs (including Try Center),

community leaders, word-of-mouth, and early participant referral. We obtained oral consent to audio-record the discussion at the outset. We facilitated each FGD in Arabic, using a semi-structured interview guide developed specifically for this study. The study team focused on the central topics in the discussions (early marriage, contraception, and SGBV). We further explored community knowledge and opinions on early marriage, access to SRH services – including SGBV services – and knowledge and attitudes towards EC. As is common practice in FGDs, we did not seek to elicit detailed individual experiences; rather, we aimed to explore community norms and standards as well as outliers. The FGDs lasted between 50 and 90 minutes. We provided snacks during the discussions and offered each participant JOD5 (CAD10) as a gesture of our appreciation.

I facilitated all six discussions and worked in tandem with a research assistant from Try Center who took notes and provided logistical support during the discussions. I debriefed with my colleague immediately after each discussion, a process that helped identify early themes as well as allowed for reflections on the discussion process. I also wrote analytic memos after each FGD.

Interviewing key informants

We conducted 14 key informant interviews with those providing services to Syrian refugees and leaders from the Syrian community. The aim of these interviews was to understand better key informants' knowledge of and attitudes toward SRH issues as well as their opinions about Syrian refugee women's access to and experiences with SRH services. We specifically explored child marriage and EC in-depth.

We purposively recruited a range of stakeholders working in Al-Za'atari camp, Amman, Sweileh (a suburb of Amman with a concentrated Syrian population), and Irbid. Key informants included primary health care providers such as nurses, psychologists, and physicians. We also interviewed representatives from United Nations (UN) organizations, the Ministry of Health (MoH), and management staff from IFH. I led all key informant interviews and conducted them in English or Arabic, depending on the preference of the interviewee. We received oral consent at the beginning of each interview, with each interview lasting between 60 and 90 minutes. By mobilizing our network, following up on early participant referrals, and using publicly available information, we identified appropriate individuals to partake in our study.

With the help of my supervisor, I developed an interview guide consisting of open-ended questions, which we specifically tailored to each stakeholder. During the interviews, key informants described available services and allowed us to explore their professional opinions on availability and accessibility of services, and areas for improvement. I took detailed notes during the interviews and memoed at the end of each interview.

Data analysis

Our analytic plan involved a multi-faceted, multi-step process. Analysis for each study component coincided with data collection and we initially analyzed each component separately. However, we analyzed all qualitative components for content and themes using a combination of deductive and inductive techniques. We entered information from the structured interviews with retail pharmacists in Microsoft Excel and analyzed the data using descriptive statistics to identify frequencies. We transcribed all FGDs and key informant

interviews and subsequently translated them into English. Although we generated an initial codebook for each study component based on the research questions and study instruments, we added and revised emergent codes and categories as we reviewed the data.

Both analytic memoing and regular debriefings played a large role in our interpretation. The process of memoing offered opportunities to reflect on researcher-participant dynamics (Birks, Chapman, & Francis, 2008) and assisted in organizing the data. Research team meetings, particularly between me and my supervisor, allowed me to pull together different study components. We resolved rare differences through discussion. We managed all data, audio files, transcripts, notes, and memos using Nvivo 11.4.3. In the final phase of the first component of the project we integrated our findings paying special attention to identify similarities and differences. We also triangulatied our findings with related laws, regulations, and policies.

Data collection methods: Developing and evaluating the intervention

As a result of the needs assessment and baseline research and in consultation with the larger project team, we decided to implement an intensive intervention with a cohort of 10 Syrian child brides in Irbid. The Family and Child Protection Society of Irbid (FCPS), one of the partners in the overarching UNWomen funded-project, managed the logistics of the intervention; both an international Steering Committee and a local Community Advisory Board approved and contributed to the design of the intervention. FCPS identified a cohort of Syrian child brides who had left school prior to completing secondary school and wanted to return to finish their education. The intervention consistent of a series of workshops, individual counseling sessions, and individualized resources to facilitate their preparation for returning to school. As part of the evaluation of the initiative, we conducted initial baseline interviews with

the program participants, conducted key informant interviews with those involved in the program, and conducted final interviews with program participants. We also monitored participation in events, kept records of resources requested and used, and captured pre- and post-intervention information about health, family composition, and education.

Conducting initial in-depth interviews

In 2018, I conducted 10 in-depth interviews with the program participants. These interviews focused on girls' individual experiences with early marriage, SRH, and educational attainment before and after displacement. We aimed to understand better the individual circumstances surrounding their marriages and their perceptions of its impact on their enrollment in formal schooling. These interviews followed a semi-structured format and sought information about access to education and SRH services, as well as participants' perspectives for areas for improvement. We reimbursed participants for childcare and transportation costs. Although FCPS identified these girls as candidates for participation, we used the initial interview to discuss the intervention, confirm eligibility, and assess interest in participation. All 10 of those initially identified ultimately participated in the program. We audio-recorded, took notes during, and memoed immediately after each interview.

Conducting key informant interviews

As part of the monitoring and evaluation plan for the overarching initiative, we conducted interviews with key stakeholders at multiple points during the intervention. Further, semi-annual Steering Committee meetings and quarterly Community Advisory Board meetings

allowed us to discuss challenges and course correct. Finally, at the end of the project we held a series of community engagement meetings and dissemination events which allowed us to both share information about the project and receive feedback on the initiative. Although I was involved in most of the efforts, other members of the project team were responsible for assembling this information and operationalizing feedback.

Conducting follow-up in-depth interviews

We conducted follow-up interviews with each participant after their enrollment in the intervention. We discussed the reactions of their partners and family members, their ability to partake in the intervention, perceived barriers to continued participation, and opinions on the impact of the program. We also explored participants' knowledge of and attitudes toward contraceptive methods. We again conducted all interviews in Arabic and received explicit oral consent from each participant to have our exchanges audio-recorded. Following each interview, we reimbursed participants for childcare and transportation costs.

Data analysis

We used a similar analytic approach for this component of the project. We analyzed interviews for content and themes using both deductive and inductive techniques. We compared baseline and final interviews for each participant and looked for both vertical and horizontal coherence. Because my supervisor was involved with the Steering Committee and major dissemination events, we incorporated those findings into the analysis through regular discussions. We again managed all data using Nvivo 11.4.3. Although it is beyond the scope of

this thesis project, the results from this pilot study were also incorporated into the broader evaluation of the UNWomen funded initiative.

Theoretical framework

Practical action research served as the theoretical foundation for this project, which is situated within an interpretivist paradigm (Williamson, 2012). As is characteristic of action research in general, this design embraces the planning, acting, observing, and reflecting cycle that occurs throughout the life of the project. The practical concern that we are addressing has been defined in consultation with the community. Our project prioritized collaboration and capacity building through participation and acquired knowledge with the aim of effecting social change.

Ethics

We received ethical approval from both the Higher Population Council and the Ministry of Planning and International Cooperation conduct this project. We have included those letters of approval as Appendix B. Given that we conducted FGDs in Al-Za'atari, we received research clearance from both the United Nations Population Fund (UNFPA) and IFH. In addition, the University of Ottawa's Social Sciences and Humanities Research Ethics Board approved our reproductive health needs assessment (File #05-16-20). Based on the criteria laid forth in Article 2.1 of the 2nd edition of the Tri-Council Policy Statement, the Office of Research Ethics and Integrity at the University of Ottawa determined that our study with retail pharmacists did not involve "human participants" and therefore did not require Research Ethics Board review.

Statement of contribution

As a Co-Investigator of the overarching UNWomen project, I worked with the larger study team to design the project, develop the study instruments, and obtain ethical clearance. For the parts of the project described in this thesis, I conducted all data collection and analysis and I led the writing of all three articles. My supervisor and Principal Investigator of the project provided significant guidance and contributed to all phases of the project. Furthermore, Dr. Foster led a two-day qualitative workshop in which I participated in 16 hours of interactive training on qualitative study design, instrument development, in-depth interviewing techniques, and focus group discussion facilitation. She also provided significant training on dissemination. Our local partner Majd Hammad, the Executive Director of TRY Center and Co-Principal Investigator of the project, assisted in obtaining local ethical clearance and facilitated my connection with two organizations that later helped with participant recruitment. Ms. Hammad played a central role given her enduring relationships with local NGOs in Jordan and also contributed to two articles presented in this thesis.

Chapter 3: Article #1

We have submitted this article, “Emergency contraception in Jordan: Assessing retail pharmacists’ awareness, opinions and perceptions of need” to *Contraception*. We have formatted the article for the journal’s structural, reference, and style specifications.

Emergency contraception in Jordan:
Assessing retail pharmacists' awareness, opinions, and perceptions of need

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Emergency contraception in Jordan:

Assessing retail pharmacists' awareness, opinions, and perceptions of need

Abstract

Objectives: Jordan has a robust contraceptive method mix in both the public and private sectors and oral contraceptive pills and the copper-T intrauterine device are widely available. However, Jordan remains one of only a few countries in the world without a registered dedicated product for emergency contraception (EC). We aimed to explore retail pharmacists' knowledge of and attitudes toward EC in six Jordanian governorates.

Study design: In 2016, we conducted 100 structured interviews with pharmacists in both urban and rural areas regarding their EC knowledge and provision practices. We interviewed representatives from both chain and independently-owned pharmacies in purposively selected areas of the country. We analyzed interviews for content and themes using deductive and inductive techniques.

Results: Our findings reveal a lack of knowledge of all EC modalities as well as misinformation about effectiveness and protocols for use. However, after describing dedicated progestin-only EC pills, study participants expressed tremendous enthusiasm for a dedicated product and the overwhelming majority indicated that they would stock EC pills if and when they were registered.

Conclusion: The private sector plays a major role in contraceptive service delivery in Jordan. Although pharmacists are not well-versed in post-coital contraception they appear interested in incorporating EC pills into the contraceptive method mix. Redoubling efforts to register a

dedicated progestin-only EC pill and supporting initiatives to educate pharmacists about how to use available technologies as EC appear warranted.

Implications: Lack of access to emergency contraception has significant implications for women, in general, and refugee and displaced populations in particular. Supporting efforts to incorporate EC pills into the contraceptive mix in Jordan is a first step in supporting adherence to global standards of care and could help address unmet contraceptive needs.

Key words: Arab world; emergency contraception; Middle East and North Africa; pharmacists; reproductive health

1. Introduction

Jordan has had a long-standing commitment to providing women with a range of contraceptive methods through both the public and private sectors [1]. As of the late 2010s, the contraceptive method mix included copper-T intrauterine devices (IUDs), contraceptive implants, combined hormonal and progestin-only oral contraceptive pills (OCPs), Depo-Provera, male condoms, and female sterilization. National policies and strategies dedicated to reducing neonatal and maternal mortality and morbidity, promoting birth spacing, and advancing family planning and reproductive health [2] have resulted in a decrease in the total fertility rate from 5.6 children per woman in 1990 to 2.7 children per woman in 2017 [3]. The most recent Demographic and Health Survey placed the overall contraceptive prevalence rate at 52%; 37% of married women of reproductive age were using modern methods [3].

However, about 14% of married women have an unmet need for contraception [3] and one third of all pregnancies in Jordan are unintended [4]. There are also significant differences in reproductive health indicators between different regions of the country and between different populations. Since the onset of the civil war, more than 1 million Syrians have sought refuge in Jordan [5]; roughly one in five people living in Jordan is from Syria [6]. Notably, Syrian refugees living in Jordan have a much higher total fertility rate than Jordanian nationals (4.2 versus 2.6 children per woman), a lower contraceptive prevalence rate (32% versus 38%) and greater unmet contraceptive need (19% versus 14%) [3]. None of these national statistics capture the experiences and needs of unmarried women.

