Reproductive Health of Adolescent Refugees in Camp Settings

A qualitative Cross-National Needs Assessment
Analytical Field Qualitative Study

Analysis Report and Brief lit Review

2020

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Foreword

Higher Population Council (HPC) is pleased to issue This Analysis Report and Brief lit Review on "Reproductive Health of Adolescent Refugees in Camp Settings", which aims to develop an understanding of RH needs and risks of adolescent refugees in the context of forced displacement, and availability of, access to and barriers to services about which there is very little data.

Reproductive health greatly effects on the general health of individuals and society and reflects the health level of women and men of reproductive age and is the subject of increased attention from a development point of view to its fundamental effects on comprehensive development. The third goal of the sustainable development goals was considered to ensure that everyone enjoys healthy in all ages in terms of ensuring a healthy life and promoting well-being for all ages, an indispensable component of sustainable development.

Adolescents' reproductive health (RH) is a priority for the international community (WHO, 2016), however there is a paucity of evidence in relation to the experiences, perspectives and needs of adolescent refugees (AR) in camp settings. A significant gap exists vis-à-vis RH needs and health-seeking behavior of adolescents, and in particular those young refugees who are caught in humanitarian settings. Adolescents in refugee camps have limited access to services and face specific SRH needs and risks. Adolescents face specific vulnerabilities during displacement, and they suffer damage to support networks as well as intersectional discrimination and interrupted education. Moreover, many ARs in camps face several barriers including accessing services such as family planning, counselling (Lee et al, 2017), lack of supplies/period poverty and access to education, protection, and gender-based violence. This acts as a push factor for many ARs to leave settlements and move to urban areas where they are exposed to more risks and vulnerabilities.

The Higher Population Council attaches great importance to the issue of reproductive health, as an important component of population dynamics, HPC compare RH as good component to supports its efforts to achieve a balance between population growth and economic resources for the advancement of development, and creating an appropriate environment for realizing and investing the population opportunity, and strives to strengthen national programs Reproductive health, which greatly integrates family planning services, to allow Jordan to achieve stable and sustainable population growth and economic stability.

Secretary General

Dr. Abla Amawi

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The (HPC) also expresses thanks to the staff of the (HPC) who worked on the technical support, review, guidance, and direction for the study in its final form, hoping that this research will be a reference for researchers, and policy makers to add new tangible knowledge for influencing to produce better policies and practices in SRH&RR for adolescent at national and region level.

Contributors

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Executive Summary

Providing quality and comprehensive sexual and reproductive health (SRH) services for adolescents demands significant support and extensive efforts because of their rapid physical and emotional development and the potential risks imposed on them. Refugees are at higher risk of several issues such as early marriage and pregnancy, unplanned pregnancies, and sexual and gender – based violence.

Jordan host the second highest number of refugees per capita. Their continuous social and medical needs necessitate continuous support and organized efforts to achieve quality SRH services, which if unmet, progress into social and economic problems. There are 91,051 refugees in the 0 -4 age group, 140,227 in the 5-11 age group, 94,515 in the age group 12-17, 192,207 in the 18-35 age group, 114,808 in the 35-59 age group, and 26,856 in the 60 and above age group.

Assessing adolescent SRH needs, challenges, and barriers is essential to provide quality and comprehensive care. This report summarizes specific research findings and policy recommendations to improve SRH services for Syrian adolescents in Jordan. This report was co-developed with the Higher Population Council (HPC) in collaboration with the main investigator of the study. The research fund was specific for the assessment of SRH services needs and barriers encountered by Syrian adolescent refugees in Jordan. Adolescents and youth assessed in the study aged 17 – 24.

The Higher Population Council attaches great importance to the issue of reproductive health, as an important component of population dynamics, HPC compare RH as good component to supports its efforts to achieve a balance between population growth and economic resources for the advancement of development, and creating an appropriate environment for realizing and investing the population opportunity, and strives to strengthen national programs Reproductive health, which greatly integrates family planning services, to allow Jordan to achieve stable and sustainable population growth and economic stability.

Results of the study showed that Syrian adolescent refugees living in Jordanian camps, especially males, lack awareness and hence utilization of available SRH services they need. However, female reproductive health care in the refugee camp seems to be relatively adequate but there is generally a lack of knowledge and a low level of awareness about several topics related to SRH. Many interviewed participants excuse their aversion of seeking information about their SRH needs by the absence of any SRH problem or disease, thus, there should not be a reason to ask for an advice or seek help from someone. Participants also agreed that they

have not received any sexual education or any SRH services at school.
Key informants indicated the poor awareness level of Syrian adolescent refugees regarding sexual and reproductive health. Poor awareness and the fear of shame and stigma hindered adolescents from using many available reproductive health services. In addition, some cultural and social barriers affected their attitude toward accepting important sexual and reproductive health services, such as sex education, testing sexual transmitted diseases, abandoning child marriage, and more. Many of these issues were rarely addressed by most organizations, except for family planning and child marriage that were included in many organizational programs.

The findings and recommendations provided in this report are useful for all organizations working on SRH in Jordan including the Ministry of Health, non – governmental organizations, and academic institutions.

Chapter One
Introduction and Methodology

Preface

1. Although Jordan is endorsed with good primary health care that is readily available to the public, limited services are available for sexual health, especially for males, with almost no access to those who are not married, due to social stigmatism. Unmarried adults and adolescents of both genders, as well as divorced women and widows, are prey to such social barriers that prohibit their use of most, if any, SRH services. Fulfilling adolescents physical and sexual needs is essential, especially that they constitute 30.5% of the total population in Jordan. In the past, adolescents' needs were neglected, which led to misconceptions about SRH, seeking untrusted sources of information about SRH, and unsafe sexual behaviors. More recently, studies from the Jordanian HPC were showing that most adolescents and youth who participated in these studies expressed their urgent need for SRH awareness programs; addressing the challenges they encountered. Adolescents SRH needs have been neglected globally, which is evidenced by the lack of satisfactory research addressing adolescent SRH issues and needs.

2. This study was organized in five chapters; chapter I present the objectives and the methodology. Chapter II reviews the theoretical framework and previous studies which discussed refugees sexual and reproductive health, particularly in Jordan. Chapter III presents an analysis of the statistical data extracted from the refugees residing in Al Zaatari camp and from key informant providing services for refugees and provides a summary of the main findings. Chapter IV provides a conclusion of the results and recommendations.

Study Objectives

THE OBJECTIVE OF THE RESEARCH IS TO:

1. Develop a high depth of understanding on the reproductive health risks and needs of adolescent refugees in Jordan in the context of forced displacement, and availability.
2. Identify the availability of services and barriers to access SRH services.
3. Develop policy recommendations to improve the services provided to adolescents' refugees and will help in summaries the key findings and recommendations. and will be an increased desire for up-taking key findings to advance the development agenda of Jordan, particularly in relation to SDG3 and SDG5.

THIS STUDY WILL ANSWER THE FOLLOWING QUESTIONS:

1. addressing the RH needs and risks of adolescent refugees in the context of forced displacement, and availability of, access to and barriers to services about which there is very little data.
2. To inform public health policies and humanitarian programming in the field of refugee reproductive health in Jordan.
3. will help in highlight the need to factor access to sexual and reproductive health SRH services for adolescent refugees and host populations into the planning for transition from humanitarian aid to the humanitarian aid-peace and development nexus. It will contribute to social inclusion of refugees into planning for health of the host populations.

Methodology

The research design pursued a holistic approach to examine reproductive health of Syrian adolescent refugees, assessing any environmental and cultural barriers and psychosocial needs that impact their access and usage of reproductive services.

Study Community and its Sample

The study used a descriptive qualitative design with a detailed interview guide including open – ended questions. The World Health Organization (WHO), The United Nations Children's Fund (UNICEF), and the United Nations Population Fund (UNFPA) defined "youth" as those who are between 15 and 24 years old. However, the interviews were conducted with adolescents and youth refugees aged 17 to 24 years living in Al Zaatari camp in Jordan and with Key informants who worked directly or served adolescent refugees in SRH. Al Zaatari camp is in the northeast part of Jordan. The current estimation of registered Syrian Refugees in Jordan is 659,673 as of September 2020. About 125,484 are in camps and the rest are outside camps. Al Zaatari camp, which is in the northeast part of Jordan, is home to 76,688 refugees. This is the largest camp in Jordan. Therefore, participants were selected from Al Zaatari as it contains the largest number of Syrian refugee population. Youth between the ages 12 and 17 comprise 14.5% of the total population of refugees in Al Zaatari camp. In addition, Al Zaatari camp have a wide range of services, including community, health, education, and social services. It also provides food assistance, energy, water and sanitation, and provides protection. Key informants interviewed were providing direct service to adolescents, collaborating with an NGO that works with refugees, or worked on projects that targeted refugees. However, the work or service provided by all key informants was directly related to SRH with a long history of experience working on such projects or service.

