Primary

Women's Health
Volume 15: 1–10

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DOI: 10.1177/1745506519861224
journals.sagepub.com/home/whe

Reproductive health care utilization among refugees in Jordan: Provisional support and domestic violence

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Abstract

Objectives: Conflict and displacement are associated with poverty, disruption of services, loss of identity, reduced care for reproductive needs, and reduced provision of health care, among other things. This article uses the framework outlined by Obermeyer and Potter to test how refugee and native status influence utilization of reproductive health services and experience with domestic violence in a context of high refugee inhabitants and strong refugee-focused non-governmental organization presence. This article addresses the following: (1) coverage, source, and method of contraceptives; (2) variation in reproductive health experience by source of contraception; and finally, (3) factors determining variation in the utilization of reproductive health services and domestic violence experiences for individuals living in and out of refugee camps.

Methods: The data is the 2012 Jordan Demographic and Health Survey, and the method utilized is logistic regression.

Results: Findings suggest that refugee women serviced by the United Nations Relief and Works Agency have greater access to health-related resources (family planning and contraception), but they have weaker positions in the family as evidenced by domestic violence experiences.

Conclusion: It is plausible that provisional resources are the easiest for an aid organization to provide, while the complications of identity loss and the loss of a sense of space pose a challenge for refugees and aid organizations.

Keywords

displacement, domestic violence, maternal health, refugee, reproductive health

Date received: 3 July 2018; revised: 1 May 2019; accepted: 31 May 2019

Issues facing refugees and displaced persons are some of the most complicated humanitarian issues facing the Middle East, and perhaps the world. The UN Refugee Agency reports that there are 65.3 million people seeking protection and assistance as a consequence of forced displacement. Globally, 21 million are refugees, with 5.2 million of those listed as Palestinian refugees registered with the United Nations Relief and Works Agency (UNRWA). As of 2015, Jordan hosted the second largest number of refugees in relation to its population, with 87 refugees per 1000 native inhabitants.[1] Jordan has an extensive history with refugees, particularly Palestinian refugees since the 1948 displacement of more than 700,000 Palestinian civilians.

Conflict and displacement are associated with loss of livelihood, poverty, disruption of services, loss of identity, reduced care for reproductive needs, and reduced provision of maternal care, among other things.[2,3] In addition, maternal and neonatal mortality among refugees can be high due to limited reproductive health care available in most refugee settings, leaving many needs unmet.[4] Women are also more vulnerable to rape during times of displacement and flight, making refugee women particularly vulnerable to gender-based violence during flight from conflict and in refugee camps.[5]

As a response to this constant Palestinian refugee crisis, the UNRWA was created in December 1949 in order to provide relief services, including health, to Palestinian refugees.[6] Over the years, governments and non-governmental

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organizations (NGOs) have heeded the opportunity and obligation to step in to provide the services often lost in displacement. Following the Geneva conference of June 2004, UNRWA implemented several reforms. While underlying its role in advocating and providing for the development and humanitarian needs of the Palestinian refugees, the agency has a renewed commitment to meeting the human development aspirations of refugees through basic education, primary health care, social safety nets, infrastructure improvement, and microfinance.[7] This raises an important question: when displacement severs ties to health care, schools, and economic means to provide health care, can governments and NGOs make up the difference? Or, at least in the case of Palestinian refugees, do 50 years of exile and three generations of refugees engender different experiences of "refugee-ness" causing different attitudes of adaptation to changing political contexts and economic opportunities and investment in government and NGO support? While this research cannot prove the causal relationship here, it can only demonstrate convincingly that the political and social forces behind Palestinian displacement are too comprehensive and long-lasting to not be random.

Obermeyer and Potter[8] looked into the patterns and determinants of maternal health care utilization in Jordan, using data from 1983. This research uses their model as a framework to test how refugee and native status influence utilization of reproductive health services in a context of high refugee inhabitants and strong refugee-focused NGO presence, with particular focus on the intersections between refugee status, reproductive health, and social dynamics. This article addresses the following:[1] the regional coverage, source, and method of contraceptives;[2] variation in reproductive health and social experiences by source of contraception; and finally,[3] factors determining variation in the utilization of reproductive health services and experience with domestic violence.