Notably absent from the contraceptive method mix in Jordan is a dedicated emergency contraceptive pill. Indeed, Jordan remains one of only a few dozen countries worldwide without

a registered progestin-only product [7]. Given that progestin-only emergency contraception (EC) has long been a part of the global humanitarian response [8] and that Jordan is a major host of refugees and displaced people, this omission is even more striking. However, numerous brands of combined estrogen-progestin OCPs [9], progestin-only OCPs [9], and IUDs are widely available and are often provided by retail pharmacists without a prescription. Thus several modalities of emergency contraception, that is, medications and devices that can be used after sex to prevent pregnancy [10], do exist in Jordan. EC has the potential to address a significant unmet need, if providers and potential users know about this option.

Pharmacists play a key role in contraceptive service delivery in Jordan and are trusted health care providers. In 2016, we conducted a qualitative study in Jordan to explore retail pharmacists' knowledge of, attitudes toward, and perception of need for EC. Through this study, we aimed to identify barriers to existing modalities of EC as well as potential avenues for improving access to services.

2. Methods

We based our study design on previous EC research with retail pharmacists [11-13]. In the fall of 2016, we visited a stratified random selection of retail pharmacies in six Jordanian governorates (see Fig. 1). We chose these governorates because they reflect the geographic diversity within the country [3]. Within each area we also purposively identified pharmacies in different communities and neighborhoods in order to ensure inclusion of those serving diverse populations with respect to national origin, socioeconomic level, ethnicity, and religion.

[Figure 1 about here]

2.1 Study sites

Amman is Jordan's capital and home to about 4 million people or 41% of the total population. Amman is the administrative and cultural center of the country and the governorate includes some of the wealthiest areas in Jordan (such as West Amman) and well as neighborhoods with concentrations of recently settled Syrian refugees (such as Sweileh). Ma'an is located in southern Jordan. With a population of around 42,000, Ma'an is considered one of the most socially conservative areas of the country and is characterized by strong tribal culture and identification. Aqaba is located at the southernmost part of the country. As the only Jordanian coastal city, Aqaba serves a major economic role through tourism and trade and hosts a large population of foreign workers. Irbid is the third largest city in Jordan, is located close to the Syrian border, and has a large number of both documented and undocumented refugees. Azraq is a small town of roughly 16,000 located in the arid region of central-eastern Jordan. Al-Salt, is located northwest of Amman and is the capital of the Balqa Governorate. The city of over 89,000 is considered the administrative center of Western Jordan and the agricultural hub of the country.

2.2 Data collection

We aimed to visit 100 retail pharmacies, approximately 50 in greater Amman and 50 in the remaining five sites. Our logistically and analytically feasible sample represented about 5% of the roughly 1,900 community pharmacies registered in the country, of which slightly more than

half are located in Amman [14]. In addition to geographic diversity both between and within governorates, we also aimed to include a complement of independent and chain pharmacies in the sample.

IE, a quadrilingual Canadian-Egyptian-Norwegian master's student in health sciences at the University of Ottawa and an Amman-based Research Fellow for Cambridge Reproductive Health Consultants, conducted all in-person visits. She received training from AMF, a medical anthropologist and medical doctor with extensive experience conducting sexual and reproductive health research in the Middle East and North Africa and on EC in particular. IE identified the location of pharmacies in each area through Google Maps and then explored specific communities by private car, taxi, or foot to identify other pharmacies in the vicinity. Upon arrival at the pharmacy she introduced herself as a Canadian-Egyptian researcher conducting a study on the availability and accessibility of emergency contraception and requested time to conduct a short interview with the head pharmacist or senior pharmacist on duty.

Using a structured interview guide, IE began with questions about client demographics, pharmacy operations and structure, and demand for contraception. She then turned to questions about emergency contraception, including awareness and provision of different EC modalities. She concluded by asking general questions about the respondent's attitudes toward EC and the ways that contraceptive services could be improved in Jordan. During and after the interviews she was able to observe the layout of the facility, the available sexual and reproductive health products, and pharmacist-patient interactions. IE conducted all interviews in Arabic or English (per participant preference), which averaged 25 minutes in length. She took

brief notes during the interview and field coded responses; she then took more extensive notes upon leaving each pharmacy. At the end of each field day, IE formally memoed, a process that allowed her to reflect on the general dynamics of the encounter and initiate the analytic process.

2.3 Data analysis

We entered our data into Microsoft Excel® and analyzed the findings using descriptive statistics. We reviewed notes and memos and evaluated the overall interactions for content and themes using both deductive and inductive analytic techniques [15-16]. Regular meetings between IE and AMF complemented an iterative analytic process and guided our interpretation. We resolved differences through discussion.

2.4 Ethical considerations

Based on the criteria laid forth in Article 2.1 of the Tri-Council Policy Statement, 2nd Edition [17], the Office of Research Ethics and Integrity at the University of Ottawa determined that this study did not require Research Ethics Board review. In this article, we have redacted or masked all identifiable information about individual pharmacies and their personnel. We organize our results around domains of inquiry.

3 Results

3.1 Pharmacy characteristics

Over the course of the study, we visited 100 pharmacies in Amman (n=57) and the five other areas (n=43). We provide information about the sample in Table 1. The majority of the pharmacies we visited were independently owned (n=78) and the remainder were chain pharmacies (n=22). The majority of chain pharmacies were located in Amman (n=17); the remaining chain pharmacies were located in Irbid (n=3) and Aqaba (n=2). We purposively included pharmacies in seven neighborhoods of Greater Amman that reflected both the socioeconomic and sociocultural diversity of the city. The vast majority of pharmacists working in both independent and chain pharmacies (n=94) reported that they had trained in Jordan, often within the pharmacies where they were currently employed. The remaining pharmacists (n=6) had been trained in other countries: Iraq, Morocco, New Zealand, Pakistan, Saudi Arabia, and Turkey.

[Table 1 about here]

3.2 Knowledge and provision of emergency contraception

The majority of pharmacists (n=76) interviewed had not received any family planning or contraceptive training throughout their academic or professional careers. Most who had received training received it through their employer (n=21) and the rest (n=3) received their contraceptive training outside of Jordan. Pharmacists who worked at two of the largest chains in the country reported that the employer had taken the initiative to provide staff with training on contraceptive methods. A handful of pharmacists supplemented their income at the retail pharmacy by doing contract work for various sexual and reproductive health organizations and

had learned about contraception through that employer. However, all pharmacists reported providing contraception, in general, to pharmacy clients.

Forty pharmacists knew about at least one modality of emergency contraception (see Table 2). Fourteen pharmacists described dedicated progestin-only EC pills and variably used the terms “Plan B,” “the morning after pill” or “honeymoon pill”. Almost all incorrectly reported that the medication needed to be used within 24 hours of sexual intercourse. Twenty-six participants referenced the post-coital use of combined OCPs (the Yuzpe method). Most of those who expressed some knowledge of the Yuzpe method (n=20) erroneously believed that a single, high dose of a combined hormonal oral contraceptive should be given within 36-48 hours of sexual contact. The six pharmacists who had accurate information about the Yuzpe method reported that they had gotten their information from the Arabic version of the not-2-late.com website [18]. The overwhelming majority of pharmacists who were familiar with any form of EC worked in chain pharmacies and/or were trained abroad. None of the pharmacists in our study mentioned the IUD, ulipristal acetate, or low dose mifepristone as alternative modalities of EC.

A small number of pharmacists (n=4) provided the Yuzpe method to their clients, one in Irbid and three working in pharmacies located in shopping malls in Amman. In addition, one participant working in a chain pharmacy reported that she had used the Yuzpe method herself. Several other pharmacists reported that they had provided the Yuzpe method to friends but not to clients out of fear of breaching company standards. Another group of pharmacists (n=20) reported that they had “unwittingly” provided EC by filling prescriptions for high doses of oral contraceptive pills (either combined estrogen-progestin or progestin-only). Although most

complied with the physicians' instructions, four pharmacists stated that they refused to fill these prescriptions and demanded the women return to their doctors.

[Table 2 about here]

3.3 Attitudes toward emergency contraception

After assessing pharmacists' knowledge of EC in general, we provided all participants with information about a dedicated progestin-only EC pill. Nearly all participants (n=95) were enthusiastic about the prospect of a dedicated progestin-only EC pill and 97 pharmacists indicated they would stock the medication if it were registered in Jordan (see Table 2). Almost all of the pharmacists (n=96) believed women would benefit from an EC product as it would provide an additional option for pregnancy prevention. Participants explained that many women enter the pharmacy with young children or newborns in tow and express an explicit desire to space or delay subsequent pregnancies but ultimately do not use ongoing contraception and thus become pregnant again quickly. However, a number of pharmacists added caveats about which types of patients they saw as candidates for EC. Although many pharmacists reported that they routinely provide medications, including OCPs, to patients without a prescription, most pharmacists made it clear that they would only be willing to offer EC to women with prescriptions from doctors or to women whom they trust and whose "situations seem clear".

In contrast, five participants, located in Amman, Aqaba, and Salt, had reservations about progestin-only EC. They reasoned that women should be responsible "enough" to use ongoing

contraceptive methods and that the availability of EC would make women more sexually irresponsible. These pharmacists also argued that that this type of contraception would interfere with God's will. In addition, several of these pharmacists noted that the Jordanian Ministry of Health would already offer an EC product if the medication were safe, a dynamic which cast doubt on safety and efficacy.

Of all the sites we visited, Al-Salt pharmacists expressed the most negative attitudes toward EC. Although the number of pharmacies was small, pharmacists in Al-Salt repeatedly conflated EC with misoprostol, a drug that is highly regulated in Jordan because of its abortifacient properties [19]. One pharmacist expressed the belief that EC would be a gateway to abortion: "This is an amazing product, but women shouldn't know about it because it will make them be more reckless and increase the chances of them trying to get an abortion." Notably, condoms, lubricants, and OCPs were not visibly displayed or advertised in these pharmacies, a finding that suggests that there may be more aversion to providing sexual and reproductive health products, in general. However, all of the pharmacists in Al-Salt expressed a willingness to stock a progestin-only EC pill if the Jordanian Food and Drug Administration approved a dedicated product.

We also spoke with pharmacists about the post-coital use of both combined and progestin-only oral contraceptive pills. Again, the overwhelming majority (n=92) responded positively and three-quarters of our participants thought it was a "great alternative" in the absence of a dedicated EC product. Upon hearing about the post-coital use of OCPs for the first time, one pharmacist described this as a "beautiful, amazing, smart idea". However, eight pharmacists expressed reservations about using OCPs to prevent pregnancy after sex. These

pharmacists explained that women would be scared of taking so many pills at once and that promotion of the Yuzpe method ran the risk of stoking widespread fears that hormonal contraceptives cause infertility.

4 Discussion

Our findings suggest that pharmacists in Jordan are largely supportive of incorporating progestin-only EC into the contraceptive method mix and would stock and dispense the product if registered. Pharmacists in Al-Salt were notable outliers with respect to enthusiasm but even these pharmacists would carry the produce if registered. That Jordanian regulatory agencies have not approved a dedicated progestin-only EC pill sends a signal that the medication is not safe or effective. The time has come for the Jordanian Food and Drug Administration to join the other 147 countries worldwide, and the other 11 countries in the Middle East and North Africa [7], and register a dedicated EC product.

However, both OCPs and IUDs can be used post-coitally and are widely available in Jordan. Working with pharmacists to ensure that they have accurate information about both the Yuzpe method and the use of progestin-only OCPs as EC is a priority. This includes providing evidence-based information about regimens and timeframes for use and addressing concerns about the use of “too many” oral contraceptive pills at once. Incorporating information about the IUD as EC into these efforts is also critical. Creating continuing medical education opportunities and ensuring that there are resources available in Arabic is essential; working with national pharmacist associations may be an appropriate strategy. Finally, identifying ways

to incorporate contraception education, including information about EC, into pharmacy training is also an important part of ensuring a highly trained workforce.