Interview Guide

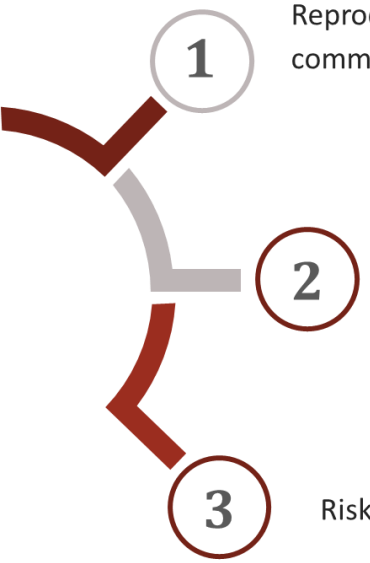
The interview guide used in this qualitative study has open – ended detailed questions that were developed based on the literature review related to from studies in the literature pertained with reproductive health among adolescents, especially studies focusing on refugee adolescents and youths. The guide used for the interview with youth and adolescents focused on the following issues:

1) Knowledge, attitudes, and utilization of reproductive services.
2) Availability, accessibility, and needs of reproductive services in schools and communities.
3) Adolescent and youth sexual behaviors including family Planning.
4) Experience of pre-natal, intra-natal and post-natal care for girls.
5) Sexual health including access to care, sexual violence, sexually – transmitted

infections, prevention and awareness programs, as well as abortion.

6) Adolescent and youth refugees' needs particularly in early marriages and mental health support.

FOR KEY INFORMANTS, THE INTERVIEW GUIDE WAS DEVELOPED TO MEET THE FOLLOWING THEMES:



1. Reproductive health services, including services availability, language and communication, barriers to care, visit information, and broader programming.
2. Adolescent refugee's reproductive health services, including specific needs, child marriage, contraception, sexually transmitted infections, patient safety and comfort, follow-up, and external care.
3. Risk factors in adolescent refugees

Data Analysis

Transcriptions of the recorded interviews were used for the analysis. Directed content analysis, also called Deductive content analysis approach was used in the current study, in which analysis was based on predetermined questions that needed to be answered by the participants during the interviews. This approach is useful in focusing on the research questions and providing predictions about the outcome measures of the study, and hence, help in determining the initial coding and relationships between codes. According to Elo and Kyngäs (2008) this approach can be used when a researcher has some idea about the responses from the participants. After transcribing all the interviews, data analysis began by identifying key concepts as initial coding categories. The interview questions were used as a guide to analyzing data, in which researchers identified all examples of a predetermined code. Coded data were then categorized into themes and subthemes.

Responses of each participant were typed into their corresponding questions then used to code the responses and group them based on the themes of the study. Answers were grouped within themes developed in the interview guide and the

overall attitude of the participants toward a specific aspect or concept within each theme was considered as a description of participants' response on that theme. Further, key messages were pointed out in the results to highlight their importance, which include quoting some statements of participants that illustrated these key messages.

The interview guide was initially developed in English, but to assure that participants fully comprehend the questions, it was translated into Arabic and then translated back to English to check the validity of the questions. The interviews were conducted in Arabic using the translated version of the guide.

Study Determinants

It is well known that qualitative studies - which are not limited to numbers and readings and are based on the experience of the studied groups - require relatively more time than statistical studies. The research team has a time limit for completing the study, therefore, it was not able to hold more interviews in other refugee camps in other part of the Kingdom.

Such sensitive studies require that the research team be fully committed to the ethics of research, and that participants and volunteers participate in the study, the matter which limits the access to more diverse and different experiences.

Finally, it is known that qualitative research does not lead to the generalization of its results. Consequently, the results of this study will not be distributed to other Syrian adolescent refugees in Jordan or to Jordanian adolescents except in relation to the statistical axis, and the magnitude of sexual and reproductive health needs and barriers for adolescents in Jordan, while the knowledge, perceptions and practices are pertained to study participants who are Syrian adolescents and key informants.

The challenges in the study were the sample of girls in our study does not entirely represent the actual situation of girls inside the camp in terms of level of education and working status. This issue is possibly due to the snowball sampling technique that we used to recruit participants. Second, having three Syrian refugee women who reported working with NGOs and providing education and awareness to the refugee community about SRH raise bias about their responses. Therefore, future qualitative research needs to use a different sampling technique to recruit participants, and thereby, ensure representation.

Study Features

The importance of assessing sexual and reproductive health of adolescent refugees is not limited to meeting their needs and improving their wellbeing, but it also reflects on the economic development of the host countries. Fulfilling adolescents physical and sexual needs is essential. However, most of the time, adolescents don't approach the right source of knowledge for safe sexual practices and correct reproductive knowledge, which commonly lead them to seek untrusted sources of information. These alternative sources of information, including the internet and peers, result in risky behaviors toward fulfilling their physical and sexual needs. As a result, unprotected sex, unwanted pregnancy, unsafe abortion, and sexually transmitted infections often occurs [8]. Such negative attitudes with limited access to financial resources will increase the likelihood of creating adults who possess irresponsible and risky behaviors that make them contribute less to their communities and form a source of nuisance to the society.

Lack of appropriate access of reproductive and sexual health services in refugee camps was one reason for the development of a common problem among adolescent of refugee camps, which is early marriage. In Jordan, one woman out of each four of registered Syrian refugees (25%) were of reproductive age, and among them, 2% were pregnant. As of June 2020, 11% of birth in Jordan's Zaatari Camp were to Syrian girls under the age of 18. In 2015, almost one third of marriages with Syrian women involved adolescents. Teenage marriage of young females limits their chance of continuing their education. Lack of education is devastating to young generations, and often results in low socio – economic status families that compose a burden on the healthcare system and the development of the economy. Additionally, pregnancy of adolescents was associated with high morbidities and mortality rate. Bearing a child at an early stage of life holds threats to the health of the adolescent mother and the infant. Physical composition of adolescent mothers, their level of maturity and awareness, and the lack of reproductive services are possible reason of the increased rates of such casualties. Maternal expectation of adolescents' close family members and surrounding environment that entails many cultural views on the responsibility of the girl to build a family on an early time of her life is a major challenge that opposes the efforts of many organization with family planning, prevention of early marriages, safe and healthy pregnancy and more. Possibly, the low acceptance among many families to these efforts is attributed to the thoughts that these organizations are preventing their thrive. This is another challenge that necessitate in depth analysis and profound knowledge of adolescents' reproductive needs and challenges, which could help in addressing these challenges to them and their families and

share possible solutions. Therefore, this study aimed to investigate sexual and reproductive health needs and barriers of Syrian adolescent refugees living in Jordan.

The study will open up crucial spaces for policy makers and humanitarian aid practitioners to critically examine the study findings, to evaluate how the findings from the study relate to their work/the landscape in which they operate and to reflect on current practice and possible new directions. The study is timely as there is considerable interest in Jordan for reliable data for informing programmatic interventions. Many articles and research pointed to the importance of including trauma and psychosocial wellbeing, multiple threats, including physical and mental abuse, STIs and pregnancies that many female adolescent refugees face in research to generate new evidence for informing policy and practice. Moreover, early/child marriage is increasingly becoming a key issue in the programmatic intervention in many of the humanitarian settings. Its significance is underscored by UNFPA/UNICEF launching a 'Global Consultation Ending Child Marriage in Humanitarian Settings'.

Chapter Two
Theoretical Framework and Previous Studies

Adolescent Reproductive Health

Adolescents and youth aged 10 to 24 years old account for 1.8 billion worldwide, mostly living in developing countries. Global issues of this age group occupy a large portion of population growth and its development. One of the most crucial issues for adolescents and youth is their reproductive health, which is considered a priority for the international community and was highlighted as one of the global essential needs within the Sustainable Development Goals for 2030.

With the Syrian refugee crisis that affected many countries around the world and more particularly those countries on the border with Syria, like Jordan for example, many health and social issue had been on the rise significantly, including reproductive health issues. The number of registered Syrian refugees in Jordan is 659,673 has exceeded 1.23 million refugees as of the census of September of 2020, most of them (80.6%) resided outside the assigned Syrian refugee camps. There are 91,051 refugees in the 0-4 age group, 140,227 in the 5-11 age group, 94,515 in the age group 12-17, 192,207 in the 18-35 age group, 114,808 in the 35-59 age group, and 26,856 in the 60 and above age group. This large number has been creating a huge pressure on Jordan, which has limited financial resources and only receiving 36% of financial requirements to cover the needs of those refugees for the 2016 – 2018. However, Jordan with the international committee has endorsed a budget of 6.6 billion USD for the 2020 – 2022 period. Deficiency in resources and the increased needs of refugees have constrained services available to the general population and reduced the development of the infrastructure. Additionally, this crisis had affected the demographic structure of the Jordanian population and dismantled affected the National Strategy for Reproductive Health (2013-2018), especially that since most Syrian refugees are children aged 0-17 and women, who comprising 49.4% of the total refugee population in Jordan. It is imperative, thereby, to explore the needs, threats, and challenges of Syrian refugees living in camps when planning the national reproductive health care plans for the Jordanian families. This is a crucial step to be able to properly assess, manage, and plan reproductive healthcare services provided in Syrian refugee camps and hence reduce cost resulting from lack of proper planning in the national strategies.