The sociodemographic situation

Jordan is an almost entirely landlocked country located in the Middle East with a population of 6.5 million. Obermeyer and Potter[8] noted that Jordan was going through rapid social and demographic changes in the 1980s. At that time, Jordan had a total fertility rate (TFR) of 7 lifetime births per woman, some of the shortest average birth intervals ever recorded, and 26% contraceptive use among married women of reproductive age.[8]

Looking three decades later, the population has a relatively high TFR (3.31 births per woman) compared to the world average and surrounding countries—Syria (3.00), Israel (3.04), and Saudi Arabia (2.70)—but drastically reduced from a TFR of 7 in 1983.[9] Even quicker gains have been made for reproductive health.[10] Knowledge of contraceptive methods is very high in Jordan, almost 100% starting in 1990.[10] Current contraceptive use has significantly increased from 40% in 1990 to 61% in 2012, and the percentage of women using modern methods is higher than those using traditional methods throughout those years.[10] Since the report from Obermeyer and Potter, Jordan has continued to experience drastic changes where some indicators have neared completion and others still have significant room for improvement; but overall, reproductive health indicators are improving throughout Jordan.

Recent health policies in Jordan

Policy efforts by the Jordanian government may play a role in this reproductive health progress. The first official population policy was proposed and accepted in 1993 when the National Population Commission (NPC)[11] of Jordan adopted the National Birth Spacing Program. The Birth Spacing Program was intended to increase maternal and child health and reduce fertility while considering the social, national, religious, and free-choice dimensions of Jordanian society. In 1996, the NPC created the National Population Strategy for Jordan, which was later updated in 2000. The strategy was written in light of international and regional recommendations and focused on four domains: reproductive health, gender equality and empowerment of women, population and sustainable development, and population and enhancing advocacy.[11]

The current policy climate is focused on renewed attention to the basics. The Ministry of Health (MoH) has created the National Health Strategy for the years 2008–2019. All programs, plans, and policies from these strategy documents focus on primary, secondary, and tertiary health care.[12] In addition, The Higher Population Council of Jordan compiled a "Policy Document" titled, The Demographic Opportunity in Jordan, which was presented in October 2009. This document established goals to be met by 2030 to utilize a window of opportunity for Jordan.[11] Like many countries before, a decline in fertility rates, paired with social and economic improvements, opens a window to a period of great potential.[13]

The National Health Strategy, presenting the importance of investing in the demographic opportunity, suggests the importance of complementing and supporting the National agenda as well as national strategies such as the National Population Strategy, the National Reproductive Health/Family Planning Action Plan, as well as education training.[11,12] Reproductive health provides important indicators that can be used to assess a country's socioeconomic situation and quality of life.[14] They are also useful to measure quality of health programs and guide future policy decisions. The following are policies to accelerate the demographic shift and reach the demographic opportunity period that are relevant for this research: further reducing the TFR, increasing effectiveness of reproductive health/family planning (FP) programs, and raising awareness and knowledge about the relationship between population issues and FP.[11,12,15–23]

Since the early 2000s, national level policy has placed great emphasis on improving reproductive health throughout Jordan. This suggests that Jordan should have high levels of care and good outcomes for their nationals as well as their more vulnerable populations.

Severed ties for refugees

Displacement has been shown to sever ties to health care, education, and safety.[5,24–26] Disruption with reproductive health services, in particular, is problematic because it is often seen as a first line of defense in protecting against female ill health in conflict or flight settings where resources are often inadequate or unavailable.[26] Research suggests that refugees experience reduced access to reproductive health care services, causing limited contraceptive use around the world.[24] This limitation can stem from unfamiliarity with FP or other health programs, ineligibility for health benefits, time barriers, financial limitations, or transportation difficulties. At the same time, they may have less access due to supply limitations or a lack of facilities or staff.[20] In addition, the susceptibility for unintended births and other reproductive health risks increase as women begin sexual relationships at earlier ages, take more sexual risks, and face exploitation on the absence of traditional sociocultural constraints, all of which are associated with displacement.[25] Moreover, women in displacement, left in situations accompanied by powerlessness, poverty, and lack of security, may resort to prostitution or trading sex for protection of food in order to survive.[26]