That several of the pharmacists in our study had obtained information about EC from the not-2-late.com website was heartening, as this was the first Arabic-language online resource dedicated to EC [18]. However, the website is out-of-date and has not been optimized for smart phones. Supporting efforts to overhaul and update the website could be valuable, especially if this resource could then be incorporated into broader continuing medical education programming and pharmacy training.

Finally, any efforts with pharmacists should include values clarification and transformation exercises. Pharmacists are a highly respected and trusted health service provider in Jordan and wield significant power within their communities. Some of our interviews suggested that even if a dedicated EC product were registered and stocked, pharmacists would use their judgment to determine who could access the product without a prescription. This, of course, places the pharmacist in the role of gatekeeper and can create hierarchies of deservedness [20], where only specific types of women and girls, or those who have had specific types of sexual encounters, get access to the medication. Ensuring that all women and girls who need emergency contraception have access is critical.

4.1 Limitations

Our study has several limitations. Although we visited pharmacies in six urban and rural governorates, we did not explore the perspectives of pharmacists working in other areas of the country. Further research would benefit from their perspectives. We also did not capture

demographic information about the individual pharmacists, including gender identification. However, because we conducted our interviews during the day we likely encountered a disproportionate number of women pharmacists, as professional women are less likely to work in the evenings or at night than their male counterparts. Women pharmacists may be more positively inclined toward EC than their male colleagues. Finally, pharmacists are only one member of the health professions corps in Jordan. Future research that includes the perspectives of other health care providers would be valuable.

4.2 Conclusion

Dedicated emergency contraceptive pills should be a part of the contraceptive method mix in all settings. However, the absence of a registered product in Jordan complicates service delivery. Pharmacists play a key role in the provision of contraception in Jordan and expressed enthusiasm for stocking the medication should it become available. Supporting efforts to introduce a dedicated product and expanding health service providers' knowledge of evidence-based alternatives to dedicated progestin-only pills appears warranted.

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Table 1: Location and type of study pharmacies (N=100)

	n	%
Location		
Al-Salt	5	5
Amman	57	57
Aqaba	11	11
Azraq	3	3
Irbid	16	16
Ma'an	8	8
Type of pharmacy		
Independently-owned	78	78
Chain	22	22

Table 2: Study participants' knowledge of EC and provision practices (N=100)

	n	%
Knowledge of emergency contraception		
No knowledge of any modality of EC	60	60
Knowledge of at least one modality of EC	40	40
Knowledge of a progestin only ECP	14	14
Knowledge of the Yuzpe method	26	26
Ever dispensed any method of emergency contraception		
Never dispensed an EC method	76	76
Dispensed any modality of EC	24	24
Filled prescription for a high dose of OCPs	20	20
Dispensed the Yuzpe method without a prescription	4	4
Attitudes toward a registered emergency contraception product		
Would stock a dedicated EC pill if registered	97	97
Would not stock a dedicated EC pill if registered	3	3

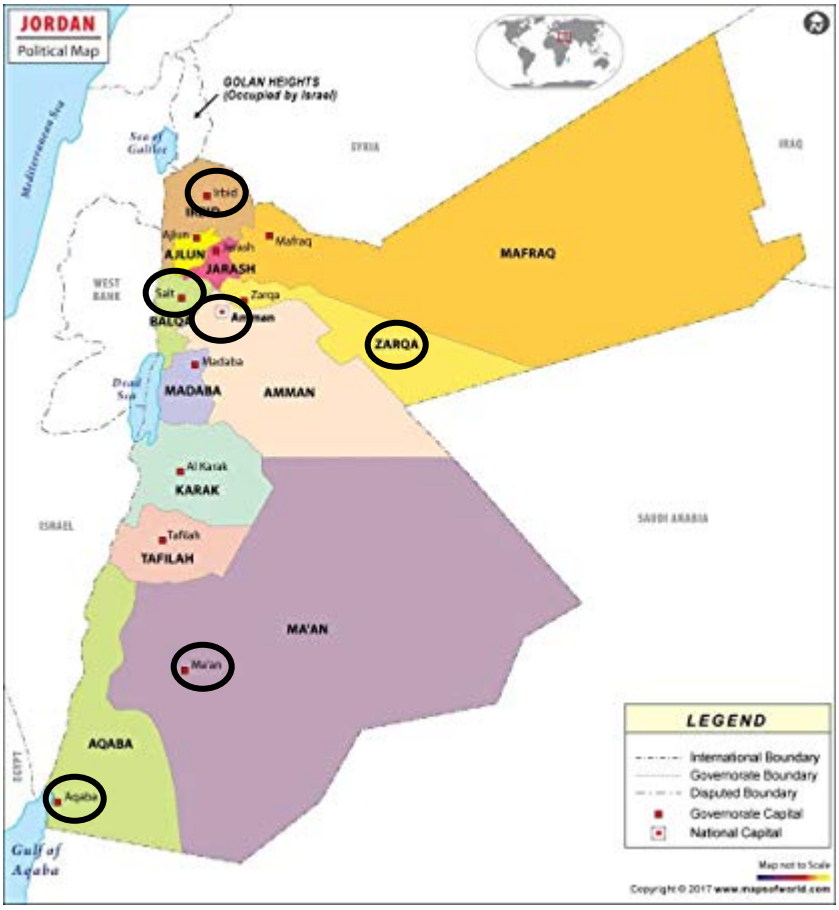

Figure 1: Map of Jordan with study sites indicated

Chapter 4: Article #2

We have submitted this article, “Child brides’ knowledge of and attitudes towards emergency contraception: A qualitative study with Syrian refugees in Jordan,” to *Critical Public Health*. We have formatted the article for the journal’s structural, reference, and style specifications.

Child brides' knowledge of and attitudes toward emergency contraception: A qualitative study with Syrian refugees in Jordan

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Child brides' knowledge of and attitudes toward emergency contraception: A qualitative study with Syrian refugees in Jordan

By the end of 2017, more than one million Syrians resided in Jordan. This massive displacement has led to a substantial increase in early marriage rates among Syrian refugees residing in Jordan. These women and girls are at a significant risk of sexual and gender-based violence and unintended pregnancy. Our study aimed to explore the availability, accessibility, and acceptability of emergency contraception among Syrian child brides in Jordan. In 2017, we conducted interviews with 14 key informants who work with Syrian refugees and facilitated six focus group discussions with 46 Syrian women and girls who married while under the age of 18. We audio-recorded and translated from Arabic to English all discussions and analyzed the transcripts for content and themes using deductive and inductive techniques. Our participants reported that their families arranged all of the early marriages during or after displacement to Jordan. Almost all of our participants became pregnant shortly after their wedding and faced pressure to become pregnant repeatedly. However, most participants wanted to space or prevent future pregnancies. Emergency contraception is not available to urban refugee populations and although none of our participants had heard of any modality of EC, all but one expressed interest and excitement about post-coital methods of pregnancy prevention. Given this enthusiasm, EC could play a key role in addressing an unmet need. Increasing awareness of and access to EC appears warranted.

Keywords: Early marriage; emergency contraception; Jordan; Middle East and North Africa; refugees; sexual and reproductive health; Syria

Introduction

Since 2011, the Syrian civil war has resulted in massive displacement of people both within Syria and into neighbouring countries (Balsari et al., 2015). The United Nations High Commissioner for Refugees (UNHCR) declared that in 2018, Jordan housed over one million Syrian refugees (UNHCR, 2018). This number included approximately 650,000 registered refugees and as many as 700,000 unregistered individuals who are unable to return to Syria (UNHCR, 2018). Results from the 2017 Jordanian Census indicated that approximately one in five people residing in Jordan had fled from Syria; women of reproductive age comprised about half of this population (Samari, 2017). The overwhelming majority of the Syrian refugee population reside outside of camps and are settled in urban and rural areas across Jordan (UNHCR, 2018). Individuals who reside in urban and rural settings experience more difficulty navigating the Jordanian health care system than those who reside in camps (Gavlak, 2013). The influx of refugee populations into Jordan has placed unsustainable pressure on infrastructure and organizations have been unable to meet the needs and demands of both refugees and local residents (UN Women, 2013).

Syrian refugee women of reproductive age in Jordan have significant unmet needs with respect to sexual and reproductive health (Krause et al., 2015; Sami et al., 2014). Topics surrounding sexual and reproductive health are often difficult to address in this context due to strong social norms and customs (Dabash & Roudi-Fahimi, 2008). Several recent studies indicate that high rates of sexual violence and early and forced marriage, low contraceptive prevalence rates, and high rates of unintended pregnancy characterize the experiences of both camp- and urban-based refugees in Jordan (JCAP, 2016; Khawaja, 2004; Krause et al., 2015b; Samari, 2017; Sami et al., 2014). Consistent with conflict-affected and displacement settings around the work, many families face significant financial insecurities and safety concerns and attempt to mitigate these conditions by marrying their daughters, often at young ages (Sahbani et al., 2016). These girls' husbands are often the primary decision-makers with respect to family formation and child brides generally lack the autonomy to access comprehensive reproductive health services (Clark et al., 2017; Sahbani et al., 2016). Despite efforts to increase women's and girls' access to comprehensive sexual and reproductive health services through awareness campaigns and family planning programming, choices remain limited (Sahbani et al., 2016).

In Jordan, the legal age of marriage for both boys and girls is 18. However, legislators made a change to Personal Status Law No. 36, Article 5-13 in 2010. Under "Conditions of Marriage", the law now states that a marriage cannot be legally registered if a child is under the age of 15 (UNICEF, 2014). Exceptions to this law are made in cases of pregnancy, but registration of the marriage is postponed until the girl turns 15 (UNICEF, 2014). For those between the ages of 15-17, the marriage must be approved by a judge from the Shari'a court (The Save the Children Fund, 2014). Such approval may occur only under specific conditions, including: non-disruption of education for both parties, a religious and economically stable groom, and a consenting bride with permission from a male guardian (Kabbani, 2017). If all requirements have been met, the judge must document the reasons for the exception (The Save the Children Fund, 2014).

The rate of early marriage among Syrian girls between the ages of 15 and 17 increased threefold since the civil war began, from 12% in 2011 to 32% in 2014 (CARE, 2015). Poverty and lack of accessible education characterize the experience of many Syrian refugees in Jordan, dynamics which in turn place pressure on families to seek relief through matrimony (Alnuaimi, Kassab, Ali, Mohammad, & Shattnawi, 2017; Save the Children Fund, 2014; UNICEF, 2014). These girls are also less likely to be protected from early marriage because of perceptions among Jordanians that child marriage is a traditional Syrian custom. Displaced Syrian girls in general, and those who are married early, in particular, are disproportionately affected by sexual and gender based violence which further contributed to an increased risk of unintended pregnancy (Clark et al., 2017; D. Spencer, 2015).

Given this context, emergency contraception (EC) could play an important role in meeting pregnancy prevention needs. Emergency contraceptives are medications or devices that are used after under-protected or unprotected sexual intercourse to reduce the risk of pregnancy (Trussell, 2012). The progestin-only pill is the most commonly used form of EC worldwide; as of 2019, 147 countries had registered at least one dedicated EC pill (ICEC, 2019). Jordan has long been an outlier and remains one of a small number of countries without a registered product. However, both the intrauterine device (IUD) and oral contraceptive pills (OCPs) are widely available in Jordan (El-Mowafi & Foster, 2019) and can be used post-coitally

to prevent pregnancy (Trussell, 2012). Further, providing the means to prevent pregnancy after sex has long been incorporated into the standards for sexual and reproductive health service delivery in humanitarian settings (UNHCR 1999; IAWG, 2018; ICEC, 2018). Consequently, dedicated progestin-only emergency contraceptive pills are available through the Inter-Agency Reproductive Health Kits (RH Kits) and thus a supply of EC is available to humanitarian implementing agencies even when there is no local source for a dedicated product (IAWG, 2018).