Adolescents and Youth living in refugee camps encounter limited access to health and social services and are prone to many health risks and safety issues. The social, mental, and physical damage caused by the Syrian civil war and the vulnerabilities resulted through displacement have led to interruption of education, increase of discrimination, changes in health behaviors, and an overall deterioration of their wellbeing. Such negative consequences affected adolescents and youth behaviors and led to unfavorable outcomes in the condition of many families, like family planning, counselling, and protection issues, gender-based violence, and early marriages. Many governmental and non – governmental organizations provided support to relief their suffer, but several financial or environmental barriers are yet existing. While many youths live with their families in refugee camps, some are scattered in shelters which lack the essential healthcare services because of the limited resources available to them and the lack of access to proper care.

Utilization of Reproductive Health Services

There is generally a lack of knowledge and a low level of awareness about several topics related to SRH among adolescents. Limited knowledge and awareness about SRH and related services caused Syrian adolescent refugees to avoid accessing or using available SRH services, which intensify the need to include sexual education at an early age in schools, community centers, and awareness campaigns. A common problem in school education is the superficial and deficient sexual education and any SRH services provided at schools. There is a strong evidence that sex education at schools is important, cost – effective and provides safer choices and healthier outcomes for adolescents, especially for issues related to STDs and unplanned pregnancies. The lack of awareness about SRH can lead to serious consequences such as early marriage and unplanned pregnancies, and lack of interest in available SRH services. Besides that, many adolescents excuse their aversion of seeking information about their SRH needs by the absence of any SRH problem or disease, thus, there should not be a reason to ask for an advice or seek help from someone. This reflects the low level of awareness that caused such an attitude, besides that some adolescents are embarrassed to express their SRH needs. This attitude is likely to happen among adolescents as studies of several countries also reported that adolescents do not seek SRH services unless they encounter a serious SRH problem that force them to seek attention. Moreover, some services, such as STDs services are still significantly underutilized by adolescents compared to adults. A study by Tanabe et al. 2017 found that adolescent girls aged 15–19 years were less likely to use methods of contraception

or access SRH services, in addition to having a lower level of awareness. The difference in awareness levels between the two age groups was attributed to numerous factors, including marital status, educational level, and site of refuge. Many studies have reported a variety of causes that lead to lower utilizations of SRH services by refugees.

Adolescence have special needs, which are related to provide a specialized SRH services and adolescent friendly' service delivery where they feel comfortable and that their needs are met. Friendly and safe spaces encourage adolescents to seek services and benefit from their availability. For instance, a large-scale adolescent program lead by Kanesathasan et al. (2008) in India found that friendly services resulted in increased awareness and use of contraceptives among married adolescents. Unfortunately, many organizations don't offer specialized services and friendly spaces for adolescents, specially girls, are not embraced with safe spaces for services, thus, are more prone to all kinds of violence and abuse. The UNFPA assures safe space for women and girls, which are closely linked to reproductive health services. Through which, comfortable and trusted services are provided, and girls are protected from GBV. A safe space is known to provide quality services with absence of trauma, severe stress, violence (or fear of violence), or abuse, and customers feel physically and emotionally safe. Most studies are concerned with girls and young women because they are particularly at a high risk of sexual violence, sexual exploitation, and early marriage. Yet, a study by Bartels et al. 2018 concluded that both genders of Syrian adolescents, and not only females, had concerns around sexual and GBV.

Family Planning

Family planning results in safer pregnancies, healthier babies, and fewer medical problems for the mother. Not only that, but it provides an opportunity for the mother to continue her education or develop her professional skills and career opportunities. Family planning is a choice for all women in refugee camps, but only a few understand the benefits of this service and utilize it. Furthermore, refugee women mostly use one method of family planning, despite that she might be aware of other methods of contraception. West et al. 2014 reported that many of women did not use family planning services available to them, including counselling or methods of contraception, and all of them preferred only one method even if they were aware of several other methods. Lacking knowledge about contraception is common among refugees and could hold them back from utilizing family services. Using at least one method of contraception by all married in our study complies with their religious beliefs about the permissibility of FP in Islam. Islam do not

refuse but could encourage the use of FP on certain occasions. Furthermore, most women don't choose the method of FP by themselves but is shared and confirmed by their husbands, which is another cultural factor that affect the method of FP. Roudi-Fahimi et al. 2003 indicated that 1 in 4 Syrian women has no say on that and the decision about FP purely relates to the husband. Nonetheless, most women of that study shared the decision with their husbands.

Sources of information about family planning are commonly received from healthcare workers at the NGOs. A study using the 2012 Jordan Demographic and Health Survey by Pierce et al. 2019 found that Palestinian refugee women received better contraception advice and information from the United Nations Relief and Works Agency (UNRWA) workers than from a family member or a friend. However, this is contrary to West et al. 2014 study which indicated that the participating subjects who were Syrian female refugees in Jordan predominantly gained information about FP from female friends and family in personal social networks. Thus, it is expected to have a lower use of FP, regardless of the availability of services or the source of information about FP, which mainly attributed to the low level of awareness, especially that specific FP knowledge among girls and women in the camp was not accurate. Further, FP services became obvious to participants only when they had birth at the hospital and healthcare workers advised using a FP method. Moreover, healthcare workers from NGOs outreach women who delivered through hospitals by taking names of those who delivered. This will provide a higher chance for women who had babies in the camp to be informed about FP and other SRH services, which explains the higher level of awareness of married female adolescent in the camp about reproductive health compared to unmarried female adolescents. Other studies noted that those who had previous babies were more willing to use FP services in the short course.

Chapter Three
Results of The Study

Opinions on Reproductive Health Services: Adolescents Perspectives

Sociodemographic Characteristics of Participated Adolescents

Participants were 7 male adolescents and youths, 3 of whom were married at the time of the interview and one was previously married, and 8 female youths and adolescents, 4 of whom were married, and one was previously married. Participants ranged in age from 17 to 24 years. Most of them were from Daraa, which is a province in the southern part of Syria that borders Jordan. All married participants had children, except a previously married male participant and a recently married female participant. The previously married female participant had one child while the rest had 2-3 children. Husbands were considered the head of the household by all participants and the one responsible for the healthcare and health choices of household members. Most participants reported that they migrated in 2012 to Jordan, and 2 participants said that they moved in 2014. Participants had either one or two bedrooms regardless the size of their families. All female participants completed high school, except one who did not reach high school. Five female participants had a college degree. On the other hand, none of the male participants reached high school and 2 of them reported weak reading and writing skills. Most participants were occasionally working, while 3 ladies reported working with NGOs on a monthly contract.

1 Knowledge, Attitudes and Utilization of SRH Services

All male participants denied having SRH services and some expressed that it is available for females only. One of them said: “There are hospitals that provide services for women reproductive health like pregnancy services, but there’s nothing for men... I am sure there’s no place for male services unfortunately”. One

However, a female participant working as a health educator in reproductive health confirmed that by saying: "There is no place for boys, only for girls and women…poor boys…they have no place to go to if they need help or advice". However, she commented that only reproductive services for women are common but sexual services are not. Reproductive services that are available in the camp are pre and post – natal care, in addition to family planning services, as described by participants. Nonetheless, female participants utilized SRH mainly during pregnancy and rarely, if ever, before marriage or if they were not pregnant.

Most participants, of both genders, agreed that health education and consultation is often not available through a fixed office or clinics, but rather through training workshops and educational campaigns, including home visits. Yet, most female participants described the presence of community centers that provide educational workshops on SRH regularly. For example, an organization named "Nour Al-Hussein" was mentioned a few times by some female participants as a place that supports women and provides reproductive health. Nonetheless, out of the 15 participants, four females and only one male have previously participated in such educational workshops. They expressed that these workshops although were free of charge and readily available, they were not of high interest to them. One female participant explained: "these workshops only provided very basic information that's not very useful, and the information taught was already known to us…nothing new to us". The knowledge and experience gained through working with the NGOs, as health educators, was much more fruitful, as one female participant commented. One participant, who work includes home visits with an NGO, mentioned that health education given in hospitals is very deficient. She compared hospital-based education with home-based education by saying; "what really helps most women is the health education and consultation received by these NGOs during home visits not that given in hospitals". It seems that female participants were more aware of educational programs in the camps and were more interested to participate than male participants.

Sources of information for participants if they have a question on SRH was the internet or one of their parents, and some said that they would ask a physician. On one hand, all participants agreed that they would see a doctor if they have a serious SRH problem. On the other hand, all participating adolescents denied any previous visits to the doctor for such a reason. One male participant said: "I never needed to see the doctor as I never had an issue with my reproductive health, thanks God". Both genders barely admitted that they need to ask anyone about SRH. They were shameful to expose their source of knowledge about SRH.

Although all participants, except one, were not attending school at the time of the interview, they did not recall any service related to SRH available at schools they

attended. One male participant said: “I remember only a lecture or two that talked about reproductive health in general…but nothing detailed”.