A possible paradox arises when looking at immigrant health. A systematic literature review about immigrant woman's health, including refugees, found that for all types of health services, immigrant women are more disadvantaged and face greater barriers to utilizing health services than nonimmigrant women.[27] Regardless of barriers to utilization, a few studies noted that infant birth weight, prematurity, and mortality are often superior among immigrant women, though these findings may not be tied to the refugee population. Scholars attribute these superior outcomes to lifestyle choices regarding smoking, drugs and alcohol use,[28,29] or an increase in family support during pregnancy.[30] Nevertheless, there are many pregnancy-related problems for immigrant women; tuberculosis (TB) infection, parasites, and depression are particularly high among refugee women.[31]

Domestic violence against women is seen as a violation of human rights and a significant public health issue. One in three women has been coerced into sex, beaten, or otherwise abused in her lifetime.[32] Women of all reproductive ages are at risk of intimate partner violence and marital status, and pregnancy does not protect women from this physical or mental abuse.[33] Refugee women are especially vulnerable to gender-based violence during conflict, flight from conflict, and in refugee camps, when disintegration of social structures or flight from war-torn countries is occurring.[5] Domestic violence against women has been linked with nonuse of contraception, unwanted pregnancy, and obstetric complications.[34–36] Despite its increasing global importance, there has been little research on domestic violence against women in the Arab region. The studies that are available suggest that the majority of Palestinian refugee women are subjected to physical or emotional abuse at some point in their lives.[33,37,38] An additional finding is that men and women have a similar disposition about wife beating (acceptance around 60% in Jordanian refugee camps), which has only become more acceptable.[39] In addition, 44.7% of women in Jordanian refugee camps will experience domestic violence in their lifetime.[38]

The available data on reproductive health suggest that poor outcomes are common in many populations affected by conflict.[16,20,40] Considering the disruption in services and increase in certain risk factors, the literature suggests that this research will discover lower use of contraceptives, restricted access to FP services, and increased experiences with domestic violence.[20,33,37,41] However, these outcomes may be no more common in refugee camps than in extremely poor host or home countries with a lack of infrastructure and services.[27] Women in refugee camps may in fact receive better care than was available in their home country, or is available to the local population if the infrastructure is in place to serve their needs upon displacement. Most research on the effects of displacement on women's health has been almost exclusively problem or risk oriented. A more balanced view of refugee women is warranted due to the conflicting research findings.[27]

Government and NGO reproductive health services in Jordan

Ties to health care are severed upon displacement, thus increasing the chance for negative health outcomes.[15,16] However, there is a conflicting body of research that suggests that displaced women may be better off in certain health indicators.[27] These conflicting findings intimate that in some refugee settings, interventions can be utilized to offset many potentially detrimental factors introduced upon displacement. This opens the door for government and NGOs to implement policy and programs to increase access to health care for refugees.[7,23]

As a response to the refugee crisis affecting Jordan since 1948, the UNRWA was created to provide relief services, including health, to Palestinian refugees.[6] By July 1993, UNRWA became one of the leading providers of FP services in Jordan when they adopted a more comprehensive maternal health strategy. UNRWA currently works through a network of 23 clinics both inside and outside refugee camps, providing free care to Palestinian refugees. All Palestine refugees registered with UNRWA in Jordan—whether they

reside in camps or outside camps—are eligible for UNRWA services. However, those living in or near the camps have easier access to services.[7]

The UNRWA supports health facilities and community development centers that offer a wide range of programs to women in the Palestinian camps. These services include reproductive health care, economic empowerment that enhances female economic opportunities through training on traditional and non-traditional skills, income-generating programs, and cultural and educational programs, including legal literacy.[42] In regard to violence against women, the United Nations reports that UNWRA provides legal counseling, psychological counseling, referrals, health care, investigation, court representation, advocacy, help hotlines, campaigns, and networks to support women.[43]

