Socio-Cultural Barriers and Opportunities to Accessing Contraception among Palestinian Refugees in Jordan

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DISCLAIMER: The author’s views expressed in this publication do not necessarily reflect the views of the United Nations Relief and Works Agency for Palestine Refugees in the Near East or Share-Net
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<th>Full Form</th>
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<tbody>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>HC</td>
<td>Health Centre</td>
</tr>
<tr>
<td>HCU</td>
<td>Health Care User</td>
</tr>
<tr>
<td>ICF</td>
<td>Informed Consent Form</td>
</tr>
<tr>
<td>IMR</td>
<td>Infant Mortality Ratio</td>
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<tr>
<td>IUD</td>
<td>Intra-Uterine Device</td>
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<tr>
<td>LAM</td>
<td>Lactational Amenorrhea Method</td>
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<tr>
<td>LMIC</td>
<td>Low or Middle Income Country</td>
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<td>MMR</td>
<td>Maternal Mortality Rate</td>
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<td>PI</td>
<td>Principal Investigator</td>
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<tr>
<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
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<tr>
<td>UNRWA</td>
<td>United Nations Relief and Works Agency for Palestine Refugees in the Near East</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Executive summary

**Background:** Maternal mortality is a problem of global concern as most maternal deaths can be prevented. It is especially an urgent problem in low and middle-income countries (LMICs) as 99% of maternal deaths occur in such countries. Likewise in Jordan, maternal mortality is a vital problem. The amount of maternal deaths has increased among Palestinian refugees from 3 in 2013 to 11 deaths in 2016. Immediate action is needed to prevent future deaths. Risk factors for maternal death are ‘too early’ and ‘too many’ pregnancies. Women who deliver before the age of 20 or who practice short birth intervals are at increased risk of complications such as eclampsia or maternal death. ‘Too early’ and ‘too many’ pregnancies furthermore tend to occur among women who have had little education and have a low socio-economic status. ‘Too early’ and ‘too many’ pregnancies can be prevented through modern contraception. Modern contraceptives are methods such as long-acting reversible contraception or hormone-releasing implants such as the intra-uterine device (IUD); hormonal methods such as oral pills; injectables; vaginal rings; and barrier methods such as condoms. These methods are most effective in reducing pregnancy when provided in combination with counselling on how best to use these methods. Contraception is provided for free to Palestinian refugees in Jordan. Yet, contraception usage has decreased among this population. Research indicates that socio-cultural barriers can play an important role in ensuring access to contraception. This study aims to improve this access by understanding currently existing socio-cultural barriers and opportunities to accessing contraception among Palestinian refugees in Jordan.

**Research question:** What are socio-cultural opportunities and barriers to accessing contraception among Palestine refugees in Jordan?

**Methodology:** Focus group discussions (FGDs) were conducted with male and female health care users (HCUs) as well as with health workers from a rural and urban site. Inclusion criteria for HCUs were age and willingness to sign the informed consent form. The inclusion criterion for health workers was willingness to sign the informed consent form. Urban HCUs who participated in FGDs were selected and recruited from the urban HC. Participants of FGDs conducted in the rural setting were partly recruited by health workers through telephone calls and partly recruited from the rural HC. Health workers were invited through staff of the HC. A script was used for inviting participants. Topics discussed during the FGDs were derived from previous scientific research and FGDs conducted as part of this study. FGDs were conducted with the help of a local translator. Notes were taken both by the moderator and translator. FGDs were tape recorded, transcribed verbatim, translated to English and entered into MaxQDA for analysis. Analysis was conducted by two researchers independently using predetermined and emergent themes. The researchers subsequently discussed findings with each other and came to consensus on main and sub themes emerged from FGDs.