2 Adolescent and Youth Sexual Behaviors

All participants denied having any sexual intercourse except with their married spouses. One male participant said: “I never had any sexual type of a relationship with any girl…it’s just not acceptable at all”. Most of married participants had previously discussed family planning with their spouses, and they were satisfied with the number of children they had and did not plan to have more any time soon. None have said that their religion (i.e. Islam) prohibits the use of contraception. One female participant said” “I don’t have any trouble with my husband to convince him on the timing and number of kids we want”. Contraception have been used by all married participants except one young man who denied using any. That man proudly said: “why should we use a method if my wife can have more…kids are a gift from Allah ‘God’?”. Most common methods used, as identified by participants, included condoms, oral contraceptives, and external ejaculation ‘withdrawal’. Although female participants were aware of different methods of contraception, they were limited to one method only, which they felt comfortable with. Male participants though were not open to this question and thus did not say much, except one participant who barely said that he uses condoms. Male participants also denied receiving any information or instructions about the use of contraception, advantages of spacing or family planning.

On the other hand, female participants reported that they were offered contraceptive services at hospitals and organizations, such as “Nour al Hussien” organization that offers a full range of contraceptive services. Services included free contraceptive materials, information, and instruction to use, benefits of spacing, and blood tests for those using oral contraceptives to biologically monitor its effectiveness. Overall, female participants did not complain from services they received, except one participant who said, “all kind of contraceptive services are available, but the staff there don’t treat us well…I feel that they don’t respect us”. When she was asked for clarifications, she said: “they’re rude and don’t provide enough information”. This participant was working as a health educator with one of the NGOs at the time of the interview. She commented that NGOs have a much better performance on SRH education and consultation through home visits. She also noted that: “organizations and hospitals prefer spacing and they get upset if you get pregnant right away after your last birth”. However, male participants said

that they had never received help or provided advice on contraception, which was the opposite to female adolescents who reporting the contraception services was frequently offered to them.

3 Pre-natal and Post-natal Care

All participants in our study preferred having birth in hospitals than in their homes. One participant prescribed having his first child home. He said, "I prefer hospitals off course, but because of certain circumstances outside our control we had our first child at home, and I had to deliver the baby myself, it was a painful experience…but we made a big mistake by calling the midwife afterward and not the ambulance".

Everyone receives a pregnancy card for peri-natal care, which provides a full 'free of charge' services to a pregnant woman, including pre- and post-delivery care. One woman happily said: "they gave me a card when I got pregnant… you get to have plenty of services for free". Most participants said that they had a planned pregnancy, and they visited the physician regularly for pre-natal care. All interviewed women agreed receiving blood work and ultrasound examination during these visits, in addition to receiving the required vaccination and supplements including multivitamins, ferritin, and folic acid. Women mentioned that they were asked about their diet and smoking habits but received little guidance or information, if any. One woman said: "in the first visit, the doctor asked me whether I smoke or not and what type of food I usually eat…I told her everything but she said nothing afterwards…I expected that she would provide me with advice about my diet during pregnancy…but I received none".

Women walked for about 15 – 30 minutes to reach the hospital during antenatal care. Delivery experience was positive for all participating women who gave birth in the camp, except the notice of one woman, whose children were born in Syria, complaining that she hears from many women that their delivery experience in the camp was horrible. She sadly said "I heard from several women here in the camp that the nurses don't treat them well…they even beat them during birth…it's just very depressing to hear such stories…thanks God because all my births were back in Syria".

Women mentioned that they were served by both physicians and nurses during delivery and they only stayed a day after delivery in the hospital, and then were discharged because they did not experience any complication during or after delivery. Only one lady experienced shortness of breath because she was asthmatic, but she was also discharged the next day. Two women had a c-section delivery without any complications. All women had visited the doctor

after delivery, were examined with their baby, received medications for infections and pain killers, as well as information about breast feeding by a health educator. One woman said: "a midwife came to me the next morning I gave birth…just before I was going back home…reminding me of the proper way to breast feed my child…I knew most of the information she told me, but it's good to hear it back once more".

Post – natal care was not well prescribed by women as it seems they did not visit the hospital or seen a doctor after they were discharged. Nevertheless, the female participant who works as a health educator emphasized the importance of home visits of NGOs in supporting post – natal care by saying "women receive post – natal care at the hospital but health educators take the names of women who delivered and make 7 visits to their home, monitor their health and ask for their needs… this is more helpful and convenient than post- natal care at the hospital".

Health in Conflict

ACCESS

Almost all participants were very young in their home country (i.e. Syria) at the time they migrated to the refugee camp in Jordan (age ranged from 5-12 years old), so they do not recall or were aware about SRH services in Syria. For those who did recall or experienced the SRH in Syria, their responses make the comparison between the SRH services in Syria and the refugee camp in Jordan quite challenging. Overall, the general opinion was that reproductive health services in Syria were good regarding pre – and post – natal care both in public and private hospitals, but mainly focusing on treatment than on health education or family planning. Efforts in the refugee camp, however, were more obvious to focus on family planning, awareness campaigns and home visits. A female participant-comparing her experience of pregnancy in Syria and the camp in Jordan-complained: "I had one of my kids in Syria…it's a pretty good service…we were happy there…we rarely heard about family planning services…most care was on how to care of myself and the baby after birth…A year ago though, I had the youngest here in this camp…It's pretty much different experience…all they want you to know is 'not' to have another child…that's it…so much focus on family planning part but much less on the care itself!".

In addition, some female participants mentioned that primary health care services have a great connection with the local community in Syria. One woman said "Services in Syria are great and more convenient in both private and public

hospitals... for example, the doctor would come to my house after birth and check on me...but here we have to go ourselves to the hospital…walking about half an hour holding the baby and mostly having other kids with us". Another woman said: "Medicine in Syria is better I guess but awareness campaigns here are much better... one hospital named [the Emirates hospital] is in the camp, where I received training on hospital administration, was a great hospital". However, it seems that refugees home country (i.e. Syria) has a few educational workshops on SRH as one of the female participants noted: "I had all my children here but there were good reproductive health services in Syria like making frequent workshops and calling women in the local community to attend them…these workshops were very frequent… I had a certificate of training for one of these workshops provided by the Syrian women Union". Male adolescents were not interested to provide answers to this question and most of them said that they were kids at that time in Syrian. Female adolescents tried to provide a comparison based on services they experienced in Jordan.

SEXUAL VIOLENCE

Most interviewed youth refugees did not recognize seeing or hearing about incidences of sexual violence such as sexual harassment, rape, or gender – based violence. However, some participants from both genders agreed that sexual harassment is common; mainly young men harassing young ladies. Surprisingly, one lady said: "we are used to that and don't think it's a problem". Nevertheless, one lady narrated her personal experience with child harassment occurred with her child. She sadly said: "my child disappeared for many hours until the evening… I asked few young men to help me finding him… finally, we managed to find him with some adolescents who kidnapped him and were trying to rape him… Thanks GOD we weren't late before anything bad happened... My child was only 6 years old at that time…you can't imagine what I went through while he was missing…it's just unbearable experience…I don't think me, or my son would ever forget it". Another male participant shared his experience as well: "I had a fight with a guy who sexually harassed my previous wife when we were having a walk… This guy had sexually harassed many women several times and no one could stop him".

Although there are several places in the camp to report and protect against sexual violence and harassment, not all participants were aware of such places. Some participants responded that they are not sure but there could be such programs, like a young man who said: "I think there's a program for family protection but not entirely sure". Only few participants were fully aware about protection programs. One lady who was working with 'Save the children' said: "There are plenty of

protection programs available… For example, 'Nour al Hussein', and 'save the children'. The first is for adults and the second is for children". Employers at these organizations keep the full privacy and confidentiality of victims, as one young woman mentioned: " I'm part of group called [network of enforcing women] which is part of UNHCR that encourages women to talk about experience, help and refer them while keeping full privacy".

SEXUAL TRANSMITTED INFECTIONS (STIS)

Most interviewed participants said they heard about AIDS (Acquired immunodeficiency syndrome (AIDS)) through the TV, friends and acquaintances, the school, or workshops at the camp. Some women added they think Hepatitis is sexually transmitted. When participants were asked about what they know about STIDs, the only response of participants was that it is transmitted through sexual intercourse, while only few female participants added that it could be transferred through blood and needle sticks. Participants denied or did not know of any available STIDs services (i.e. testing, treatment, preventive measures) in the camp.

Some participants responded that the best way to protect oneself from STIDs is to stay away from prohibited sexual acts, and do not use other belongings or items, including a used needle at the hospital. However, males only responded that staying away from a sex relation outside marriage is the way to protect from STIs, while some females were aware about the caution of using others' equipment, especially disposals, such as surgical needles. None of the participants thought that STIDs is a problem in the refugee community, as one female participant said: "Most people are conservative here…so this problem isn't a big deal here…we never heard of it". Yet, most participants were motivated to the idea of increasing awareness campaigns about STIDs that target everyone, and some preferred to target the youth population. One lady who works with an NGO said, "we're currently increasing awareness about Hepatitis because of the increasing numbers of reported cases, but more campaigns won't hurt, I think". On the other hand, a few participants did not feel that there is a need for these campaigns. One male participant said, "It could have some benefits, but I feel that young generations are fully aware of these issues…they have access to information from the internet and from their peers". Another female participant disagreed: "We don't need such awareness because of our religion that prohibited illegal sexual intercourse.