The data

The data used in this analysis comes from *The Demographic and Health Survey* (DHS), which has been administered in over 90 countries, advancing global understanding of health and population trends in developing countries. DHSs are nationally representative household surveys of women of childbearing age (15–49). They include information regarding health, nutrition, and FP. This analysis utilizes the individual recode data, which has one record for every respondent. This specific data set is the *Jordan Population and Family Health Survey* (JPFHS) and was gathered from September to December 2012. The JPFHS 2012 is a collaborative effort between the Jordanian Government, the U.S. Agency for International Development (USAID), and other outside donors. This location and year were selected because there is access to information about refugees and domestic violence, which are not always available in other DHS country data sets. The sampling methodology of the JPFHS yielded a sample of 10,105 women aged 15–49.[44]

The JPFHS sample for the refugee camp areas was identified by the Department of Statistics based on UNRWA records. The camps are defined at the block level. A cluster is defined as camp if refugees represent 80% of the total population or more of the cluster. With this cutoff, only 33 clusters with refugee population were not counted in this domain. For reference, there are 13,025 clusters in Jordan. The average size of a cluster is 74 households in the urban areas and 62 in the rural areas. The overall average size is 72 households, which is adequate for a sample of 20 households per cluster. The refugee camps exist only in urban areas.

Measures

The outcome variables include modern contraceptive use, being taught FP at a health facility, being given contraceptive advice from medical personnel, source of contraception, and experience with domestic violence. Modern use and intent is a dichotomous variable comparing those who currently use modern contraception or intend to use modern contraception later and those who use traditional methods or do not intend to use modern contraception later (coded 1 = modern or intent and 0 = traditional or no intent). Taught FP at health facility is a dichotomous variable that compares women who reported being taught about FP at their health facility in the last 12 months and those who reported no mention of FP at the facility (coded 1 = taught FP at health facility and 0 = no FP at health facility). Similarly, FP advice from medical personnel compares women who reported being advised on contraceptive methods from medical personnel and women who reported having no outside advice or advice given from a family or friend (coded 1 = FP advice from medical personnel and 0 = FP advice from family, friends, or no one). Source of contraception is a dichotomous variable coded as 1 = UNRWA and 0 = private or public. Experience with domestic violence is a dichotomous variable coded as 0 = no experience with domestic violence and 1 = at least some experience with domestic violence, with domestic violence including women who have ever been pushed, shook, slapped, punched, arm twisted or hair pulled, kicked, dragged, strangled, burnt, or threatened with a weapon. And finally, experience with emotional violence is a dichotomous variable coded as 0 = no experience with emotional violence and 1 = experience with emotional violence. Emotional violence experiences include being humiliated by your husband, being threatened with harm by your husband, or made to feel bad by your husband. It is important to note that the emotional violence is often bi-directional. Men engage in it against women, but women engage in it against men as well, but these data do not allow me to test for this.[44]

Results—the coverage of reproductive care

The analysis of the use of reproductive health services is based on the entire sample of ever married women. However, all analysis completed with domestic violence measures is based on data from a subsample of women who were selected for the domestic violence module. There were 6570 such women out of the 10,105 women in the total sample. The sociodemographic characteristics of the subsample were similar to those of the sample as a whole (Table 1).

Table 1 presents the overall distribution of the maternal, household, and socioeconomic variables in this subsample and the domestic violence module subsample. Almost 9% of the population lives in a refugee camp, while 4% of the domestic violence subgroup lives within the camp. Both the whole population and the domestic violence subsample are predominantly aged 25–39, with just over 30% being 40–49 and 13% being 15–24. Overall educational levels are

Table 1. Individual and household characteristics of the 10,105 women interviewed (JPFHS 2012).