The context and lack of literature on women's experiences accessing emergency contraception motivated our study. In 2017, we conducted a multi-methods assessment to explore the availability, accessibility, and acceptability of EC among Syrian child brides' in Jordan. Through this project we aimed to identify strategies for improving access to EC within this community.

Methods

In 2017, we completed a multi-methods qualitative study that included key informant (KI) interviews and focus group discussions (FGD) with Syrian women and girls who married under the age of 18. We modelled our study after previous studies conducted on EC in humanitarian and post-conflict settings (Hobstetter et al., 2015; Gure et al, 2016). We conducted our fieldwork in multiple cities across Jordan. We chose locations based on the significant presence of a Syrian population and a high prevalence of early marriage in the area (Higher Population Council, 2016).

Data collection: Key informant interviews

In order to obtain a range of perspectives of those working with Syrian refugee populations, we interviewed health care providers, lawyers, teachers, community leaders, and non-governmental organization (NGO) directors and managers. We identified well-positioned individuals by agency affiliation and title as well as through the professional network of the study team and early participant referral. We used a semi-structured interview guide to explore key stakeholders' personal and professional demographic information, experiences working with Syrian populations, and knowledge of early marriage among Syrian refugees. We also explored key informants' knowledge of and attitudes toward EC and their perspectives on provision of EC to Syrian refugees, in general, and girls in early marriages, in particular. We concluded our interviews by asking KIs to reflect on how services could be improved. We adapted each guide to the specific informant. IE, an Egyptian-Norwegian-Canadian graduate student in interdisciplinary health sciences, conducted all interviews in English and Arabic, after having received training from AMF, a medical doctor and medical anthropologist with extensive experience conducting sexual and reproductive health research in the Middle East. Interviews lasted approximately one hour. We obtained verbal consent at the outset and, with permission, audio recorded all interviews. IE took notes during each interview and wrote formal analytic memos after each encounter.

Data collection: Focus group discussions

To understand community norms and collective experiences related to emergency contraception, we held FGDs with women and girls who had been married before the age of 18. We organized six focus groups; four with women residing in urban settings and two with women residing in the Al-Za'atari camp, the largest refugee camp in Jordan. IE and MH recruited participants for the study through community-based organizations (CBOs) and with cooperation from community leaders. We held the discussions in the meeting rooms of CBOs that serve Syrian refugees.

We began each discussion with introductions and basic demographics. Using a facilitation guide developed specifically for this study, we then explored women's experiences early marriage and migration to Jordan, their knowledge of and experiences with EC and other methods of contraception, their attitudes toward EC and perceptions of need, and suggestions for how reproductive health services could be improved for Syrian refugees residing in Jordan. With permission, we audio-recorded all discussions which IE facilitated in Arabic. Two research assistants from TRY Center co-facilitated and took notes during the discussions. As a thank you for participating in the study and to cover any associated travel costs, we gave each woman JOD5 (approximately USD7). IE debriefed with co-facilitators in the wake of each discussion and analytically memoed shortly thereafter.

Analysis

IE transcribed and translated into English (as needed) all KI interviews and FGDs. We used ATLAS.ti to manage our data comprising transcripts, notes, and memos. IE developed a preliminary codebook of a priori codes derived from the literature, study instruments, and previous research by the study team members. As we worked through the data we created additional codes to reflect emergent ideas. With these tools we analyzed the data for content and themes (Elo & Kyngäs, 2008; Denzin & Lincoln; 2011). Group discussions between IE, MH, and AMF guided our interpretation. We initially analyzed each study component separately; in the final analytic phase we combined the findings from the interviews and FGDs to explore concordance and discordance.

Ethical considerations

We received approval to conduct this study from the Higher Population Council (Jordan) as well as authorization to travel to the Al-Za'atari refugee camp. We organize our findings around key themes and we have removed or masked all identifying information. We use pseudonyms for our FGD participants and describe our KIs by profession.

Results

Participant characteristics

We interviewed 14 key informants: four doctors and two nurses working in urban clinics serving Syrian populations, two doctors working in Al-Za'atari refugee camp, four teachers and principals, two NGO representatives, two psychologists, one lawyer, and one psychosocial case manager. We spoke with 46 girls and women during our six FGDs. Our participants ranged in age from 12 to 45; we conducted four focus groups with participants age 18 and younger and two FGDs with women who had been married under the age of 18 but at the time of the discussion were over 18. Of the 46 girls and women, 21 were still married and 25 were

divorced; all participants had at least one child. Of the participants who were under the age of 18 at the time of the discussion, three were married to Jordanian men and the rest were married to Syrian men. All of our participants had migrated to Jordan after the onset of the Syrian civil war in 2011.

Child brides have limited sexual and reproductive health knowledge or autonomy

> On my wedding night, I was so happy and pleased with my wedding dress, makeup and accessories, but at the end of the night I wanted to go back to my family's place. When I was taken upstairs in the room with my husband it was the first time I was alone with a man that wasn't my immediate family. When he asked me to undress, I started screaming. I screamed louder with every touch. I lost my voice that night. His aunt finally came in to take me out in fear that I was going to bring a scandal to the family…I was only ever asked if my period had been missed that following month, I was in demand to provide my husband with children. Preventing it was out of the question (Yazmine, 16 years old)

All of our FGDs participants reported that prior to their marriage they lacked basic knowledge of sexual intercourse, pregnancy, and sexual and reproductive health. Participants repeatedly discussed how they were not aware that they were expected to engage in sexual activity on their wedding night; when Yazmine share her story, others in the room nodded in agreement. The majority of our participants discussed extensive pressures from their husbands and immediate family to prove their fertility. They felt there was an imperative that they become pregnant as rapidly as possible to demonstrate their value as a wife.

All but one of our FGD participants became pregnant within a year of their wedding; more than three quarters (n=36) got pregnant within six months. The one outlier got married at the age of 16 in Al-Za'atari waited two years before becoming pregnant. She credited her exceptional experience to workshops provided by aid groups in the camp that helped convince her husband and here husband's family that delaying a first pregnancy was beneficial for her health.

Our FGD participants explained that after marriage, and particularly after the birth of their first child, the learned much more about contraception. Most of the women and girls in our FGDs knew that a range of contraceptive methods were available and had basic information about different options. However, misinformation – particularly related to the infertility risks associated with non-permanent methods of contraceptives – abounded. These misconceptions were often intertwined with their husbands' and extended families' disapproval. As 21 year-old Nora explained:

> I was married to a Jordanian man during the war and I was promised a safe life here. I started coming to the clinic after I had found out I was pregnant, when I came in to check with the doctor after I gave birth, she talked to me about family planning…I decided to get the IUD, but I didn't tell my husband…after a while he found out, and I don't have to tell you what happened…My mother-in-law came with me to the clinic when she found out, she stayed in the room to make sure that the doctor took out the IUD…I had the IUD for less than two months.

Misinformation combined with pressure from husbands and in-laws impacted behaviors; unlike Nora, three quarters of our participants who were over the age of 18 (n=26) had never used a modern method of contraception. For the 13 participants who were under age 18 at the time of the discussion, three were pregnant, four were using a contraceptive method, and six were not using a method of contraction. The eight women and girls across all groups who were currently contracepting all resided in Al-Za'atari. However, although few of our FGD participants had ever used a modern method of contraception, most expressed a desire to space or prevent future pregnancies. As Mia, age 16 explainedd:

> My mother-in-law wouldn't let me use any contraceptives for fear that I would become infertile in the future...She threatened that he [my husband] would bring in another wife, and I can't let that happen – so I obeyed her.

The reports of key informants were generally consistent with those of our FGD participants. Providers in particular discussed how challenging it is to provide contraceptive services to child brides, evidenced in the following:

> When we are told that one of our patients is a child bride, we always try and convince them to bring their husbands with them so we can educate both of them on family planning. It is easier to work with Jordanians because they have a base of information on family planning, while Syrians do not. If they do have information on family planning, it will all be nightmare stories on their aunt's experience with the IUD...they will tell you stories like my aunt used the IUD and it travelled to her heart and that's how she had a heart attack.

Key informants consistently expressed that Syrian refugee girls and women have little to no information contraception and birth spacing. An NGO representative argued: 'Syrian women and girls do not know anything regarding contraception, when we arrange workshops on family planning it is *"3al fadi"* – not worth it – because we do not have a base of information to work with.'

Emergency contraception is generally not available to Syrian refugees

Our interviews with key informants working in both Al-Za'atari and urban areas indicate that dedicated EC pills are not generally available. Health care providers with experience in Al-Za'atari explained that dedicated progestin-only EC pills are available through the RH Kits and are part of the standard of care for the clinical management of rape (CMR). Although key informants explained that few women presented to a clinic within five days of a sexual assault, they were grateful for being able to offer EC in this cases. A doctor working in Al-Za'atari explained:

> The girls are so young, they have seen so much…If a girl [is] raped and the psychological and physical issues that comes with that, and we can, as a physician,

> remove the fear of a pregnancy, of course EC is beautiful. All women need and should have EC.

However, all of our key informants who worked in Al-Za'atari made it clear that progestin-only EC was only available to survivors of rape, not to women who had unprotected or underprotected consensual sex.

Those working with urban refugee populations painted a different picture of EC availability. Clinics that serve a large proportion of Syrian refugees also have access to dedicated progestin-only EC pills through the RH Kits. However, because there is no registered dedicated product in Jordan, a number of our key informants believed that providing EC, under any circumstance, was illegal. As one Ob/Gyn working with Syrian refugees in Amman explained, 'We have hundreds of them [EC pills] in the CMR kits downstairs, but we do not provide them to the women, as we know it is not allowed.' This dynamic was also described by an NGO representative who said:

> I have piles of [EC] in our office, but physicians don't want to take them out of the kits...You can give the pill to Syrians but not Jordanians, so doctors don't want to get in trouble so they give [EC] to no one.

The lack of a registered dedicated product also means that progestin-only EC is not available in urban areas outside of the Inter-Agency Reproductive Health Kit system. However, all eight of our health care providers and several of our other key informants were aware that both combined hormonal and progestin-only OCPs could be used post-coitally to prevent pregnancy. Some of our key informants were less clear on the details, such as how many pills would need to be used and the timeframe for use, but felt confident they could find the information if needed. But one key informant described the downside to using the OCP for EC:

> When a girl [who was raped] is referred to us by family protection services, we have to refer her to the doctor where the doctor will give her multiple pills. The girl, who is already scared and shocked, is provided with a million pills that she doesn't understand what to do with.

All eight of the health care providers we interviewed discussed the lack of EC education during their medical training; their first introduction to post-coital contraception occurred after joining their respective clinics and receiving inter-agency training. Our key informants expressed considerable confusion as to why the Jordanian Food and Drug Administration had not registered a dedicated EC pill. The health care providers in our study were also unanimous in their belief that Syrian women lacked any awareness of EC.