ABORTION

Most participants thought abortion is illegal in Jordan, with an exclusion of medical necessities, as raised by some participants. Most participants, of both genders, denied knowing or hearing about abortion services or if refugee women

could seek abortion. Some even denied that women in the camp would do that because of religious prohibitions, which was a comment made by some female participants. A female participant commented: "I never heard about anyone in the camp who' would do that because it's prohibited in our religion-Islam… I have dealt with almost half of the refugees in the camp because of the nature of my job in education but never encountered any case of abortion". Contrary to that, one woman disagreed, "Women choosing abortion try that in camp hospitals but the medical staff refuse to do that…I honestly don't know where these women seek abortion or the reason they have to abort for". Another male participant responded about abortion for medical purposes: "I think there should be a pre and post care for women who wants to abort their baby, because she should receive services, she paid for… In the camp, they won't provide services for women who choose abortion... I think they will only refer her to another place to do abortion if they believe abortion is necessary such as in medical emergencies". This young man believed that the reason that some women choose abortion is that they do not want more children. This opinion was supported by another young male participant who said: "Women seek abortion if they don't want more children... they get pregnant by mistake or despite their will". Other reasons given for choosing abortion are if the mother's life is threatened or the fetus died in the womb.

5 Adolescent and Youth Refugees' Needs

STIGMA AND RESOURCE UTILIZATION

Most participants think that it is acceptable for adolescents and youths in their community to access reproductive health services, and some said they must use it if they are available to them. One young woman said, "there's no place for boys, only for girls and women", and another added "if young people know what these places offer, they'll accept to go". Some even believed that youth are not interested to explore such services, as one lady noted: "They're in need for such services but youth aren't interested in that because they're looking to work and gain money and think it's a waste of time to visit these places". One male participant reasoned not using these services by arguing: "I don't think young men need it, they think they know everything… many people think it's a stigma to seek these services…that's why they get embarrassed and decide not to explore them". Most male participants agreed that there is a tendency for men to use these services only if they find a problem after marriage. A young male participant said: "I don't think young men will seek these services before marriage but will do if a man finds he has a problem after marriage". This opinion was supported by a

comment of a female participant saying: "I don't think youth will use these services before marriage, unless there's a problem…it's just how we're used to think of such services…it's even embarrassing to seek these services before getting married". Reproduction and sexual intercourse are related to marriage in many cultures and religions, as a male participant said: "such services are only appropriate after marriage". Surprisingly, most participants admitted that they grew up in a culture where they received no knowledge or information about changes in their bodies. It was common among both genders that SRH is only sought-after marriage, or if there was a serious health issue related to SRH.

Participants did not identify specific reproductive health needs, but some noted that youth need knowledge and awareness, as one young man said: "Sure, they need some information about sexual and reproductive health before marriage…especially nowadays where everything is available to young people". Another added: "Yes, they need knowledge… Drugs, for example, affect sexual and reproductive health and there should be awareness programs… Smoking is another example that young people need to be educated about as it affects sexual and reproductive health". One female participant thought that the way to address youth issues and increase their awareness is by having knowledgeable physicians; she said, "They need a good, knowledgeable, and experienced physician who understands their needs and don't judge them". However, it seems that some participants think that even awareness education, and information services should be connected to marriage, as a male participant said: "I think these services are only after marriage, they're not appropriate before marriage". Both male and female participants assured that increasing awareness is an important SRH need for adolescents and youths. However, some female participants provided ways to increase awareness among youth and adolescents in the camp.

EARLY MARRIAGE

Most interviewed participants believed that the legal age of marriage is 18 years, and some said 18 years for boys and 15 years for girls. However, some thought that legal age of marriage should be more, as some of them preferred 24 or 25 years old. Almost all participants thought that early marriage the greatest problem in the camp. Only a male participant who was single at the time of interview commented: "I think it's a great thing to marry early… A boy should marry once he kicks adolescence". Another one commented that early marriage could have an advantage at certain conditions. He explained: "It depends on the reason... If it makes the boy more mature, then it's beneficial…another reason that a mother wants to get her boy married is to have a daughter in-law who helps her in house chores". A single female participant thought that early marriage is not a problem nowadays as it used to be in the past when the refugees first migrated to the camp. She said: "It was a problem back then but not anymore, it's much less now… This is because young couples get divorce often and girls get more education, thus, I noticed that early marriage is decreasing,".

On top of that, there were different reasons mentioned for why people in the camp practice early marriage. The most common reason was norms and traditions, which was the frequent response for males. On the other side females reported a variety of reasons, such as Other responses were 'lack of awareness', 'girls have nothing to do', and 'boys are unemployed, and 'marriage could encourage them to be independent', and 'girls could have a better life'. Male participants were not open to this question or were not aware about the reasons for early marriage compared to female. Females provided a variety of reasons. For instance, One female participant said: "girls get married early as they have nothing better to do…they're not educated, not employed…so they might have a better life at their husband's house, especially if their parents are poor…most parents with several kids can't afford having too many kids…". Another commented that mothers try to protect their girls and therefore, make them marry at a young age, and some do that because they are poor. Other cultural reasons were also provided, as a male participant said: "It's a cultural habit and because some people get jealous when they see someone they know got married at an early age, they do the same thing…!". Another participant added: "boys are always free and aren't busy with anything in life and they marry early in life because there's nothing else to do. However, some adolescents push for that and some are forced by their parents". Apart from such sociocultural reasons provided by these participants, a female participant provided a different reason; she said: "this is because organizations support the child's rights and the child uses this support to force the parents to get married. Otherwise it's a cultural thing. Some men want to marry a very young girl because they think they can raise her the way they like…it's because they believe that she has no previous experiences in life and thus he will influence her choices and behaviors". A married, young male participant who thought that early marriage could be beneficial said: "We marry early because we want our kids to grow up with us, so once I get little old, I have a man next to me…this is how we look at it".

When participants were asked about the source of information provided to the married couple, many responded that family members are their source. Male participants reported members, like an older brother, provides information for his younger brother. W, while female participants reported that the mother is the one who usually provides information to her daughter just before she gets married. Another source of information mentioned by only few female participants was organizations who educate and conduct awareness programs.

Regarding the consequences of early marriage, few participants thought that girls could continue their education after marriage, however, most participants, of both genders, said that it is more likely the girls will not be able to do so. Negative health issues associated with early marriage and childbearing were well – noted

by some participants, mostly females, who provided possible psychological and mental effects, as well as an endangered pregnancy because of the physical development of the girls' body that is still growing as a normal part of adolescence stage. One female participant said: "I think the young girl's body is still developing… and getting pregnant overwhelm her growing body and harm her… In addition, her facial appearance looks much older and her psychological status changes as well…she should live her age not given responsibilities beyond her abilities". Another opinion was shared: "Psychological problems, and because they are young, the idea of marriage is hard for them to accept… They are still kids; pregnancy risks and illnesses are of a higher probability". Another opinion was by a married male participant who believed that risks depend on the mentality of the couple; he said: "It forms risks on some people who are ignorant and know nothing about marital life... For example, you notice a young lady who have an infant with her and when the infant cries she beats him to stop crying… Another example is my cousin who got divorced because his wife is educated, and he's not… after the divorce, she refused to take her baby girl and raise her". In general, female participants were more aware about the negative consequences of early marriage than male participants, who did not provide any physical or mental adverse effects.

MENTAL HEALTH SUPPORT

It is interesting that none of male participants were aware about mental health services available at the camp, while almost all female participants were aware about the availability of the services and some know the name and location of these services. Even though, those who were aware about the services, they denied ever using it. One female participant said: "I thought about using it once, but people think I'm crazy, so I didn't go". Another female participant admired these services when were first provided to them at their arrival to the camp. She added: "When we first came in, my friends and I received mental health services which were very beneficial for us… However, I was recently referred by an employee working for one organization to mental health services, but I rejected to use these services…I was afraid to get stigmatized and rejected by the society we live in…it's very judgmental".

Nevertheless, most participants supported the idea of providing special mental health services for adolescents and youths. A young woman said: "Yes, because many youths need to talk to someone and don't find any, but I prefer replacing the world 'mental' by 'psychological health' because this term keeps people away from such services". Another one added that she provides mental health support to youth as part of her job. However, both male and female participants were

ashamed to reveal if they have ever used mental health services, or if they need to use it. Regarding the place where mental health support should be provided to adolescents and youths, most agreed that school is the best place, while some thought that community centers are better for this mission because of the possibility of a wider and more comprehensive services.