Characteristic	Category (if continuous)	Percent (mean)	Domestic violence subsample percent (mean)[a]
Resides in refugee camp		8.95	4.18
Woman's age	15–24	12.57	12.91
	25–39	56.54	55.39
	40–49	30.90	31.70
Number of children living	(1–15)	(3.602)	(3.497)
Women's education	(0–19)	(10.937)	(11.085)
Employed		17.92	16.43
Standard of living (electricity, flushing toilet, TV and refrigerator)		94.88	94.90
Number of people in household	1–4	29.29	30.12
	5–7	48.27	47.89
	8+	22.43	21.99
Children in household aged 5 and under	0	35.62	36.87
	1–2	55.80	55.43
	3+	8.58	7.71
Husband's education	None	1.67	1.21
	Incomplete primary	6.17	5.89
	Complete primary	5.49	4.64
	Incomplete secondary	49.39	46.10
	Complete secondary	13.36	13.14
	Higher	23.60	29.02
Experienced mild domestic violence			21.04
Experienced severe domestic violence			5.69
Experienced emotional violence			24.71
Domestic violence is ever justified		24.32	21.35

[a]Domestic violence subsample N = 6570.

relatively high, with a mean completion of 11 years of schooling. About 18% of women work in the private sector or are self-employed, and 95% of houses have all amenities—electricity, flush toilets, television, and refrigerator. Almost 50% of women have 5–7 people in their household, with 1–4 people and 8 or more people equally sharing the remaining 50%. In addition, over half of these households (55.80%) have one to two children age five and under in the household, and only 9% have three or more children in the house. In terms of experience with domestic violence, 21% of women say that they have ever experienced mild domestic violence (including ever been pushed, shook, slapped, punched, arm twisted, or hair pulled), almost 6% say they have experienced severe domestic violence (including ever been kicked, dragged, strangled, burnt, or threatened with a weapon), and 24% of women say they have experienced emotional violence (including ever been humiliated, threatened, or insulted by husband). All of this considered, over 24% of women say that domestic violence is ever justified in cases of a wife going out without telling her husband, neglecting the kids, arguing with husband, or less often, if the wife burns the food.

The distribution of respondents according to their utilization of contraceptive services is presented in Table 2. Around 40% of women currently use modern contraception in all three regions, with the highest percent in the refugee camp (43%), next in urban areas (40%), and finally in rural areas (39%). Among such women, the most prevalent method is the intrauterine device (IUD) in all three regions. In the refugee camps, 35% of women use the IUD, 20% use the pill, 13% use the condom, 19% use withdrawal method, and 13% use others methods (comprising injections, female sterilization, periodic abstinence, lactational amenorrhea, and diaphragm). The method mix for urban and rural women is similar to each other. The specific method mix for rural women is 28% of women use the IUD, 17% use the pill, 10% use the condom, 27% use withdrawal method, and 17% use another method. The main source of contraception for the urban and rural women is the government, while 55% of refugee women rely on the UNRWA.

Table 3 presents information on the type of reproductive health choices and care women have or receive according to the provider of modern contraception and attempts to give, however crudely, some sense of their reproductive health and domestic violence experience. Reproductive health experience is based on their visitation from a FP worker in the last year, their introduction to

Table 2. Percent distribution according to the use, source, and method of contraception, by region (JPFSH 2012).

Variable	Refugee percent	Urban percent	Rural percent
Contraceptive use and intention			
Using modern	42.70	39.83	39.00
Using traditional	14.38	18.36	21.41
Intends to use later	18.47	21.04	19.75
Does not intend to use	24.45	20.76	19.83
Contraceptive source			
Government	14.81	49.67	57.63
UNRWA	54.81	4.93	2.56
Private/pharmacy	29.31	43.18	37.78
Other	2.08	2.23	2.03
Modern contraceptive method[a]			
Pill	19.96	13.45	16.86
IUD	34.88	34.31	28.42
Condom	13.37	11.53	9.98
Withdrawal	18.60	24.58	27.25
Other[b]	13.18	16.13	17.48

[a]Only for women currently using modern contraception, so n = 5924.
[b]Others include injections, female sterilization, periodic abstinence, lactational amenorrhea, and diaphragm.

Table 3. Percent distribution of women using modern contraception according to reproductive health variables, by source (JPFSH 2012).