**Results:** Twelve FGDs were conducted with eighty-four participants. Forty female and twenty-seven male HCUs from the rural and the urban site participated in eight FGDs, separated by gender. Seven health workers from the rural health centre (HC) and ten health workers from the urban HC participated in two FGDs. Two additional FGDs were conducted with male HCUs, as no data saturation was reached during FGDs with male HCUs. Five themes emerged from the transcripts which might play a role in accessing contraception among Palestinian refugees in Jordan. Firstly, some cultural norms and traditions might influence the use of contraception. Participants mentioned that husbands or family oppose the use of contraception for various reasons. Some of these reasons...
were gender preferences for children, pride in having many children and stigmatization of people who do not uphold with traditional gender norms influence. The wish to expand or continue the family’s name or clan was also mentioned as a barrier to the use of contraception. Disapproving cultural beliefs do not seem to play a significant role. However, participants did express their mistrust towards providers of contraception. Fear of side effects such as infertility was mentioned to discourage people from using contraception. The incorrect use and use of traditional methods was mentioned, indicating a lack of information on contraception. Furthermore, a lack of resources and staff, and unwillingness to provide contraception in some cases, was mentioned. Health workers indicated experiencing a dilemma in deciding about the provision of contraception. In addition, the location of the HC was mentioned to be a barrier for some HCU units to use contraception. Providing children with their rights and improving family live were seen as opportunities for using contraception. Use of contraception and birth spacing was seen as an opportunity to enable women to work and to improve women’s mental and physical health.

Discussion: Husband or family opposition motivated by cultural norms and traditions; and fear of side-effects were the main themes which might affect access to contraception. Furthermore, the incorrect use of contraception seemed to be especially current in the rural community. Findings of this study are in line with findings of other studies that were conducted in Jordan. This study also provides new insights. This study in unique because it examines the role of the health workers and male HCU units. Through this, a better understanding of husband’s opposition is provided, as well as an understanding of the role of health workers, as experienced by HCU units. Additional research, however, is needed to understand the magnitude of findings yielded by this study. In addition, so as to increase access to contraception for Palestinian refugees in Jordan, it is recommended to increase resources for training health workers and improving counselling on contraception. Training should provide health workers with solid tools on how to deal with dilemmas related to the provision of contraception. Counselling on contraception should address the incorrect use of contraception and the use of traditional methods. Furthermore, counselling should provide information on the correct use of contraception and emphasize the opportunity of providing children with their rights by practicing birth spacing.

Conclusion: Husband or family opposition, motivated by cultural norms and traditions plays a role in accessing contraception among Palestinian refugees in Jordan. Also fear of side effects and a lack of information influence the use of contraception. More resources are needed to improve access to contraception by training health workers and improving counselling.
1. Introduction

This report is prepared for Share-Net International, a knowledge platform on sexual and reproductive health and rights (SRHR) which is based in the Netherlands (Share Net International, 2017). Share-Net International was initiated by the Dutch Ministry of Foreign Affairs and aims to ensure that knowledge relevant for achieving improved SRHR is identified, shared, generated and used to achieve international development goals. Share-Net awards small grants to organizations or individuals who conduct activities in the interest of the countries of Burundi, Bangladesh or Jordan and which are relevant or contribute to the Share-Net International aims and aims of the Dutch policy regarding SRHR.

This document is the final report of a study conducted with a small grant awarded by Share-Net International to the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) which is based in Amman, Jordan. The UNRWA is an intergovernmental organisation commissioned in 1948 to provide assistance and protection to Palestinian refugees in the Near East. UNRWA currently aids over five million refugees in Jordan, Lebanon, Syria, Gaza and the West Bank (UNRWA, 2014).

Activities described in this report aim to increase learning on improved access to reproductive health commodities, which is one of the four core areas of Dutch policy regarding SRHR (Government of the Netherlands, 2017). This study aims to understand the currently existing socio-cultural opportunities and barriers to access modern contraception among Palestinian refugees in Jordan.

This report firstly describes the current situation for Palestinian refugees in Jordan in terms of maternal health and health care, followed by information on the opportunity of preventing maternal mortality through modern contraception. Subsequently, the study setting, design, participant selection, data collection and analyses are described. The fifth chapter of this report compares findings of this study with findings from previous research on the same topic and considers limitations of this study. The chapter finishes by providing recommendations for future research and policy on improving access to contraception to Palestinian refugees in Jordan.
2. Background

This chapter provides the background and rationale for this study. Firstly, the global and local context of maternal health and maternal health care is described, followed by an analysis of risk factors for maternal mortality. Contraception as a means of preventing maternal mortality is then described, which forms the rationale behind this study. A conceptual framework is introduced to describe access to health care. This chapter ends presenting the main research questions used in this study.