Opinions on Reproductive Health Services: key informants' perspectives

TABLE 1: summarized the background information of participants scope of work in SRH services. The interviewed key informants vary in their level and kind of experience they have with refugees. Some of them occupied high administrative positions, while others were directly providing services for refugees in the field. There are several funders that support organizations where participants work and most of these organizations cooperate with the host government (i.e. Jordan) and the United Nations High Commissioner for Refugees (UNHCR), as shown in Table 1. Humanitarian documentation didn't seem to be necessary for receiving service in for many of these organizational works.

i. Reproductive Health Services

SERVICES AVAILABILITY

All participants were working or contracting with organizations that directly offered SRH for adolescents. Some organizations were only offering education through raising awareness while others offered many kinds of SRH services to refugees. Al organization, for example, offers SRH consultation, awareness programs, treatment of STIs, family planning (FP), neonatal vaccination, pre- and post-delivery care, gender-based violence (GBV), post-rape services, and more. The director of the Institute for family health stated, "we offer all kinds of SRH services". Other services were more specific, mainly focused on one point regarding SRH services for refugees and adolescents. For instance, a project lead by the refugees and migrants center in Yarmouk University focused on early marriage. The director of that project said, "We ethnographically and deeply studied the cultural roots and refugees' social conditions that lead to early marriage and came up with conclusions about solution to guide the refugee community toward healthier practices.....we also focused on change theory, which are basically healthy behaviors that we could affect or change after the study", she continued saying, "one of the good changes is that some parents reconsidered early marriage and so reconsidered practicing it". However, one consultant who worked for 15 years with refugees in general, and with Syrian

refugees since the crisis started commented that not all SRH services are available and most organizational projects are, at most, limited to education and awareness. She said, “let me be honest here, most programs in Jordan are merely limited to education and consultation”. This seems to be true for services inside camps, where outside camps services are more diverse, based on responses of some participants.

There was a referral mechanism applied by some organizations, even if the service provided was educational only, as a health educator said, “There is an employee responsible for referral. He takes the lead to guide and arrange medical appointments for people we refer to him”. Another participant assured the role of an assigned health educator in referrals, she said, “A health educator took this role. We connected health education with referral. Health educators identify the issue, or the problem and then refer. The health educator refers to the organization he/she works for, refer to the project partners, or refer to the ministry of health”.

LANGUAGE AND COMMUNICATION

All services provided to refugees were in Arabic, including educational and teaching materials. All participants indicated working with organizations that provided informational pamphlets and brochures in languages that refugees would be able to read or read to them if they cannot read. Other measures of communication were provided by participants, such as focus groups and community gatherings. One participant said, “There are community gathering groups that assist us to approach people. There’s also a cooperation with other NGOs that provide services related to SRH to refugees like early marriage consultation”. However, many key informants provided the importance of using of refugee volunteers who were trained to communicate with refugees who needed services. Participants commented that their presence in the project was a great success. A key informant said, “we don’t only rely on our office service, but on those volunteers, who support our mission a lot”. Its fortunate that those volunteers were peers to target adolescents. Many commented on the advantage of peer education in approaching adolescents and making an effect. A key participant commented on their use by saying, “We formed group discussions from gatherings formed by community groups. During these discussions, we trained adolescents to conduct peer education, which was very helpful”. The director of the institute of family health magnified its significance as it could be the most successful way of sex education for adolescents, he said, “one of the most successful ways to break through sex education resistance is through peer education. We educated first year college Syrian students and they lead the path

of teaching Syrian adolescents about SRH and about the risk of early marriage".

BARRIERS TO CARE

Key informants working with refugees indicated several barriers that refugee adolescents encounter to achieve SRH services. Their opinions about SRH services that are missing and the main barriers to delivering SRH services to refugees in Jordan are illustrated in Table 2. Several services were reported missing, including special services to adolescents, SRH services for males, long-term FP, STIs services, or preventive care. One of the participants said, "Proper training for SRH providers and a friendly environment of services are lacking. Healthcare providers don't have enough knowledge about adolescent physical development, their mental health needs, and how to provide services.....further, most of training programs focus on family planning, domestic violence, and early marriage, and other kinds of services are not covered by any entity".

The main barrier to deliver SRH services to adolescents specifically, and refugees generally, is feeling shameful and fearing stigma while seeking or receiving SRH services. Responses of key informants about that included statements like, "Many refugees feel shameful to seek SRH services or to expose any incident like GBV or rape. Males feel more shameful than females", or "Refugees stigmatize those who are not married if they seek SRH services". Another common reason was the lack of awareness about SRH services provided, their availability, and their importance. One of the key informants noted, "A main barrier is the lack of awareness and knowledge among youth and among parents as well as organizations about SRH, which is both true for Jordanians and Syrians". Another one added, "Lack of awareness among youth about the importance of SRH, thinking that SRH is only limited to married men or women only..... parents lack awareness as well". This participant also added, "There is also a cultural issue among parents thinking that its unacceptance to take their child for such services.....and the provider of health services in many organizations feel embarrassed, as well, to provide these services". Hence, it seems SRH services and stigmatization are well connected in many refugees' minds. One notation was made on that, "One of the cultural barriers is the belief that a young male/female usually don't have any physical problem including SRH problems. And if youth seek any of SRH services, suspensions and wrong thoughts start to surround them". However, it seems that some of these cultural beliefs started to change, as a key informants commented, "Males used to refuse having a male physician to see his wife.....now they prefer quality of care over cultural views". However, all participants added that they or their organization consider the cultural context when providing SRH services to refugees.

VISIT INFORMATION AND BROADER PROGRAMMING

All SRH services provided by organizations are free of charge. The first visit varies among organizations based on the organization's role in SRH services. Organizations that provide educational services only don't have a difference between the first and other visits for beneficiaries. However, those organizations providing several SRH services conduct a complete checkup, obtain history information, and provide treatment if needed at the first visit. The importance of the first visit was emphasized by one of the key informants as it reflects the success of the following visits. She said, "The first visit is the most critical because we don't know the expectation of the adolescents, the image they take, and if ever will come back……..we sell hard to make it successful, but we don't know if it is good enough to keep the adolescent interested in coming back again". At the first visit, Adolescents and other refugees are usually seen by a social worker or a midwife. A physician intervenes when necessary, as one of the participants, who is a medical doctors, said, "A midwife is always available to see people coming to the clinic, and in case there is a need for a doctor, I or any of my colleagues serve them".

Most organizations are pro-active in providing FP for women before conception, which is done through education, consultation, and home visits. When asked about attempts made to include sex education in SRH services, all the participants reported that serious attempts were made but minimal achievements resulted due to cultural barriers. One participant said, "It's not easy to talk about this topic among refugees, especially that most refugees in Jordan are from rural areas of Syria". Peer education was an excellent way to approach refugees, including adolescents, and communicate information on SRH to increase awareness. A key informant provided, "We were trying hard to increase awareness on sex education through contacting and coordinating with different entities, but we face some resistance……however, one of the most successful way to break through this resistance is using peer education ".

ii. Adolescent Refugee's Reproductive Health Needs

SPECIFIC NEEDS

Not all organizations have specific SRH programs or services for adolescents. Nonetheless, all participants believed that adolescent refugees have specific SRH needs. More than one participant confirmed the need to increase adolescents' awareness about the importance of SRH services, and to support their needs and rights related to SRH. A key informant provided, "They need to be informed about their SRH needs, how to seek information or service and get it……they also

need comprehensive sexual education including gender – based violence, human and reproductive rights, body developmental changes, male- female relationship, pregnancy, STIs, early marriage, and more". Other specific needs were to train providers on meeting adolescents needs, and a clear guideline that is nationally accepted on SRH services for adolescents. One of the participants paid the attention on other kinds of SRH needs for adolescents, which are SRH services for adolescents with disabilities. He said, "There is a huge and clear gap on the availability of any service pertained to adolescents with disabilities". In addition, different age groups have different SRH needs. A project manager, who lead a research project on refugees, noticed that every age had its own SRH needs, and therefore, health policies should not be general to all ages, but should be tailored to each age group.

In comparison of SRH services in refugee's country of origin (i.e. Syria) with the host country (i.e. Jordan), almost all participants agreed that Jordan is likely to provide more services with higher quality than services in Syria, even before the civil war. One of the key informants commented, "we have great services in the camp which I think it surpasses services anywhere.....we noticed the huge difference in refugees level of awareness when they first got here and now. Early marriage is decreasing, family planning is applied somehow..... there is a lower number of births for many families". Only one of the participants, who is Syrian, disagreed with that by saying, "Services here are free and easy to access, but in Syria services were broader, more accessible, available to everyone regardless to the place of residence. Here, services are confined to your place of residence".

Organizations used different methods to assist adolescents in accessing SRH. Most of these methods relied on volunteers from refugees who helped to attract adolescents and other refugees to SRH services, as one of the participants said, "we formed community groups that included youth whom we can use to increase awareness", and another said, "we used volunteers from refugees". Other methods were also used to assist increasing the access to SRH services. One of the key informants provided "There are several ways we used, like visiting youth social centers where youth gather, lecturing and establishing programs in schools and universities, talking to parents to make them more interested, and collaborating with organizations such as the 'All of Us are Jordan' or the UNISEF".