	Source of contraception[a]		
Reproductive health variables	Public	Private or pharmacy	UNRWA
Visited by family planning worker in last 12 months	20.15	18.07	35.98
Told about family planning at health facility	35.74	28.58	48.36
Person who advised family planning method			
No one	35.24	33.90	29.63
Medical personnel	51.78	49.29	55.56
Family or friend	12.98	16.82	14.81
Modern contraceptive method			
Pill	26.56	15.86	34.66
IUD	35.64	63.12	35.71
Condom	19.04	11.33	24.87
Other[b]	18.76	9.69	4.76
Experienced domestic violence			
Mild	19.13	15.21	30.60
Severe	5.21	3.13	8.62
Emotional	22.21	18.75	31.47
Beating is ever justified	25.17	22.13	31.22

[a]Source of contraception is only listed for women receiving modern contraception, so n = 2845.
[b]Others include injections, female sterilization, periodic abstinence, lactational amenorrhea, and diaphragm.

FP at a health facility, the person advising their choice of contraception, the modern contraception method, and their experience with domestic violence. For the women who receive their modern contraception from the public sector and pharmacy or private health sector, they were about half as likely to be visited by a FP worker in the last year compared to women who received their contraception from UNRWA (20.15, 18.07, and 35.98, respectively). Similarly, they were less likely to talk about FP in a health facility. Medical personnel advise the greatest proportion of contraceptive methods in all three cases, followed by no outside advice and then advice from a family member or friend, but women receiving contraception from UNRWA had slightly more advice given from medical personnel. The women who receive their contraception from UNRWA are more likely to have experienced mild, severe, and emotional domestic violence and more likely to say that beating is ever justified in certain

Table 4. Logistic regression of reproductive health showing odds ratios for background variables (JPFSH 2012).

Variable[a]	Modern use and intent	Taught FP at health facility	Given FP advice from medical personnel	UNRWA source of contraception	Experienced domestic violence	Experienced emotional violence
Residence (urban)						
Refugee camp	1.109	1.751**	1.154	13.331**	1.248*	1.379**
Rural	0.906	0.762**	0.953	0.477**	0.677**	0.706**
Woman's education	1.053**	1.021*	0.997	0.990	0.928**	0.946**
Woman's age (15–24)						
25–39	0.559**	0.704**	1.173	0.617*	1.001	1.235
40–49	0.181**	0.339**	1.321*	0.240**	0.812	1.157
Employed	0.750**	1.030	0.777**	0.660*	1.040	1.016
Living children	1.277**	1.092**	1.054**	1.174**	1.016	0.992
Wealth i ndex	1.068**	0.914**	1.074**	0.889*	0.828**	0.906**

[a]The reference category is in parentheses. All variables are dichotomous except woman's education, number of living children, and wealth index.
*$p \leq 0.05$; **$p \leq 0.01$.

scenarios. In total, 31% of women using modern contraception from UNRWA have experienced mild domestic violence and 9% have experienced severe. In comparison, 15% and 3% of women who use contraception from a pharmacy or private source have experienced mild or severe domestic violence, respectively.

Results—differentials in reproductive care

Although substantial differentials exist in the various measures of reproductive health and domestic violence experiences according to these social and demographic variables, it remains to be seen to what extent the observed relationships are independent of each other. How are the differentials in access and utilization altered when the association is adjusted for the simultaneous effect of the different characteristics of the respondent? To address this question, I carried out a logistic repression analysis of the variation in each of the reproductive health care and social measures. The predictor variables are the respondent's residence, education level, age, employment status, number of living children, and wealth index.

The results of these analyses are presented in Table 4. The first analysis looks at the use of and intent to use modern contraception compared to women who currently use a traditional contraceptive method or do not plan to use contraception in the future. The model indicates that educational attainment, age, employment, number of living children, and wealth have a significant effect on use of modern contraception. Increased education, a larger number of living children, and higher wealth are associated with increased use of modern contraception, while older age and employment are associated with less use of modern contraception. Residence proved not to be a significant predictor of utilization of modern contraception, though living in a refugee camp increased the likelihood of using modern contraception.