Although knowledge of EC among Syrian child brides is non-existent, great enthusiasm exists

> I was trying to not get pregnant after my third child…I was told that if I was breastfeeding that I wouldn't be able to get pregnant…had I known about this method [emergency contraception] it would have helped me with what I wanted. I wish I could have used it. (Sara, 19 years old)

The perceived lack of knowledge about EC among Syrian refugee women was confirmed by our FGDs; none of our participants had ever heard of post-coital pregnancy prevention methods. Indeed, when we initially asked about emergency contraception and described how these types of pills or devices can be used after sex to prevent pregnancy, participants immediately turned to a discussion of abortion. Six of our FGD participants disclosed their own abortion experiences during these discussions and women and girls talked about a range of both safe and unsafe practices. Redirecting the conversation to post-coital contraception proved difficult; women and girls had a hard time conceptualizing how a pill used after sex could prevent pregnancy.

However, once we were able to describe progestin-only EC pills FGD participants were intrigued. Child brides in our study noted that this form of contraception could be particularly useful in the context of sexual violence as well as when marital sex was unpredictable or infrequent. As one FGD participant explained,

> This is beautiful, very beautiful – my husband comes back from work every few months, can you believe it? I could use this [EC] with each visit instead of taking on all the shitty side effects of the [oral contraceptive] pill.

Our FGD participants also felt strongly that EC would be particularly valuable that younger child brides. They explained that these women less autonomy and had a harder time convincing their husbands about the need for contraception and birth spacing; participants believed girls in these situations could exercise quiet control over pregnancy. Most of the older women who participated in our study had daughters who were also child brides; these mothers thought EC could be an important option for their daughters.

Participants in urban areas also reacted positively to how cheap the use of OCPs could be. A packet of Microgynon®, a widely available brand of progestin-only OCPs, costs JOD1.35 (USD1.90) and often can be obtained directly from pharmacists. One of our younger participants suggested with excitement, 'It would be cheaper for us to go to the pharmacy than to take the bus to this clinic and back, thank God'. And although we mentioned that post-coital insertion of an IUD could also prevent pregnancy after sex, enthusiasm for this modality of EC was muted.

Increasing awareness of EC is a priority for both providers and child brides

> Well of course we need to tell these girls about [EC], but in a careful way…We need to educate in a way where people won't misunderstand, we live in a very conservative society. You inform them [about EC] they will say this causes abortion…but we push, we have to push. These girls are losing their bodies in giving birth so young and so many times…we need a solution. (Physician working with Syrian refugees in Amman)

KIs and FGDs participants both conveyed the importance of raising awareness of EC. Key informants of all professions discussed the importance of providing accurate information to women about EC as they believe this will enable women and girls to relay accurate information within their communities. Clinicians also indicated that it would be

important to engage with husbands and in-laws to ensure that misinformation about EC is addressed. However, providers noted that this could be a "discrete" method of pregnancy prevention that might be especially relevant for child brides and those with relatively limited autonomy. The health care providers we interviewed were also extremely enthusiastic about the prospect of receiving training on provision of EC and learning more about best practices outside of CMR.

The participants in our FGDs were very excited about spreading the word about emergency contraception. Indeed, all but one of our FGD participants declared that they would be interested in using progestin-only EC pills themselves and sharing information about this modality of contraception with others. As Sarah explained,

> God provides women with great gifts, but our men continue to bury them. If I had known that EC was available it would have helped my heart.

Discussion

Although provision of emergency contraception has long been integrated into different phases of humanitarian emergencies, the findings from our multi-methods qualitative study suggest there are considerable barriers to implementing the global guidelines in Jordan. The absence of a registered dedicated progestin-only EC pill undermines provision of this life saving intervention both in the context of CMR and in the context of underprotected or unprotected consensual sex. Redoubling efforts to ensure registration of a dedicated pill appears warranted and could help address unmet pregnancy prevention needs of Syrian refugees and Jordanian women alike.

But even in the absence of a dedicated product, a number of efforts could be undertaken to improve the availability of EC. The lack of a registered EC pill in Jordan creates a dynamic where providers do not believe they can legally provide the medications in the RH Kits. Clarifying for providers that the EC pills in the RH Kits can be used legally despite the absence of product registration could help allay fears. It is also important to emphasize that any woman who is eligible for progestin-only EC and who wants to prevent pregnancy should be offered the medication; EC should not only be offered to survivors of rape. Finally, identifying ways to raise awareness about how existing technologies, and progestin-only ECPs in particular, can be used post-coitally could be of value.

Our findings indicate that although knowledge of EC among Syrian child brides was non-existent, enthusiasm for progestin-only EC pills was considerable. Participants in our FGDs found that a discrete, female-controlled contraceptive that was directly tied to the act of sexual intercourse was culturally resonate. Older women in our discussions were especially hopeful that this could meet the needs of younger child brides who often have even less agency. Humanitarian implementing agencies should be encouraged to follow the recommendations of these participants and integrated information about EC into their clinical encounters and educational sessions.

Our findings suggest that Syrian women and girls in early marriages have significant unmet contraceptive needs. Complex social and familial dynamic create pressure on newly weds to "prove" their fertility status and thus pregnancy prevention did not arise for almost all

of participants until after they had delivered their first baby. However, most of our participants expressed a strong desire for birth spacing and for delaying subsequent pregnancies. While EC is an important tool, it is not a panacea; humanitarian agencies need to continue to ensure that child brides have access to a full range of contraceptive services. Initiating discussions about contraception during the pre-natal visits and ensuring that husbands and/or mothers-in-law are included, with permission in those discussions could be an effective strategy.

However, this will require additional training, support, and encouragement. Providers in our study held a number of biases and stereotypes about Syrian refugees, in general, and those engaged in early marriage, in particular. Facilitating values clarification and transformation workshop could be an important step to advancing comprehensive non-judgmental contraceptive care.

Limitations

Our study focused on women and girls who resided in four regions in Jordan. As a result, the lived experiences of Syrian child brides in other parts of the country may not be reflected in our findings. In addition, we recruited participants through CBOs and professional networks thus groups of women who are not connected to services were less likely to participate. Finally, participants in our focus group discussions were necessarily mobile and thus child brides who are more isolated and who lack freedom of movement would not be able to participate. These dynamics may limit the transferability of our findings.

The positionalities of the research team members undoubtedly influenced the participant-researcher interaction as well as our interpretation of data collected. Through memoing and regular debriefings we attempted to reflect on and understand these dynamics, thereby enhancing the credibility and trustworthiness of the findings.

Conclusion

Jordan remains one of only a handful of countries in the world without a registered, dedicated progestin-only pill. Inclusion of emergency contraception into the contraceptive method mix could provide all women in Jordan another tool to prevent pregnancy. As Syrian refugees who have been married early face considerable barriers to accessing ongoing contraceptive methods, EC may be especially resonant with this population and had the potential to address a significant unmet need. Identifying avenues for increasing awareness about emergency contraception among both providers and potential users and redoubling efforts to register a dedicated progestin-only product appear warranted.

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Chapter 5: Article#3

We have will submit this article, ""Knowledge for women is a sword and I want to be able to hold that sword not only for me but for my daughter": Results of an intervention to respond to Syrian child brides' educational and reproductive health needs" to Sexual and Reproductive Health Matters. We have formatted the article for the journal's structural, reference, and style specifications.

"Knowledge for women is a sword and I want to be able to hold that sword not only for me but for my daughter": Results of an intervention to respond to Syrian child brides' educational and reproductive health needs

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Keywords: Jordan, Sexual and Reproductive Health, Child brides, Syrian refugees, Education, Early Marriage

“Knowledge for women is a sword and I want to be able to hold that sword not only for me but for my daughter”: Results of an intervention to respond to Syrian child brides’ educational and reproductive health needs

Abstract

In 2017, there were over 650,000 Syrian refugees residing in Jordan. A combination of financial and social imperatives related to the Syrian civil war have led to a threefold increase in early marriage rates. In 2017-2019, we embarked on an educational intervention where we enrolled 10 Syrian refugee girls who were married under the age of 18 into an informal educational program with the aim of enabling them to return to grade level. As part of the intervention we provided participants with sexual and reproductive health (SRH) workshops. We conducted initial in-depth interviews with the 10 girls to understand better the circumstances in which they dropped out of school and their knowledge and attitudes towards SRH services. We also conducted follow-up interviews with the girls after their completion of the program. Using both inductive and deductive techniques, we employed a multi-phased analytic plan to identify content and themes. Our findings shed light on the complex dynamics shaping early marriage among Syrian refugees and suggest that Syrian child brides have significant unmet SRH needs. Our experience suggests that improving educational and health outcomes for child brides requires a multi-sectoral approach. Working with humanitarian stakeholders to identify ways to expand access to informal education while also incorporating SRH workshops appears warranted.

Introduction

Addressing and preventing early, coerced, and forced marriage has been on the global humanitarian agenda for several decades. The United Nations highlighted the reduction of early marriage as a priority in the Millennium Development Goals and subsequently reinforced the importance of preventing the practice during the establishment of the Sustainable Development Goals (SGDs) in 2015 (United Nations, 2000, 2017). Specifically, SGD 5 focuses on gender equality and the empowerment of women and girls through the elimination of child marriage. Progress toward meeting SDG5 is monitored at a country level (United Nations, 2017) by assessing the rates at which women between the ages of 20-24 marry under the age of 18 (United Nations Department of Economic and Social Affairs (UN DESA), 2018).

In 2017, an estimated 21% of women between the ages of 20-24 reported they were married or involved in an informal union before the age of 18. Therefore, over 650 million girls were married under the age of 18 globally (UN DESA, 2018). Rates of child marriage tend to increase during times of war, conflict, and displacement; this is precisely what occurred following the outbreak of the Syrian civil war in 2011. The lack of security and financial instability that accompanies displacement has led many refugees and internally displaced persons (IDPs) to marry off their daughters, often at a young age (Clark et al., 2017; Sahbani, Al-Khateeb, & Hikmat, 2016). Marriage rates among Syrian girls under 18 increased from 12% in 2011 to a staggering 41% in 2018 (CARE, 2015).

In Jordan, the Personal Status Law states that the legal age of marriage for both boys and girls is 18 (Sahbani, Al-Khateeb, & Hikmat, 2016). However, girls are legally permitted to marry at age of 15 and boys at 16 if the union is authorized by a judge from the Shari'a (religious) court and the petitioning couple is able to document how specific requirements have been met (UNICEF, 2014). These requirements include: a religious groom who can provide for his bride financially; the bride's full consent to the marriage; the permission of the bride's male guardian; and attestation that the marriage will cause no disruption in education for either party (Kabbani, 2017). Anecdotal evidence from NGO representatives suggests that Syrian girls under the age of 18 are less likely to be protected from early marriage in the Jordanian context due to perceptions among Jordanians that child marriage is a traditional Syrian custom. As a result, judges may be more likely to approve marriages of young Syrian girls than those of young Jordanian girls.

Child marriage plays a pivotal role in lower educational attainment (Delprato, Akyeampong, Sabates, & Hernandez-Fernandez, 2015), reduced levels of literacy (Nguyen & Wodon, 2014), and lower economic participation, which, in turn, lead to higher poverty rates (Chaaban & Cunningham, 2011). Further, early marriage is correlated with high fertility rates and increased risk of sexual and gender-based violence (SGBV). Further, women and girls often lack the autonomy to access comprehensive sexual and reproductive health (SRH) services as their husbands are the primary decision makers (Clark et al., 2017; Sahbani, Al-Khateeb, & Hikmat,, 2016). Consequently, girls who are married early are at heightened risk of unwanted pregnancies (Al-Badayneh, 2012). Despite efforts to increase comprehensive sexual and reproductive health services (Sahbani, Al-Khateeb, & Hikmat, 2016) and educational

interventions (Swan, 2018) among Syrian refugees, child brides' continue to be a highly vulnerable group in Jordan.