2.1 Context analysis

Every day 830 women die during pregnancy or child birth due to mostly preventable causes (United Nations, 2015b). More than half of all maternal deaths occur due to three major preventable causes; haemorrhage, sepsis and hypertensive disorders in fragile states or humanitarian settings (United Nations, 2015a). Nearly all of these deaths, 99%, occur in low and middle income countries (LMICs), making maternal mortality a problem of especially poor populations.

Likewise, maternal mortality is an urgent problem among Palestinian refugees living Jordan. Between 2013 and 2016 the amount of maternal deaths increased from 3 to 11 deaths, indicating an increase of 100.4% in maternal deaths (UNRWA, 2013, 2016). Most deaths were due to haemorrhage and pulmonary embolism.

Primary health care is provided free of charge to Palestinian refugees in Jordan by UNRWA, which currently operates 25 health centres (HC) and serves over 1 million refugees in Jordan (UNRWA, 2016). Part of the primary health services of UNRWA are maternal health services. These services comprise of family planning, preconception care, antenatal care, delivery care and postnatal care. Furthermore, during pregnancy, women are encouraged to attend four antenatal care visits. Hospital deliveries are subsidized for women with high risk pregnancies. Currently, 99.9% of deliveries reported to UNRWA took place in hospitals.

For over 60 years, UNRWA has delivered primary health services and has thereby been able to reduce the infant mortality rate (IMR) from 160 to 22.6 per 1,000 live births (Riccardo et al., 2011; UNRWA, 2011), IMR being one of the main indicators for population health (CDC, 2014; Reidpath & Allotey, 2003).

2.2 The problem of ‘too early’ and ‘too many’ pregnancies

Especially young pregnant women are at risk of maternal morbidity and maternal mortality (Blanc et al., 2013; Ganchimeg et al., 2014). Nulliparous pregnant women aged below 20 years have higher chances of complications such as hypertension (pre-eclampsia or eclampsia) or maternal death, compared to pregnant women aged 20 – 30 years (Azevedo et al., 2015; Berhan et al., 2014). Early pregnancies are also related to increased numbers of abortion, emotional problems, school drop-outs and the loss of jobs. In addition, research suggests that 75% of early pregnancies are
unintended and occur in an environment of low household income and low education (Freitas et al., 2013; Neal et al., 2015; Okigbo et al., 2015).

Among Palestinian refugees in Jordan the age of first pregnancy is unknown. However, the mean marital age of women was 20.3 years in 2015 (UNRWA, 2016). The percentage of women married before the age of 18 was 24.6. This indicates that a large amount of women marries before the age of 20. Soon after being married, it is common practice for Palestinian women have their first child. This means that there is a high amount of young pregnant Palestinians in Jordan who have an increased risk of maternal morbidity or mortality.

Pregnancy patterns do not only influence maternal health, they also influence neonatal and infant health. Women with short birth intervals (<18 months) are at increased risk of neonatal complications or neonatal death of their babies (Berhan et al., 2014; Conde-Agudelo et al., 2006; Kozuki et al., 2013; Liu et al., 2015). Research indicates that short birth intervals increase the risk of anaemia and perinatal death. Research conducted in LMICs indicates furthermore that short birth intervals are often not desired by women and frequently occur among women with lower socioeconomic status living in rural areas, circumstances which are similar to that of young pregnant women (de Jonge et al., 2014; Yoder et al., 2013; Yohannes et al., 2011). Obviously pregnancy patterns do not only influence maternal health but also impact the health of neonates and infants of Palestinian refugees in Jordan.

In Jordan, the percentage of Palestinian women with a birth interval shorter than 24 months was 27.7 in 2015. No data are available on the number of women with birth intervals of 18 months or less. However, it is likely that a number of women practices birth spacing less than 18 months and thus is at increased risk of adverse pregnancy outcomes. In addition, a high percentage of Palestinians lives in poverty, confirming that adverse pregnancy patterns occur in populations with a low household income. In 2013, 30.7% of Palestinians living in a camp had an income which was below the national poverty line (Tiltnes et al., 2013). In comparison, among the local population this was only 14.4% (UNDP, 2013).