The second and third analyses look at a respondent's interaction with FP and contraception in health facilities. The second model specifically looks at women who have discussed FP at their health facility. The model indicates that living in a refugee camp, education, and having more living children significantly increases the likelihood of talking about FP at a health facility. Living in a rural setting, older age, and increased wealth significantly decreases the likelihood. The third analysis looks at a woman's chance of receiving contraceptive advice from medical personnel in contrast to no outside advice or advice from family or friends. Being aged 40–49, larger numbers of living children, and increased wealth are significantly associated with increased advice from medical personnel. Alternatively, employment was significantly associated with decreased advice from medical personnel. Residence and education level did not have a significant effect, though living in a refugee camp increased the likelihood of medical personnel advice.

The fourth analysis looks at having UNRWA as a source of contraception for women who are currently using a form of modern contraception. Women in refugee camps are over 13 times more likely to utilize UNRWA for their contraception, and women with larger numbers of living children are also significantly more likely to use UNRWA. Increased age, employment status, and increased wealth are significantly associated with less use of UNRWA for modern contraception.

Finally, the last two models look at experience with domestic violence. Residence, years of completed education, and wealth have a significant effect on domestic violence, both physical and emotional. Women who live in a refugee camp are about 1.3 times more likely to have experienced domestic violence and 1.4 times more likely to have experienced emotional violence, while women who have more education and increased wealth are less likely to have experienced these forms of violence.

Findings—refugee risk factors

The overall impression given by this survey is that the Jordanian population receives adequate reproductive health care services, but there are differentials within the population that are important to note. The refugee population receives reproductive health care that is on par or better than the care received by Jordanian nationals in urban and rural settings. The refugees have slightly higher modern contraception use and a similar method mix to the rest of the population. This is important bearing in mind that almost 55% of this population receives their contraception from UNRWA. Considering that care provided by UNRWA is high among refugees, looking at the FP experience of women who receive contraception from UNRWA tells us how a majority of refugee women are experiencing FP. Receiving contraception from UNRWA is associated with a greater chance of being visited by a FP worker, more chance of talking about FP at a health facility, and more contraceptive advice from medical personnel. This suggests that UNRWA provides more thorough FP care than both the private and public sectors. Similarly, UNRWA provides adequate prenatal services, similar to the private and public sectors. Most of these associations are statistically significant.

An additional statistically significant implication of refugee status is experience with domestic violence. Almost 31% of women who receive contraception from UNRWA have experienced mild domestic violence, almost 9% of women have experienced severe violence, and over 31% have experienced emotional violence. In comparison, 15%, 3%, and 19% of women who receive contraception from the private sector have experienced mild, severe, and emotional domestic violence, respectively. In addition, 31% of women who receive contraception from UNRWA believe wife beating is ever justified compared to 22% of women who receive contraception from the private sector. Similarly, women living in a refugee camp are almost 1.3 times more likely to have experienced violence. Women in these camps may be the same or perhaps better off in some regards, but their experience with domestic violence cannot be overlooked.

Discussion

This research suggests that being a female refugee hurts in some instances and seems to benefit in others. This seemingly unspecific conclusion begins to take clearer form upon further investigation. Though that answer remains, being a refugee is both beneficial and harmful, the data suggest that a single cause can have contradictory effects. In the case of female refugees in Jordan, camps improve outcomes tied to provision, while we simultaneously see breakdowns in outcomes tied to social life. The social breakdown and provisional success concepts begin to put structure to the ambivalence. Women appear to have greater access to health-related resources (FP, contraception, etc.), but they have weaker positions in the family, as evidenced by a wide range of physical and emotional domestic violence experiences.

It may be possible that this outcome does not just apply to refugee circumstances. All organizations providing aid or relief to any group of the population may get satisfied when it comes to success with provisions. Provisional success may be the easiest to administer and measure, making it a logical first step for an organization, but it cannot be the final goal. The implications for these social inadequacies are large with drastic problems that arise with domestic violence. This suggests that UNRWA and other organizations alike must figure out how to address social concerns as well as fulfilling the physical needs of their constituents.

We know that displacement severs ties to resources in the home country, including reproductive health care.[5,14–16,25,26] The available data on reproductive outcomes suggest that poor outcomes are common in many populations affected by conflict.[15,16] However, this research alternatively found that an organization with proper infrastructure could overcome many of the severed ties introduced with displacement.