Given the varied detrimental effects of child marriage on women and girls' lives, there is a clear need for holistic, evidence-based interventions to meet child brides' educational, socioeconomic, and health needs (Svanemyr, Chandra-Mouli, Raj, Travers, & Sundaram, 2015). In 2017, a Family and Child Protection Society of Irbid (FCPS), TRY Center for Training, Research and Education (TRY Center), and Cambridge Reproductive Health Consultants (CRHC) embarked on a two-year initiative to respond to the educational and SRH needs of Syrian child brides in Jordan. Funded through Women's Peace and Humanitarian Fund (WPHF), this multi-faceted initiative included a pilot intervention with a cohort of 10 girls who were married under the age of 18. In this article we describe this educational and SRH intervention and report on the findings from both baseline and end-of-program in-depth interviews with participants. These interviews shed light on the lived experiences of Syrian child brides and identify both lessons learned and areas for program improvement.

Project description

Study population and setting

Since 2011, the Syrian civil war has resulted in the displacement of more than one million people to Jordan, half of whom are women and girls of reproductive age (Balsari, Abisaab, Hamill, & Leaning, 2015). In 2017, the United Nations High Commissioner (UNHCR) reported that approximately 650,000 registered refugees and another 700,000 unregistered individuals from Syrian resided in Jordan (UNHCR, 2017). Of these displaced persons, 21% resided in camp-based settings while the other 79% resided in urban and rural areas across Jordan (UNHCR, 2017). In addition to being concentrated in the Jordanian capital of Amman, a large concentration of urban refugees are concentrated in the northern city of Irbid. We chose to focus our pilot project in this community due to the location of project partners and the potential for replicability.

Despite efforts by the Jordanian government, UNHCR, and community-based organizations (CBOs), school enrollment among Syrian refugee children has proven to be difficult, in part due to increasing pressure on already weak Jordanian infrastructure (UNICEF, 2016). Reports indicate that approximately 40% of Syrian school-aged children are not currently enrolled in formal education in Jordan (UNHCR, 2018). The *Jordan Times* echoed this reporting, indicating that over 70,000 registered Syrian refugee children are not currently enrolled in formal or informal schooling (Jordan Times, 2018). Formative research by our team and others indicate that many Jordanian school boards and teachers are under the impression that girls who are married are not legally able to remain in school. However, there is no such law governing education in Jordan and this interpretation appears to be customary. As a result, Syrian girls who are married, as well as many of those who get formally engaged, are required to leave school. Thus, in addition to the general dynamics surrounding the education of Syrian children in Jordan, child brides face specific barriers to completing their education.

Project description

We aimed to develop and implement an intensive intervention to facilitate the re-enrollment of Syrian child brides in the Jordanian school system. Based on our overall theory of change, we

applied an integrated project design framework (Fig. 1). Thus, we coupled informal educational resources and training with information and referrals for comprehensive SRH services and engagement with the extended families of our program participants.

[Figure 1. about here]

FCPS, a community-based organization in Irbid that has long been engaged informal education and vocational training efforts, identified potential program participants through their network. Participants were eligible to enroll in the program if they had left Syria after the start of the civil war and now resided in Irbid, were married before the age of 18, left the Jordanian educational system prior to completing secondary school, and expressed a desire to return to school. Program enrollees also had to be able to attend in-person workshops and trainings at the FCPS facility in central Irbid.

Once FCPS identified potential participants, an FCPS social worker conducted a detailed intake interview to obtain basic demographic information, develop a tailored educational program, and identify needed resources. We present basic demographic information about these participants in Table 1. FCPS then designed a series of educational workshops that aimed to support the girls "return to grade level". FCPS also provided school supplies, offered vocational trainings, and helped girls with their official re-enrollment through the Ministry of Education. These program components constituted the informal educational piece of the intervention.

[Table 1. about here]

Over the course of the one-year initiative, CRHC conducted a series of SRH workshops for program participants. We designed the initial workshop based on information FCPS obtained during their intake interview as well as initial in-depth interviews conducted by this project team (see below). The initial workshop focused on family planning, with an emphasis on modern contraceptive methods, including emergency contraception, and local service availability. The robust discussion that followed generated ideas for additional SRH workshops, including sessions dedicated to sex and sexual development. Participants also request an additional workshop on contraception for both themselves and their mothers-in-law; we then designed and facilitated these additional sessions. This constituted the SRH component of the intervention.

Finally, both FCPS and CRHC engaged with family members and communities. With permission from program participants, FCPS social workers and counselors met with partners and family members, to foster support for participants re-entering school. FCPS allayed fears that both the intervention and the eventual return to formal education would impede participants from fulfilling their day-to-day obligations and parenting responsibilities and worked with program participants to balance various commitments and needs. CRHC engaged with mothers-in-law in particular at the request of program participants. This was an iterative part of the program and constituted the enabling environment component of the overall initiative.

Evaluation

Data collection: Initial interviews

We collected data at the outset of the initiative to both inform the project components and establish a baseline by which to assess the impact of the intervention. In 2018, we conducted 10 in-depth baseline interview with program participants. IE, a master's student in the Interdisciplinary Health Sciences program at the University of Ottawa, conducted all interviews in-person. She received training from AMF, a medical anthropologist and medical doctor with extensive experience working on SRH issues in the Middle East and North Africa. Using a guide developed specifically for this study, we aimed to understand better the circumstances surrounding participants' marriages and their migration to Jordan. We also explored their sexual and reproductive health history, current family and marital dynamics, and their educational trajectory. Finally, we talked with participants about their experiences accessing aid and services since settling in Jordan. Our in-depth interviews also gave us an opportunity to discuss the initiative with participants, confirm their interest in participating, and identify their priorities for workshop and training content. Interviews lasted an average of 90 minutes and with permission IE audio-recorded all interviews, which she conducted in Arabic. In addition, IE took notes during and formally memoed immediately after each interview.

Data collection: End of program interviews

We conducted follow-up interviews with each participant at the end of the program. IE again conducted all in-person interviews in Arabic. In these interviews we discussed participants' perspectives on the intervention, the reaction of their partners and family members to their participation, and their opinions perceptions of the impact of the program. We explored their current practices and desires regarding pregnancy and family composition as well as their utilization of services. Finally, we explored their educational plans and goals, as well as their feelings regarding facilitators and barriers. We ended the interviews with a discussion of how the program could be improved and expanded to additional girls and young women in their community. IE audio-recorded, took notes during, and memoed immediate after each interview.

Data analysis

IE transcribed all in-depth interviews and translated these from Arabic to English. We employed an iterative analytic approach and began data analysis during the data collection phase (Denzin & Lincoln, 2005; Elo & Kyngäs, 2008). The memos that IE wrote after each interview allowed for ongoing identification of emergent themes and patterns and also provided an opportunity for reflection on participant-interviewer interactions (Denzin & Lincoln, 2005; Elo & Kyngäs, 2008). Using a priori codes based on the study aims and research questions, we analyzed our data for content and themes using deductive and inductive techniques; we used ATLAS.ti to manage our data. IE coded all data and team meetings and debriefing sessions between IE, MH, and AMF guided the identification of themes and our interpretation. Presentations of these data to the larger project team also informed some of our recommendations. We initially analyzed each component of the project separately. In the final phase we compared baseline and final interviews for each participants and integrated the two components. This allows us to explore both vertical and horizontal concordance.

Ethics

We obtained approval from the Ministry of Planning and International Cooperation in Jordan and the UNWomen Jordan Office to conduct research and implement this project. In addition, the University of Ottawa's Social Sciences and Humanities Research Ethics Board approved our reproductive health needs assessment (File #05-16-20). We obtained verbal consent from participants at the outset of each interview. We informed participants that they could end their interview participation at any time without impacting their enrollment in the initiative; none chose to end the interviews early.

In this manuscript, we organize our results around major themes that emerged during the two phases of interviews. We use illustrative quotes to support our interpretation and have removed or masked all personally identifying information and assigned pseudonyms to our participants.

Results

Displacement influenced early marriage and served as a barrier to continuing education

> How is my father going to get money from in a place we are not legally allowed to work? When people hear that this man is Syrian, they won't give him a job. My father was jobless and had to provide for nine people, so marrying off one of his daughters would help. (Fatima, 16 years old)

Consistent with findings from around the world, displacement was a major driver of early marriage among our participants. Consistent with Fatima's experience, many participants explained that displacement created considerable challenges for their parents and extended families. Participants reported that the financial insecurity accompanying displacement led to their marriages; as their families struggled to find solutions to their financial problems, marrying off their daughters became an option. However, our participants noted that financial insecurity tended to continue after the marriage. Participants reported that they and their husbands had limited financial opportunities and little hope that their prospects would improve. And parents and extended families were not able to help the newly married couple because their financial straits remained dire.

Participants also emphasized that displacement was a major factor in interrupting educational attainment. Almost all of our participants discussed having intended to continue their education prior to displacement and having had goals for higher education. As explained by Marwa, a 19 year-old participant:

> I was the youngest girl of five. All my sisters had finished school. I wanted to become a lawyer…but things have changed now. Many of the girls in my hometown married [out of] fear of an empty future. I am married and I have two children, this is not what I saw for myself.

For most of our participants, the financial insecurity experienced by their parents or extended families had already called into question their ability to continue school, even prior to marriage. Several of our participants reported that figuring out how to navigate the Jordanian education system after resettlement was extremely challenging and caused delays in enrollment of up to a year, during which time other financial and social dynamics made continuing education more difficult. Our participants expressed tremendous disappointment in having to leave school and found the impact of disrupted education on their future distressing.

Concerns about safety influenced both early marriage and the discontinuation of education

> When we first arrived in Jordan, many Jordanian and Syrian men would come to the house and ask me for marriage…My family was initially very against this idea because I was 15 years old and no one in our family gets married early. I wanted to focus on finishing school, I wanted to become a lawyer…[But] I stayed home for seven months and my family didn't have a lot of money. A Palestinian man came and asked my father for me, and I felt comfortable with him right away. What was I going to do? This was the best thing for me at the time. (Lena, 17 years old)

Safety and security are one of the main reasons many of the girls in our project married before the age of 18. Indeed, three participants reported that their families arranged their marriage in order to flee Syria and ensure their ability to seek refuge into Jordan. Consistent with Lena's experience, most of our participants did not come from families where early marriage was the norm. Thus creating a safe and stable environment for their daughters was a major factor in the decision to marry them early.

However, independent of early marriage, safety and security also influenced participants' continued enrollment in school. Four of our participants reported that their parents' lack of confidence regarding safety at school led to their withdrawal. Bullying, sexual harassment, abuse, *sharaf* (honor), and neglect from other students, teachers, and boys in the community were all cited as parental concerns that led to educational disruption. As Ruba, an 18-year-old participant, explained:

> We were separated from the other Jordanian students, so our school day started in the afternoon. The young boys (*shabab*) started to hear about the split and the harassment outside of the gates got worse and worse…When I told my mother about what was happening, she told my father and I was never allowed to go back to that school.

Participants reported that their parents did not feel that the complaints they raised were adequately addressed by school officials. There also seemed to be a lack of confidence in the teachers' and school board's ability or desire to intervene, as Fatima explained:

> A boy had climbed up on the gate and took a picture of one of the girls without her hijab on. He used this picture against her for months, when one of her friends told a teacher, she said it was her fault for having taken her hijab off.

Our participants repeatedly stated that these concerns about safety were intertwined with being perceived as an unwelcomed "guest" in their host country. Specifically, participants reported that their parents were concerned that if their daughters had altercations with Jordanian children and it could jeopardize their continued ability to live in Jordan. As Rehab, age 18, explained:

> When we first arrived, everything was new…we didn't know anyone. My family had lived in our *balad* [homeland] for over 100 years. Coming into something that was so new, and leaving everything behind was tough. 7amdulillah, we have a house and food, but people do not want us here.