2.3 Prevention through contraception

This maternal, neonatal and infant morbidity and mortality can be prevented through the use of contraception (Brown et al., 2015; Byrne et al., 2012; Tsui et al., 2010; Yeakey et al., 2009). Contraception can prevent unwanted pregnancies and thereby reduce the number of ‘too early’ and ‘too many’ pregnancies, which increase the risk of maternal, neonatal and infant morbidity and mortality (Haddad et al., 2009; Kozuki et al., 2013; Kozuki et al., 2013 (1); Lassi et al., 2014). Lessening such types of pregnancies can substantially increase the health of mothers and their babies.

Two main types of contraception are distinguished; modern methods and traditional methods (Cluster & Nations, 2006; Singh et al., 2012). Modern methods usually need a device which is distributed through a HC. Traditional methods generally do not need a device. Modern contraception is more effective in preventing pregnancies than traditional methods (Singh et al., 2012). Yet, modern contraception alone are not sufficient in preventing pregnancy it is most
effective when used in combination with counselling (Byrne et al., 2012). Therefore, contraception in this report will refer to the provision of modern contraception in combination with counselling.

Even though many women aspire to delay or stop child bearing, many are not using contraception (United Nations, 2015b). Unmet need for contraception is the proportion of married women or women in union, who are fecund and want to delay or stop childbearing, but are not using, or whose partner is not using any method of contraception (Alkema et al., 2013; Rica, 2005). Worldwide, 12% of women of reproductive age (15 – 49 years) have an unmet need for contraception. Decreasing this need can substantially decrease the amount of ‘too early’ and ‘too many’ pregnancies and thereby increase maternal, neonatal and infant health.

Considerable gains can be made in lowering the unmet need for contraception. While the global unmet need has decreased from 15.4% in 1990 to 12.3% in 2010, 221 million women are still in need of contraception (Alkema et al., 2013). Unmet need for contraception is highest among unprivileged women such as refugees, migrants and urban slum dwellers and women in low-resource settings. Research indicates that by removing the unmet need, 29% of maternal deaths can be prevented (Byrne et al., 2012). The United Nations list the provision of contraception as first intervention to improve maternal health (United Nations, 2015a).

Contraception is provided free of charge to Palestinian refugees in Jordan. Available methods include hormonal contraceptives (combined oral pill, progesterone only pill and injectables), the copper IUD, spermicides and condoms (UNRWA, 2009). Availability of the IUD depends per the HC. Indeed, contraception is provided in combination with counselling by health workers in UNRWA HCs. If refugees desire a type of contraceptive which is not available at UNRWA HCs, they need to purchase this from government or private health services.

The IUD is used most among Palestinian refugees in Jordan, about 42.4% of women who are using any method contraception, use an IUD. The second and third most popular method are hormonal pills (32.1%) and condoms (22.9%) (UNRWA, 2016). Injectable hormonal contraceptives and spermicides are used by 2.5% and 0.03% of contraceptive users respectively. Contraception is provided at UNRWA HCs by a medical officer, staff nurse or midwife.

The unmet need for contraception among Palestinian refugees in Jordan is unknown. However, the number of contraceptive users among refugees has been decreasing every year since 2013, with a discontinuation rate of 6% in 2016 (UNRWA, 2015, 2016). Clearly there is room to increase the use of contraception among Palestinian refugees. It is essential to know how access to contraception can be improved so as to decrease the unmet need for contraception and improve maternal, neonatal and infant health.

2.5 Increasing access to modern contraception

To improve access to contraception, it is crucial to understand which factors are involved in ensuring access to contraception or health care in general. To understand which factors are involved, the framework of Levesque et al. (2013) will be used in this paper (see Figure 1). This Access to Health Care Framework (from now on referred to as the Access-framework) describes that access is ensured through the characteristics of both provider and demand side of health care. The provider side comprises health workers, organisations, institutions and health systems which are involved in
health care provision. The demand side comprises populations, communities, households or individuals who could benefit from health care. The provider side comprises of five characteristics which can allow for access to health care: approachability, acceptability, availability and accommodation, affordability and appropriateness. The five corresponding characteristics of the demand side are the ability to perceive, seek, reach, pay and engage. Access results from the interplay between characteristics of both sides, collectively enabling access to health care or contraception.