Although adolescents gain knowledge about SRH from different resources, key informants believed that the main resources of information are the parents, the internet, or peers. Some based their answers on what's published in the literature, like a participant who said, "Parents are the main source as studies show, followed by schools and peers. Now, internet is getting more popular". Another key informant agreed with the shift from parents, as the main source, to the internet.

She added, “Parents are the main source; peers are another source. However, youth are using the internet now more often, and therefore, we are developing a trusted website for them to use”. The shift toward the internet as a more common source of information was explained by one of the participants by saying, “Parents are the main source as studies show. But youth don’t trust the information they get from parents and many parents are reluctant to provide a full piece of knowledge because it’s considered culturally taboo to talk about details of these topics, and the fearfulness of transferring this knowledge into practice”.

Adolescents who visit SRH services, do that for a variety of reasons, asking reproductive health questions, preventing reproductive health problems, or addressing reproductive health complications. Although the confidentiality of services is essential, it is interesting that some participants reported that confidentiality is preached sometimes or most of the time. One of the participants said, “confidentiality is not ensured all the time, some health care provides don’t pay much attention about the confidentiality of people they serve”, and another added, “Not really, and this is one of the problems youth suffer from. They are not comfortable with the confidentiality of services”.

Services are accessible to adolescents in the camp but are only available during the day. However, some of the services are only available at the office where services are provided, while other organizations seek out to adolescents and refugees in schools and at their social gatherings; mainly to communicate and increase awareness. One of the participants provided, “We worked with community groups who are close to adolescents or could approach them during school or aggregations…… we also formed group discussions from gatherings formed by community groups. During these discussions, we trained adolescents to conduct peer education, which was very helpful”.

EARLY MARRIAGE

All services regarding SRH in the camp provide awareness-raising sessions on child marriage and child pregnancy. These services are mainly educational sessions that are provided through group gatherings, educational settings, or during provision of services. Some participants reported working with individuals regarding early marriage awareness through private consultations. Early marriage interventions designed to also improve access to education and jobs, as reported by most key informants. One of them said, “we used to intervene with early marriage through educational awareness programs, community leaders, peer education which help us spread awareness, and parental education……. we also developed pre- marital counselling sessions to educate the engaged couples about the risk of early marriage and early pregnancy”. Another one added, “I can provide you with an

example on how we used invented program that helped a lot in decreasing early marriage. We developed a project with several organizations, which included the ministry of education, institute for family care, The Jubilee School, and King Hussein Institution. This project targeted 300 Syrian girls who were 14-16 years old and were about to drop from school to get married. We started a program for girls and parents parallelly. The program used Syrian college girls who volunteered to help mentoring the young girls. Achievements included the development of a 10 – year life plan by girls, which included changing their idea of early marriage to continue their education, and great improvement of girl's grades at schools. Some of the girls received very high scores at the high school national exam and got scholarships to study in colleges. Regarding their parents, they were trained on economic-business skills development that focused on establishing their own business. The program improved life and academic skills of girls. It was an interactive program that ended in a great success".

None of the programs provided monetary incentives to decrease early marriage, but rather decreased that through training and education. One key informant said, "No, there are no incentives.....however, through parental education and skills development of youth.....in addition to educational and mental training and development.....we encourage families that were thinking about early marriage to re-consider their decision". Educational training and scholarships were used by some organizations to decrease early marriage. Another participant commented on that by saying, "There are no direct incentives, but many organizations provided scholarships for girls to continue college education, or training session for hand work which helped to decrease the rate of early marriage. Awareness campaigns in schools helped as well".

CONTRACEPTION

Not all organizations provided contraceptive services. However, contraceptives were provided to married adolescents only, and most of these services were mainly accessed and used by females. A key informant said, "Contraceptive services are only provided to those who are married. This is important, because by law, unmarried singles can get contraceptives services as well, but in practice, they don't get any of these services". Not all these organizations that provide contraceptives services offer medical exams to ensure the proper contraceptives are offered to adolescents. However, adolescents have the choice between different methods of contraception, which were offered for free. Moreover, knowledge about the proper use of contraceptives seemed to be limited. All participants reported that many refugees don't know how to properly use a condom. One of the participants said, "They don't have proper knowledge about

using condoms…. especially that their information is from the internet". There were other reasons to use condoms and to learn how to properly use them, as a key informant noted. She said, "Many don't know how to use condoms, and some males come to get them and ask about the way to use them properly, even if they were not married…. just to prevent STIs……females learned to use condoms to prevent transmitting STIs from their husbands or as a method of FP".

SEXUALLY TRANSMITTED INFECTIONS

Most participants reported providing educational services about STIs but doesn't seem to be enough. A key participant who worked with refugees for a long period said, "Many provide information about STIs, but most centers provide superficial information that lacks any practical or behavioral information. In fact, all SRH services is more theoretically than practically provided". Testing of STIs is not available at organizations. Unfortunately, testing is not even done unless the doctor examining the individual was suspecting a STIs. However, if a married individual was found STIs positive, the spouse is informed with the test result.

Patient Safety and Comfort

Regarding the conformability of services to adolescents, not all centers have safe spaces designated to adolescents and or provide the choice to be seen by a staff member of their own sex. However, one of the participants indicated the importance of providing special spaces for adolescents by saying, "Most of these services don't care about the confidentiality and privacy of customers including adolescents. A friendly place for adolescents is important so that they like and trust the service". In addition, all participants reported that SRH services are provided to adolescents above 18 years without parental presence, unless they are married. Unmarried adolescents – usually girls – who are under 18 years are not only offered services if they are not accompanied by one of their parents. Moreover, all participants agreed that none of the organizations they worked for have specialized training to handle adolescents.

Follow-up and External Care

Most organizational SRH services for adolescents don't have a follow up protocol after appointments, but few do. One of the participants noted, "we specially follow-up with parents and it has a positive impact so far…… we form focus groups discussions with parents and with adolescents as part of the evaluation". Informational material is provided to adolescents during appointments by all organizations. These materials are in Arabic language, and while some organizations provide a wide variety of SRH topics through these materials, other organizations focus only on female reproductive health information. Walking

through the information provided in these materials is practiced by many organizations, but some organizations do that refugees have questions on the material. When developing the informational material, or even other SRH services, some centers consult adolescent refugees and implement their feedbacks and personal needs. Regarding adopting adolescents needs, one participant said, "We consult adolescents during planning of programs. We form focus groups with adolescents and ask them about their needs", and in regard to embracing adolescents feedback, another participants who works for an organization that is funded by the UNFPA responded, "The UNFPA usually collects feedback and modify programs based on these comments or concerns and we adapt whatever the UNFPA modifies".

RISK FACTORS IN ADOLESCENT REFUGEES

There are several risk factors identified by participants. A risk factor that was frequently reported was lack of awareness, early marriage, and subsequent pregnancies. A key informant who was working directly with refugee adolescents said, "A major risk factor is subsequent pregnancies at an early age and complications resulted from that, like diabetes mellitus, hypertension, and infertility that could occur later in life….. I have an example of a 16-year-old girl who has been given conception stimulants to encourage conception right after marriage. Most families want their kids to get babies right after marriage, regardless of their age". Another participant listed a number of risk factors; he said, "There are a number of risk factors……..lack of laws and regulations that support adolescents SRH and other rights, their vulnerability to rape and harassment, the inability or limited access to continue their education, and early marriage". Another identified risk factor was "Lack of complete and comprehensive SRH services". One of the participants added that migration itself is a risk factor because of the tragic consequences it holds. Other identified risk factors were fear of stigma, poverty, and misconceptions about SRH services.

Most participants agreed that increasing awareness and sustaining SRH services for adolescents and refugees are the best ways to address risk factors. One of the participants responded, "Awareness is the most important approach to use at a national level. An example of the level of ignorance of some adolescent refugees are those girls that come to the clinic with several recurrent abortions……yet they get pregnant right after their last abortion". However, to address these factors at a national or community – wide scale, participants thought that different entities and organizations that serve refugees should inter – collaborate with integrated roles that complete and unify their efforts. A key informant

commented on that by, “There should be a teamwork from many sectors and institution…….. this needs a multidisciplinary and integrative work. Thereby, we can build an interventional program that’s comprehensive and effective”. Participants also focused on the sustainability of work as a key factor in addressing risk factors nationally. He reacted by saying, “There should be complimentary and mutual work among different organizations. Most projects are solo and not integrated with other local programs, and once a project is over, efforts and work vanish like nothing happened. Most projects that are funded by international organizations are not localized, which means they don’t try to establish a local entity to sustain and continue their work”. Other participants agreed on the importance of sustaining efforts that was already started. One of them said, “We should institutionalize the work and make it a well – structured system. It should be part of our daily life and not only a random project or effort”, and another added, “All projects and healthcare workers should unify their vision in order to ensure long-term results”.

Key informants provided many recommendations to improve SRH for adolescent refugees. These recommendations are demonstrated in Table 3. Most of these recommendations focus on raising awareness and providing safe and comfortable services.