Child brides have limited sexual and reproductive health autonomy

> My choices included providing him [husband] children or having him marry another woman who would be able to provide him that. In the end, my husband provided me a house, food, and water. Why would I bring another wife in the house? (Rula, 17 years old)

Prior to their marriages, our participants described having almost no knowledge of sexual and reproductive health, contraception, or pregnancy. The majority of the girls we interviewed discussed overwhelming pressures to become pregnant on or shortly after their wedding night. These pressures came from both their husbands and his immediate family. Becoming pregnant within the first few months of marriage is viewed as a marker of the girl's fertility, irrespective of age or the fertility of the husband. As Rula's experience showed, a new bride's fertility provides her with security within the marriage, with her husbands' family, and within their communities.

Once married and after having given birth to their first child, our participants described learning more about family planning in general, and modern contraceptive methods, in particular. Indeed, almost all of our participants mentioned that their first exposure to contraception took place during their first post-partum well-child visit; our participants subsequently had conversations with women in their family and social networks about pregnancy and pregnancy prevention.

Although none of our participants were using a method of contraception at the beginning of the initiative, most had used at least one method at some point after having had their first child. Participants had some level of familiarity with oral contraceptives pills (OCPs), intrauterine devices (IUDs), the contraceptive implant, Depo-Provera, withdrawal, and breastfeeding. Of those who had used a modern contraceptive method, most described having had a negative experience with either the IUD or OCPs that caused them to discontinue use. Our participants also held a lot of misconceptions about contraceptive methods, including the association between IUDs and OCPs with infertility.

None of our participants had any knowledge of emergency contraception and were not aware that there are ways to prevent pregnancy after sexual intercourse has occurred. When we

discussed the concept of post-coital contraception, most participants immediately turned to various methods of abortion. However, after clarifying how pregnancy occurs and how emergency contraceptive pills work, our participants became intrigued. Most thought this would be particularly useful contraceptive method given their experiences of infrequent sex and lack of preparedness. As Nala, age 18, explained: "My husband work is far away, and I do not like to deal with the headaches that the [OCPs] make me feel. This would be perfect for me to use during the days that he is home."

However, our participants explained that even if they wanted to use contraceptive methods, the decision was not their own. Rather, it is up to their husbands to decide what contraceptive methods to use and when it is appropriate to do so. Our project participants were generally aware of the physical and mental strain of having multiple pregnancies in quick succession and most mentioned having discussion with health care providers about the importance of birth spacing, especially when they were very young. However, our participants reported a lack of agency to make this decision and discussed pressures from their husbands and extended families in having many children as rapidly as possible. A Nora, age 18, explained:

> Our sons need to feel like men, how do you do that when you have [just] come out of a war? They will complain, the neighbor has ten children, and, why don't I? So…You give those men children."

Participants were extremely satisfied with the intervention

All 10 girls who participated in the program re-enrolled in school at the end of the intervention. Consequently, all of our participants expressed extreme gratitude for having a second chance to finish secondary school and obtain a diploma. Participants felt that having a high school diploma would garner greater respect within their families and communities and would enable them to be better mothers as they would be able to have more confidence. As Rehab explained:

> Being able to say that I have my high school diploma would [give me] a huge sense of pride. I will be able to help my children study when they are in school and tell them "mama finished high school"! 7amdulillah that would bring me a huge sense of pride.

Participants also repeatedly discussed how finishing secondary school would enable them advocate for their daughters to finish their education and pursue post-secondary education. As Nora expressed:

> Knowledge for women is a sword and I want to be able to hold that sword not only for me but for my daughter...Even if I am not able to go to university, I want my daughter to be able to become a lawyer or a doctor. I don't want anything to prevent her from being able to study and achieveing her wishes.

Beyond the primary aim of the intervention, participants in the program also expressed that having the ability to attend workshops and events at FCPS allowed them to form a community

with the other girls. Participants expressed comfort in interacting with other girls who had similar lived experiences. As Rula stated:

> The girls are beautiful. Each and every one of us have children, husbands, and responsibilities but are getting educated. When I talk to the girls and tell them how tired I am, I don't have to explain why…we understand each other.

Finally, participants found the integration of SRH information into this educational intervention extremely important. Indeed, by the end of the intervention, six of the participants had adopted a modern method of contraception and credited the workshops for giving them the information to make an informed decision. They also found that bringing their mothers-in-law to a contraception workshop and giving them an opportunity to ask questions made it easier for them to advocate for themselves.

Discussion

Prior to the Syrian civil war in 2011, Syria had near universal primary and secondary school enrolment (Maadad & Matthews, 2018). However, currently Syrian refugee children are now among the world's most marginalized groups and have some of the lowest rates of school enrolment globally (Watkins & Zyke, 2014). Our participants' experience reflect this broader dynamic; due to the Syrian conflict, subsequent displacement from their homes, and resultant financial strain on their families, our beneficiaries' academic goals were traded for stability and security.

Our findings shed light on the complex dynamics shaping early marriage among Syrian refugees. Prevention efforts that do not address the underlying financial insecurities of displaced families are unlikely to be successful. Further, the primacy placed on demonstrating fertility suggest that efforts to encourage new brides to prevent pregnancy are unlikely to be adopted. However, our findings suggest that Syrian child brides have significant unmet SRH needs. Incorporating educational efforts about contraception, including female controlled methods of post-coital pregnancy prevention, into prenatal as well as post-natal sessions should be prioritized. Further engaging with extended family members, and mothers-in-law, in particular, is an important strategy for creating an enabling environment for both education and sexual and reproductive health.

The response of participants to the intervention also highlights the inter-related nature of education and health. We intentionally integrated SRH programming into this educational initiative, a decision that was consistent with the practices of our local partners and informed by formative work that suggested lack of fertility control served as a major impediment to Syrian child brides' self-actualization. However, within the humanitarian system, considerable siloing occurs such that education and health are in separate "clusters". This creates challenges for multipronged initiatives that aim to address cross-cutting issues and is anathema to the practices of many community-based organization that approach social programming holistically. The success of our pilot suggests that

incorporating SRH programming into other efforts targeting women and girls could be an effective strategy for improving outcomes.

The findings from this program also suggest areas for improvement. Girls who were enrolled into our program strongly supported upscaling our initiative to other geographic areas in Jordan, specifically areas with harder-to-reach refugees. This will take considerable effort and resources and will likely require further tailoring of the intervention. Further, the girls in our pilot all identified their mothers-in-law as important stakeholders to engage. More initial work to identify additional influencers would likely add value to the initiative.

Limitations

This study has a number of limitations. Although we believe that our findings are transferrable beyond the cohort of girls who participated in the intervention, this is a qualitative study and therefore the findings are not representative or generalizable. All of the women and girls we interviewed were registered with UNHCR and therefore these findings do not necessarily reflected the lived experiences of Syrian child brides who are unregistered in Jordan. Further, our community partner recruited girls from their network, we likely spoke with Syrian refugee women who are more connected with and supported by their communities and services. Similarly, girls who were able to take part in our intervention by definition have relatively high levels of mobility and support from their partners and families. Child brides who are in more restricted environments my have different experiences. Finally, the positionality of the research team certainly impacted the interviewer-interviewee interaction. We believe that by having regular debriefing sessions and systematically memoing our team members engaged these dynamics, thus improving the trustworthiness and credibility of our study.

Conclusions

The findings from this study highlight barriers Syrian child brides experience in attempting to access education and sexual and reproductive health services in Jordan. Our experience suggests that improving educational and health outcomes for child brides requires a multi-sectoral approach. Working with humanitarian stakeholders to identify ways to expand access to informal education while also incorporating SRH workshops appears warranted.

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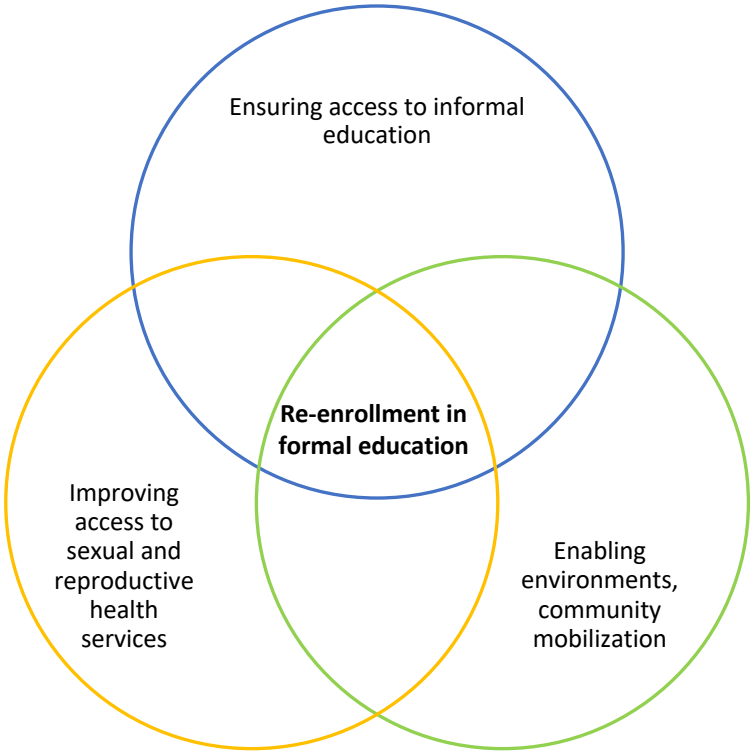

Figure 1: Integrated program design framework

Table 1. Demographic characteristics of our participants (N=10)

		n (%)
Age at the beginning of the program	16	2 (20%)
	17	3 (30%)
	18	4 (40%)
	19	1 (10%)
Age of marriage	13	1 (10%)
	14	2 (20%)
	15	3 (30%)
	16	4 (40%)
Marital status	Divorced	1 (10%)
	Married	9 (90%)
Education	7th Grade	2 (20%)
	8th Grade	0 (0%)
	9th Grade	2 (20%)
	10th Grade	4 (40%)
	11th Grade	1 (10%)
Number of children	1	3 (30%)
	2	5 (50%)
	3	2 (20%)

Chapter 6: Discussion

Integration of results

Over the last 20 years, national and international agencies have made concerted efforts to prioritize SRH in displaced and refugee communitie. However, SRH service delivery continues to lag behind the SRH needs of these vulnerable populations. The implementation of global guidelines and international policies surrounding SRH provision in humanitarian settings has also proven to be a challenge. Our study suggests that translating international policy guidelines and standards to local contexts is a direct barrier to women's access to comprehensive SRH services. Our study findings also suggest that the SRH needs of Syrian refugees are currently not being adequately met in Jordan.

The first two articles sought to explore the awareness and perceived need for EC in Jordan and Syrian refugee child brides' experiences with accessing sexual and reproductive health services and needs in Jordan, respectively. Collectively, these studies demonstrate that there is significant need for EC among Syrian refugees and that primary care providers are willing to provide this service. Despite their willingness, our findings suggest that the 2019 MISP—which expanded ECP provision as an appropriate intervention for any unintended pregnancy, not just those pregnancies that result from rape—is not being implemented at an institutional level. Therefore, primary care providers working with refugee populations are not following an integral component of the global humanitarian standards for SRH service provision.

Our results also demonstrate that there are significant challenges in the provision of EC to both urban and camp-based refugees in Jordan. Findings from our second article suggest

that the absence of a dedicated EC product in Jordan has resulted in general confusion as to its legal status. Therefore, primary care providers are hesitant to provide this service to Syrian refugee women and girls. That said, legally unambiguous technologies can be used as an EC method, as can the dedicated pills in the Inter-Agency Reproductive Health Kits (RH Kits). However, findings outlined in all three articles suggest that primary care providers are not providing any modality of EC, despite OCPs and the copper IUD being readily available in the RH kits, public and private hospitals, and pharmacies.