The Access-framework has a strong argument for its conceptualisation of access to health care as it is developed through an in depth review of published literature and scientific research on access to health care. For example, compared to other frameworks such as that of Penchansky & Thomas (1981) which primarily focuses on factors related to health workers, the Access-framework incorporates a broad array of factors such as aspects related to health care seeking individuals. Specifically the focus on characteristics of individuals seems relevant for this study as contraception is provided free of charge by the UNRWA. In addition, incorporation of characteristics of health care seeking individuals is important as they might not always aware of the availability of contraception at HCs (Haddad & Nour, 2009). Also, the Access-framework is especially suitable for this study as it applies to a variety of situations, compared to frameworks such as that of Gibson et al. (2014) or the Three-Delay model (Thaddeus & Maine, 1994) which only focus on sub-populations such as HIV/AIDS patients or acute situations.

Finally, the Access-framework is particularly suitable for this study as it integrates factors such as values and culture, which are known to play an important role in accessing contraception (Adongo et al., 2013; Bogale et al., 2011; Burke et al., 2011; Chi et al., 2015; Furuta & Mori, 2008; Mack et al., 2014; Marchant et al., 2004; Mosha et al., 2013; Motlaq et al., 2013; Petro-Nustas & Al-Qutob, 2002; Withers et al., 2015; Wood & Jewkes, 2006; Zeyneloğlu et al., 2013). An example is the social
pressure on women to have a large family which plays a role in ensuring access to contraception. Another example of values playing a role in ensuring access to contraception is male’s stigmatizing of females using contraception as it would allow females to have extra-marital affairs without being discovered by their male partners.

However, in addition to values and culture of health care seeking individuals, those of health workers can also play a role in ensuring access to contraception (Burke & Ambasa-Shisanya, 2011; Chi et al., 2015; Khan & Shaikh, 2013; Marlow et al., 2014; Wood & Jewkes, 2006). Research indicates that the attitude of health workers can hinder individuals from accessing contraception (Chi et al., 2015). Another study found that stigmatization of teen-sexuality by nurses can be a barrier to accessing contraception. As such, this study will focus on both socio-cultural characteristics (opportunities/enablers and barriers) of health care seeking individuals as well as health workers. Previously, no study on access to contraception in Jordan has focused on socio-cultural characteristics of health workers (Petro-Nustas & Al-Qutob, 2002; Sueyoshi et al., 2006).

Differences are known in characteristics and contraceptive use between urban and rural health care seeking individuals.

Differences are known between the contraceptive prevalence of urban and rural health care seeking individuals (World Bank, 1993). In addition, studies report differences in decision making when it comes to contraception between people living in urban and rural areas (Mosha et al., 2013; USAID, 2006). Hence, this study will focus on both urban and rural health care seeking individuals and providers.

This study aims to understand which socio-cultural characteristics (opportunities/enablers and barriers) of both urban and rural health care seeking individuals and providers play roles in accessing contraception by Palestinian refugees in Jordan. This study will contribute to improved access to contraception by providing recommendations for future policy on access to contraception. Findings are greatly valuable to the UNRWA as it is currently reviewing its family planning programme aiming to further improve access to reproductive health commodities and decrease the unmet need for contraception. In addition, findings are of great importance to Jordan in general as in addition to characteristics of health care seeking individuals, no previous research has looked at such characteristics of health workers.

Research questions

Main question: What are socio-cultural opportunities and barriers involved in ensuring access to contraception for Palestinian refugees in Jordan?

Sub-questions

1. What are socio-cultural opportunities and barriers in urban male and female Palestinian refugees in Jordan to accessing contraception?

2. What are socio-cultural opportunities and barriers in rural male and female Palestinian refugees in Jordan to accessing contraception?