Summary of Results

Syrian adolescents and youth refugees living in Jordanian camps, especially males, lack awareness and hence utilization of available SRH services they need. However, female reproductive health care in the refugee camp seems to be relatively adequate but there is generally a lack of knowledge and a low level of awareness about several topics related to SRH. Many interviewed participants excuse their aversion of seeking information about their SRH needs by the absence of any SRH problem or disease, thus, there should not be a reason to ask for an advice or seek help from someone. Participants also agreed that they have not received any sexual education or any SRH services at school. Poor awareness and the fear of shame and stigma hindered adolescents from using many available reproductive health services. In addition, some cultural and social barriers affected their attitude toward accepting important sexual and reproductive health services, such as sex education, testing sexual transmitted diseases, abandoning early marriage, and more. Many of these issues were rarely addressed by most organizations, except for family planning and early marriage that were included in many organizational programs.

Recommendations Based upon interviews

1. Develop programs that target the following issues: early marriage, unsafe sexual behavior, subsequent pregnancies, and sexual violence.
2. Provide specialized services for adolescents, and males, that is friendly and safe.
3. Implement SRH educational materials in in schools' curriculum.
4. Develop trusted websites that contain monitored and useful information on SRH, targeted to adolescents, and meet their needs.
5. Train health care providers, and educate parents, schoolteachers, and community health centers on assessing and supporting SRH for youth and adolescents.
6. Develop a systemized structure for SRH services that's evidence – based.
7. Innovate in educational methods to encourage higher participation of adolescents, parents, and the community, such as interactive theatre, social media, and famous bloggers on the internet.
8. Develop a sustainable strategy that is nationally adopted to ensure the continuity of SRH services to adolescents on the long run.
9. Develop coordination, networking, and collaboration between all organizations that provide SRH services for refugees to support a comprehensive plan of SRH services for adolescents.

Chapter Four
Conclusions and Recommendations

Summary and Conclusions

Although most services for refugees focus on education and consultation, findings indicated a low level of awareness among adolescents, which probably resulted from the lack of introducing sex education in schools, and the reluctancy to include it in awareness programs later in life. Other problems, like early marriage and stigmatism, are social and cultural issues that should be considered when developing interventional and educational programs. Moreover, parental and community education is essential in empowering adolescents to seek and use available sexual and reproductive health services. Community centers, members and leaders should work with adolescents in making decisions related to their sexual and reproductive health needs.

Recommendations

1. **Provide awareness programs that meet adolescents' needs, which could be beneficial through the following advises:**
    A. Create reliable online resources, specialized websites, and smart applications that provide information and accept inquiries.
    B. Involve parents in awareness programs to play their role in educating their children, which could be done by involving them in groups discussions, field activities, and decision making.
    C. Include SRH material, designed for different age groups, in the curricula of schools.
    D. Implement interactive activities and communication tools in awareness programs instead of direct lecturing.
    E. Use social media in a smart way, like inviting famous bloggers to the awareness programs, and upload videos that are targeted.
    F. Prepare a unified national training package to be adopted by all national authorities that's practical and evidence – based.
2. **Create national coordination mechanisms (multi-sectorial) and define a national umbrella that works to unify scattered efforts and activate coordination between agencies working in this field through:**
    A. Activate SRH activities at schools and community centers that are affiliated with larger agencies services SRH.
    B. Implement adolescent needs within the National Strategy for SRH and link these needs to the National Youth Strategy.
    C. Provide a national guideline that is followed by all organizations working in the field.
3. **Prepare a national awareness program on SRH for adolescents and youth, which:**
    A. Agrees with the principles of Islam and the culture of the Jordanian society
    B. Respond to the requirements according to age and gender.
4. **Develop specialized services for adolescents that are safe, friendly, and high – quality to meet the needs of adolescents and youth.**
5. **Include youth and adolescents in designing and planning their own programs. This should solidify their intention in advocating for SRH and participating in services.**
6. **Prepare a national program to train and educate staff working with adolescents in youth issues and the mechanisms for working with them, in addition to building their capacities in SRH and reproductive rights and linking them with life skills.**

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Annexes

Annex 1

Table 1: Background information of key informants' organizational work

Organization	Position	Work of the organization	Organization fund	Cooperation with host country	Cooperation with UNHCR	Documentation from service recipients
Institute for family health at King Hussein Foundation	Director	MCH, SRH, GBV, Mental Health+	UNFPA, USAID, UNICEF, UNHCR, UN Women+	Yes	Yes	No
Dorat Al-manal	Consultant and a member in the Senate of Jordan	Women enforcement, Children and youth protection and development, social justice+	UNICEF, foreign embassies	No	Yes	No
The Eastern Mediterranean Public Health Network (EMPHNET)	Public Health specialist	Public health services and technical support for partners	Local and international organizations	Yes	Yes	No
Consultant for the WHO, MOH, UNICEF	Board certified OB/GYN	Current consultation of GBV and SRH among refugees	NA	Yes	NA	Yes
Refugees and Migrants Center at Yarmouk University	Associate Professor and Director	All issues related to refugees	Foreign embassies, EU	Yes	Yes	No
Al Oun Organization	Head Chief of Clinics	Primary and secondary care including SRH	UNFPA	Yes	Yes	Yes
Jordanian Red Crescent	Health educator and trainer	Health education, consultation, and referral	Foreign organizations	Yes	Yes	Yes
Save the Children	Health educator	Protection of children rights	Multiple organizations	Yes	Yes	Yes
Organization	**Position**	**Work of the organization**	**Organization fund**	**Cooperation with host country**	**Cooperation with UNHCR**	**Documentation from service**

						recipients
Institute for Family Health at Noor Al Hussein Foundation	Reproductive Health officer	A wide variety of primary and secondary care in addition to educational and capacity building	UNFPA UNHCR	Yes	Yes	Yes
Institute for Family Health at Nour Al Hussein Foundation	Health educator	A wide variety of primary and secondary care in addition to educational and capacity building	UNFPA UNHCR	Yes	Yes	Yes

+ indicated more services are provided
MCH: Maternal and Child Health, SRH: Sexual and Reproductive Health, GBV: Gender-Based Violence, UNFPA: The United Nations Population Fund, USAID: The United States Agency for International Development, UNICEF: The United Nations Children's Fund, UN Women: The United Nations Entity for Gender Equality and the Empowerment of Women, WHO: World Health Organization, MOH: Ministry of Health, OB/GYN: Obstetrics and Gynecology, EU: European Union

Annex 2

Table 2: Services missing and barriers to care

Health services that are currently missing	*Number of participants reporting this response*	*Main barriers to delivering reproductive health services to adolescents*	*Number of participants reporting this response*
No special services for adolescents	3	Concepts of shame and stigma among refugees and adolescents, especially for those unmarried seeking SRH services	6
The referral system is lacking	1	Lack of awareness and knowledge among youth, parents, and organizations about SRH	5
No defined services for males	2	Sustainability of projects' achievement	2
No proper training for SRH	3	Lack of resources including financial cuts	2
Most services are provided for married couples only	1	General reluctance to accept STIs services	2
No long-term FP services	1	Parental objections to provide SRH services for their youth kids	2
No preventive care for SRH	1		
STIs services	1		

Annex 3

Table 3: Recommendations of key informants on ways to improve SRH for adolescent refugees.

Head Chief of Clinics at Al Oun foundation	**1. Focus on early marriage and raise awareness against it.** **2. Develop programs that correct the bad sexual behavior of many youth refugees who are singles and practice unsafe sex**
IFH Director	1. Develop a service package that's special for adolescent and train staff on this service package. 2. Develop policies that support SRH services for youth and adolescents. 3. Include local communities and adolescents in programs development.
Consultant	1. Stop separating refugees from the rest of citizens regarding health services. 2. Provide social services in addition to medical. 3. Innovate in our education (e.g. videos, social media groups, involvements of actors and famous social media bloggers).
Consultant and a member in the Senate of Jordan	1. Train health care providers, and educating parents, teachers, and community health centers. 2. Develop hotlines, certified websites, and proper media advertisements. 3. Develop a systemized structure of SRH services that's evidence – based. 4. Provide friendly centers specialized for adolescents that accommodate youth and their needs.
Director of Refugees and Migrants Center at Yarmouk University	1. Focus on education and awareness programs and include psychologists and social workers. 2. Provide awareness smart and evidence – based awareness programs
Public Health specialist At EMPHNET	1. Work on long-term plans that are inclusive which make refugees part of the community.
Health educator at Jordan Red Crescent	1. Innovate new methods to educate youth about SRH like plays in the theatre.
Health educator at Save the Children	1. Increase awareness
Reproductive Health officer at Noor Al Hussein	1. Provide more funds and policy support. 2. Develop long – term awareness programs that are integrated from many organizations. 3. Provide youth friendly services
Health educator at Noor Al Hussein	1. Include SRH in schools which can be done through extra- curricular activities 2. Work through the regular media and social media to increase awareness about SRH

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