UNRWA is a relief organization unlike any in the world. It is concentrated in a certain region, on a certain population, with extensive networks and resources.[42] This shows the good that one organization can do; however, it also shows how much work it would take to make these outcomes true for all refugees around the world. UNRWA has existed for over 60 years, working to network into communities and provide extensive care to Palestinian refugees. These positive outcomes for refugees did not happen overnight and are not the same across most refugee populations.

Regardless of the successes achieved by UNRWA, domestic violence, both physical and emotional, is an issue that must be further explored. This survey only asks about experience with domestic violence. However, research shows that in conflict situations, strangers are more likely to perpetrate sexual violence against women, that is, soldiers, guards, police, fellow refugees, local residents, and aid workers.[45] This suggests that violence is even more of an issue than this survey can show. UNRWA has many resources for refugees who experience domestic violence, regardless; over 31% of women who receive contraceptives from this source say that wife beating is ever justified. This suggests that there is significant room for improvement in domestic violence education and treatment within the UNRWA organization.

Refugee women appear to have access to health-related resources, but weaker positions in the family. This poses the questions, what does it really mean to be displaced? And what are the short and long-term consequences?

Speculation about the possible causes and consequences of this social breakdown can lead to a few conclusions. Displacement research brings up the complications of identity loss in addition to the loss of a sense of space.[3,46] Although Palestinian refugees have had a vast presence in Jordan for the last 70 years, there are still divisions in society both physically, by placing many refugees in refugee camps, and socially, through customs and practice. A commitment to the relative status positioning of the refugee and national population is clearly visible through their separation in space. When thinking about the clear social and physical boundaries that exist between much of the national and refugee population, it becomes clear how an outside organization such as UNRWA can fulfill provisional needs, but not overcome the impaired identity creation and sense of ownership one has over their physical space. It is important to note that many refugees in Jordan are not segregated into refugee camps, and refugee camps may have some national citizens as well. Regardless, this study shows that there are emotional and physical abuses occurring in the refugee camps that cannot be overlooked.

The literature on spatial cognition tends to focus on the symbolic power of place to represent people (e.g. the ghetto demeaning Black people by association).[46] This creates a paradigm worth considering. This study suggests that refugee camps have the power to help women receive on par or better reproductive care than the native population, but are these camps simultaneously creating a symbolic but pervasive sense of "other" between the refugee and native population? A sense of "other" that leaves refugee women vulnerable to abuse. This speculation is based on fieldwork in Metro Manila.[46] The research in Manila suggests that certain types of places (in my case, refugee camps), or the people associated with those places, elicit certain introspective states (mental states, including affect and motivation), which, in turn, predispose certain practices (in my case, physical and emotional abuse). Continuing with his line of thought, the idea of spatial decision making (whether to go and where to go) reminds us that Palestinian refugees are able to move into and out of these refugee camps, suggesting that certain refugees might be choosing to stay in these camps. This idea further complicates the issue—are abusive refugees abusive because they live in the refugee camp or do they choose to live in the camp because they are abusive? Regardless, research suggests that people adjust their actions in accordance to the symbolic boundaries separating spaces.[47] This suggests that there is something about these refugee camps that perpetuates domestic violence.

These complicated relationships between a sense of identity and ownership of one's space, refugee displacement, reproductive health, and support organizations is one worth focusing on; in fact, it is an issue of international urgency.[3] Displacement is affecting over 65 million people throughout the world. This research develops a more nuanced understanding of the intersection of migration, access to reproductive health care, and social dynamics and adds to the migration and health literature by proposing that displacement does not have to produce entirely negative outcomes. Governments and NGOs can step in to provide resources and care to reduce poor outcomes that are associated with populations in conflict. This research also suggests that the solution is not that simple. While camp settings provide a mechanism to provide services, is it simultaneously hurting one's ownership of their identity and their space? Is there a way that UNRWA and other organizations can address this issue? Finally, this research suggests that the work is not quick or easy, but it can be done, which should provide motivation but caution when intervening in the refugee camps.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The work was supported by the National Institute of Child Health and Human Development (grant no. T32-Hd007275).

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