3. What are socio-cultural opportunities and barriers in urban and rural health workers to providing access to contraception to Palestinian refugees?
3. Methodology

For answering the main and sub-research questions, a qualitative study approach was adopted. This chapter describes and justifies activities carried out as part of this study in terms of design and setting of the study. Furthermore, it portrays how participants were selected and data was collected. The chapter end with a description of how data was extracted and analysed.

3.1 Study design and setting

A qualitative study design was adopted for answering the main and sub research questions. A qualitative design most effective when the aim of a study is to understand certain social dynamics, which is the objective of this study (Dahlgren et al., 2007; Mack et al., n.d.). Focus group discussions (FGDs) were conducted for data collection as FGDs facilitate interaction during which social dynamics and group norms behind certain behaviour can be understood (Freedman, n.d.; Kitzinger, 1994). This is specifically suitable for this study as its aim is to understand values and norms behind the use of contraception. While conducting the FGDs, an emergent design was used to allow for new themes to emerge during data collection, in addition to predetermined themes (Glaser et al., 1968). FGDs were conducted both in an urban and rural setting. Both male and female HCU participants and health workers participated in FGDs.

FGDs were held from both an urban and rural setting. The Amman New Camp was chosen as urban site and the community of Kraymeh as rural site. Amman New Camp is a Palestinian refugee camp hosting 57,000 Palestinian refugees on an area of 0.48 square kilometres. It is located inside the city of Amman. The Amman New Camp HC is located inside the refugee camp and serves 85,112 Palestinian refugees. The HC also serves refugees who do not reside inside the camp. Kraymeh is a rural community in the Jordan Valley, populated by a high number of Palestinian refugees. The UNRWA HC in Kraymeh is located centrally in the community. The HC serves 6412 refugees. Numbers of contraceptive use are not known on health-centre level. Income level of the populations served by both HCs is below the national level.

FGDs were conducted in both a rural and urban setting and were held in UNRWA HCs. Through multiple conversations with local health workers and policy makers it was concluded that HCs were the most appropriate place for hosting the FGDs. Participants would feel most comfortable in these places as opposed to outside or other close-by community centres.

Dissemination of and dialogue about research findings was done during two meetings with different policy makers in Jordan. One dissemination and dialogue meeting was held at the health department of the UNRWA headquarters with policy makers involved in drafting family planning programming. A second dissemination and dialogue meeting was held with staff of the field office who are involved in carrying out and drafting family planning policy.

3.2 Participant selection

Participants of FGDs conducted in the urban HC were selected using opportunistic purposive sampling in the HCs. Opportunistic purposive sampling is most appropriate for this study setting as it
puts the least burden on FGD-participants (Gray, 2014). Participants do not need to attend the HC an additional time to participate in the group discussion as they are recruited while they are already at the HC. Participants of FGDs conducted in the rural HC were partly recruited through opportunistic purposive sampling at the HC and partly through telephone calls by health workers. Recruitment at the urban and rural HCs was done by researchers. A script was used for inviting participants both through telephone calls and during recruitment at HCs (see Annex 1). Both male and female HCU participants were included in FGDs. For inclusion, females needed to be aged between 18 and 49 years. A minimum age of 18 years was maintained for both ethical and practical reasons; a maximum age of 49 years was used as this is widely seen as the maximum age of female’s reproductive age (Who & Searo, 2006). Males were included if they were aged 18 years or above. Health workers were selected verbally by other health workers. Inclusion criterion was being involved in the provision of family planning at the HC.

3.3 Data collection

In total, 12 FGDs were conducted; six group discussions in each HC; three among females and two among males. One pilot FGD was held at each HC. Two of the FGDs with male participants were scheduled later as no data saturation was reached during previous discussions with males. One FGD per HC was conducted with health workers. Separate FGDs were conducted for males and females. To facilitate discussion among participants, female participants were separated into youth and adult groups (18 – 28 and 29 – 49 years), see Table 1 below. Male participants were not separated into youth and adult groups as initially only 1 FGD per HC was scheduled with male participants.