Our findings in the second and third articles suggest that although Syrian refugee women have little to no initial information about EC, once informed, they are grateful and excited about this discreet method of contraception. Given these findings, expanding and supporting access to EC in the public, NGO, and private sectors, and incorporating EC into national standards of care, should of paramount importance.

Our third article demonstrates that incorporating SRH services into interventions related to education for child brides and mainstreaming is critical. Other subjects of intervention including GBV, education, and water, sanitation and hygiene (WASH) are often segregated from SRH interventions. This should not be the case. Rather, these seemingly unrelated fields should incorporate SRH programming into their mandates. Indeed, participants from our intervention programming expressed that the isolation of these different fields is not appropriate. SRH issues, and contraception in particular, are as critical to improving the quality of life of these vulnerable populations as is violence prevention and intervention, education, clean water, and hygiene. To ignore SRH services and needs, or to address it separately, is to provide an incomplete intervention, and ultimately, inadequately address child brides' basic needs.

Finally, our findings suggest that there is a significant need to work with primary care providers to overcome biases against Syrian refugees, especially child brides. The findings from all three articles demonstrate that physicians and health service provider biases shape access to services, particularly in the form of services and accurate information being withheld from Syrian refugee women and girls. The fear of discrimination among women and girls represents a significant barrier to accessing SRH services. Therefore, incorporating more values clarification and transformation exercises into service trainings for primary care providers is a critical step to improving care.

The findings outlined above are consistent with what has been outlined and recommended by several previous National Plans in Jordan, though structural difficulties and shifting health care priorities have prevented their realization. As Jordan embarks on its next five-year planning process, "SRH in all policies" should be considered.

Dissemination of the findings

Over the last year and a half, I have prioritized disseminating the results of this study to a wide variety of audiences. In 2017-2018 I gave both poster and oral presentations at a number of international meetings and conferences. This included the 17th annual meeting of the Inter-agency Working Group on Reproductive Health in Crises (Athens, Greece) and the 2017 EC Jamboree hosted by the International Consortium for Emergency Contraception (ICEC) (Washington, DC). I also had the opportunity to present the EC-related findings at a global webinar hosted by the ICEC. Further, given that our intervention program was funded through UNWomen, we were able to disseminate our findings to the Canadian and Spanish Embassies

through multiple field visits to our sites. The initiative Steering Committee convened every four months to discuss the outcomes and challenges faced by the intervention project. During these meetings, members of the Steering Committee, including me and Dr. Foster, took the opportunity to present the findings of our study with stakeholders working on prevention of early marriage and/or sexual and reproductive health projects in Jordan. I also had the opportunity to present the findings from our study at a Middle East and North Africa regional conference hosted by TRY Center in the summer of 2019. The feedback from the participants and stakeholders at these dissemination events informed my recommendations.

Recommendations

In order to improve access to and provision of EC to Syrian refugees in Jordan, the infrastructure, health systems, and policies must align with global standards of care. Below, I offer several recommendations generated from the study and feedback from key stakeholders that aim to improve the provision of EC and SRH services more broadly to Syrian refugees in Jordan.

Emergency contraception is an important aspect of the immediate and comprehensive humanitarian response. Given that Jordan, to date, still does not have a dedicated ECP, this is a huge barrier to access for both urban- and camp-based refugees. Although ECPs are available in the RH kits, our findings suggest that these are only being provided—and infrequently so—to Syrian refugees in camps. Given that 71% of all refugees are residing in urban settings (UNHCR, 2019b), a registered ECP product must be distributed to all health sectors so Syrian refugee women and girls have access through NGOs and private and public health sectors. Further, as

EC provision remains infrequent and inadequate in camp-based settings, additional training on EC as an integral pregnancy prevention method in the MISP seems warranted.

Though registration of a dedicated ECP is a critical step, increasing access to EC through the use of existing technologies is also a priority. IUDs and OCPs are widely available through both the public and private sectors; therefore, health care providers need to be trained to provide post-coital contraception with these methods. It is also important to identify ways to provide information on EC in both English—the language of training of most physicians—and Arabic. Suggested modes of distribution include online resources and physical educational materials that can be distributed or provided in person to both clinic and community settings.

Our study findings align with a body of research that shows that women and girls are less likely to access health services if they are treated disrespectfully or if they perceive the quality of service that they are receiving to be subpar. Therefore, engaging physicians and primary care providers in culturally sensitive training and values clarification workshops (especially on how to handle the SRH needs of child brides) could be an initial step to reduce discrimination and improve service quality.

A significant barrier to SRH service accessibility is cost. Women and girls in urban settings are required to pay for services that are otherwise subsidized for those who reside in camp settings. As such, urban women interviewed for our study reported that some women are unable to access EC due to cost. Considering that child brides' social and financial situations tend to be more dire, their access to SRH services are sure to be more affected by cost than other populations. An overarching subsidy for contraceptive methods, including EC, should be considered for non-Jordanians residing in Jordan.

Access to SRH services, or lack thereof, has influences educational attainment, social capital, and economic security. Therefore, SRH cannot be addressed in a vacuum and should not be isolated from other subjects of intervention in humanitarian settings. Our intervention with the girls in Irbid addressed SRH in relation to educational attainment and retention. Initial results from our intervention indicate that SRH education and programming for child brides may contribute to their success in formal education. Though the results are not yet final, they do suggest that SRH education and access to services should be integrated into all types of humanitarian interventions.

Limitations

As is true with any qualitative study, our findings are not meant to be generalizable nor representative (Crouch & McKenzie, 2006). Rather, this multi-methods qualitative study sought to provide "a rich, contextualized understanding of human experience through the intensive study of particular cases" (Polit & Beck, 2010, p. 1452). Through our key informant interviews, we aimed to receive a wide range of perspectives, which we believe we achieved. Thus, we are confident that the results of our study are transferrable and relevant beyond the bounds of the immediate study population. However, we are unable to assess the degree to which these experiences represent broader patterns among different Syrian communities across Jordan.

We recruited women and girls for our study through two local refugee-focused organizations: the Institute for Family Health and Family and Childhood Protection Society of Irbid. Although these organizations have a wide reach due to their excellent reputations and long-standing work with refugee communities, women who are not familiar with these

organizations, or have limited mobility would not be able to partake in our intervention study. Indeed, only those women and girls with relatively high degrees of autonomy are able to participate in FGDs; lack of SRH knowledge and barriers to accessing care are likely even greater among those with less autonomy. Although I am fluent in Arabic, there are always challenges when working in multiple languages. As my Arabic dialect is Egyptian, there is a possibility that nuances or subtlety may have been lost in translation.

Positionality and reflexivity

True to any qualitative study it is important to acknowledge the positionalities of the researcher and their impact, or potential impact, on the research and interpretation of the data (England, 1994). Reflexivity is the process by which the researcher actively reflects on how her positionalities, including physical characteristics, experiences, and values, impact the undertaking of the research (Macbeth, 2001). Reflexivity provides the researcher and the overarching research team the opportunity to understand better the life-cycle of the research (Nencel, 2013). I believe I was well positioned to take on this project. My positionalities, such as being Egyptian and a native Arabic speaker, but simultaneously being from Norway and Canada added a unique dimension to my role in this setting. Linguistic and cultural similarities allowed me to build community and trust with participants; however, my Western positionality also added an element of trust as I was not an integral part of their communities. As a result, women generally felt comfortable disclosing things that they may not normally disclose within their own social networks. And as I am able to work professionally in English and Arabic I did not need an interpreter to assist me in the field. Further, after completing my undergraduate

degree, I moved to Amman for a year as a CRHC Fellow before starting my master's degree. During my time in Jordan, and through the mentorship of Dr. Foster, I was able to form a number of relationships with community organizations. During the year I spent in Jordan I gained a better understanding of customs and traditions which I was then able to more deftly navigate throughout my fieldwork.

As part of the qualitative research process, I employed extensive note-taking during interviews, debriefing sessions with my supervisor, and memoing after the interviews and focus group discussions. These activities allowed me to identify recurrent themes. It is worth noting that memoing and debriefing sessions were effective in identifying and reflecting on my positionalities. These exercises also allowed me to identify my own subjectivities and ways in which I could mitigate them.

Conclusions

The United Nations has declared the Syrian crisis the worst humanitarian crisis of the 21st century. Our study findings suggest that despite significant funding streams in Jordan, there are still service delivery and access challenges for refugees who reside both in camp and urban settings. Identifying ways to address the SRH needs of Syrian refugees, and Syrian refugee girls who marry under the age of 18 in particular, seems pressing. Implementing existing policies and regulations that benefit the SRH and educational needs of Syrian refugee women and girls would improve Syrian refugees' overarching livelihood in Jordan. Given the success of the different components of our intervention, we believe that scaling-up programs to facilitate re-enrollment of Syrian refugee girls who were married under the age of 18 into schools while

simultaneously providing SRH workshops to delay pregnancy is an effective model to improve displaced girls' lives.

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Appendix A: Map of Jordan

Appendix B: University of Ottawa Ethics Approval Letter

File Number: 05-16-20 **Date (mm/dd/yyyy):** 06/04/2019

Université d'Ottawa University of Ottawa
Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Ethics Approval Notice

Social Sciences and Humanities REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

First Name	Last Name	Affiliation	Role
Angel	Foster	Health Sciences / Others	Principal Investigator
Kate	MacFarlane	Health Sciences / Others	Co-investigator
Cari	Sietstra	Others / Others	Co-investigator

File Number: 05-16-20

Type of Project: Professor

Title: Assessing the Reproductive Health Needs of Refugees: A Multi-Country Study

Renewal Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
06/30/2019	06/29/2020	Renewal

Special Conditions / Comments:
N/A

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Appendix C: Higher Population Council of Jordan Study Approval

دراسة زواج القاصرات في االردن

يبر املجلس االعلى للسكان ان يصدر دراسة »زواج القارصات يف االردن«، والتي هدفت ابل تشخيص كمي ونوعي ملشكلة زواج االناث دون سن 18 سنة يف االردن من واقع بيانات التعداد العام للسكان واملساكن لعام 2015 ،ودراسة اسباب املشكلة واثارها وامتدادها املكاين. وقد أعدها املجلس ضمن جهوده يف متابعة التحوالت الدميوغرافية التي مير بها االردن

يعتبر زواج القارصات انتهاكا للعديد من الحقوق اإلنسانية املرشوعة للفتيات ومنها الحق يف التعليم، والحق يف تنمية القدرات واالختيار الواعي دون إجبار عى رشيك الحياة، والحق يف ضمان تكافؤ الزواج وبناء عالقات أرسية سوية، وينعكس إهدار تلك الحقوق سلبيا عى نوعية وجودة الحياة للفتاة، وعى صحتها اإلنجابية، فضا عن االثار االقتصادية، وعى قدرة االرسة عى القيام بواجباتها يف تربية النشء، خاصة ان بناء االجيال الجديدة مرهون بخصائصها، كا يهدد الخصائص السكانية للمجتمع والجهود الرامية ابل االنتفاع من مرحلة التحول الدميوغرايف التي مير بها االردن.

ويف الختام فإننا عى ثقة بأن هذه الدراسة ستشكل اضافة نوعية للدراسات الوطنية، وستكون إحدى االدوات املهمة لرسم السياسات واعداد الخطط والربامج للحد من مشكلة زواج القارصات يف االردن. وفقنا الله جميعاً لخدمة أردننا الغايل ومجتمعنا االردين بقيادة صاحب الجاللة الهاشمية املللك عبدالله الثاين ابن الحسن املعظم حفظه الله ورعاه وسدد عى طريق الخر والفاح خطاه.