<table>
<thead>
<tr>
<th>Site</th>
<th>Female 18 – 28 years</th>
<th>Female 29 – 49 years</th>
<th>Male 29 – 49 years</th>
<th>Health workers</th>
<th>Total # of participants</th>
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<tr>
<td>Urban HC</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>40</td>
</tr>
<tr>
<td>Rural HC</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>44</td>
</tr>
</tbody>
</table>

The FGD-guide was developed through review of previous research, articles and reports as well as quantitative and qualitative research findings from Jordan on social dynamics behind access to contraception. The FGD-guide for HCU participants focused on participants’ perception of contraception and contraceptive use (see Annex 2). During group discussion participants were asked to write their answers down, without speaking, so they would be stimulated to express their own opinions and experiences. Furthermore, questions were not asked directly to HCU participants, but rather asked about their thoughts and experiences on other community members. In this way, questions would be perceived less personal and participants would feel more free and safe in speaking about a sensitive topic such as contraception. The FGD-guides were prepared in English and translated into colloquial Jordanian/Palestinian Arabic by the translator. The local translator was part of the target population of Palestinian refugees residing in Jordan and had experience in translating FGDs on sensitive topics.
Group discussions with HCU started with a warm-up to break the ice in terms of speaking about contraception. After that, three exercises were carried out by participants. During the first exercise participants were asked to present perceptions of community members on contraception. During the second exercise participants were asked to provide information on what impedes community members from using contraception and what would be a catalyst for community members when it comes to the use of contraception. The final exercise of FGDs with HCU was the prioritization of barriers which were mentioned earlier during the second exercise. All barriers mentioned during the second exercise were written on a whiteboard. Participants were asked whether they agreed that the barriers written on the whiteboard were the barriers they mentioned during the exercise. If not, barriers were adapted so as to match with the participants’ ideas. Subsequently, participants were provided with two small coloured stickers which represented either two or one point. They were asked to put the sticker with two points on the barrier they deemed most important and the sticker with one point on the barrier they deemed second most important. After this, participants were asked if they agreed with the outcome or not which was sometimes followed by a discussion.

During FGDs the moderator and translator used the term ‘family planning’ (FP) instead of ‘contraception’ as ‘family planning’ was expected to be perceived more familiar by the local population as opposed to contraception.

Throughout the research process, the FGD was slightly adapted so as to allow for more useful answers during group discussions. During the initial phase of the study, the FGD-guide for HCU also included an exercise on the provision of contraception at the HC. This exercise was later replaced by the exercise on community perceptions as this exercise was needed for participants to go more in depth on the use of contraception. The exercise on provision of contraception could not remain as this would make FGDs last too long.

Group discussions with health workers also started with a warm-up to break the ice in speaking about contraception. In addition, the FGD-guide focused on community perceptions of contraception and how contraception is provided (see Annex 3). Another two exercises were included in the FGD-guide but were not carried out due to time limitations.

Group discussions were conducted in colloquial Jordanian/Palestinian Arabic, the mother tong of both participants and the translator. The principal investigator (PI) moderated FGDs, the translator translated and both took field notes during the discussions. Only one FGD was executed each day so as to allow for evaluation and emerging themes which could be interrogated upon in subsequent group discussions. Each discussion lasted approximately one and-a-half hour. An evaluation was held directly after each FGD. The translator and PI discussed what happened and what was learned during the discussion. Lessons learned were taken into account in next FGDs. Field notes were expanded digitally within 24 hours and used during analysis to supplement the translated transcripts.

3.4 Data analyses

All FGDs were tape recorded and transcribed in colloquial Jordanian Palestinian Arabic according to the transcription protocol (see Annex 4). All non-verbal sounds during FGDs were transcribed so also non-verbal communication could be taken into account during analysis. Subsequently, transcripts
were checked and translated into English. Translations were entered into MaxQDA Version 12 for analysis. As both participant recruitment and data collection during pilot FGDs went as planned, recordings of these FGDs were also transcribed, translated and incorporated in analyses.

Analysis was conducted by two researchers. Transcripts were analysed manually making use of predetermined codes, simultaneously allowing for new codes to emerge from transcripts. First, researchers read the transcripts a couple of times before starting analysis. Analysis was conducted through axial coding, which is a slightly more interpretative coding process than open coding (Lucassen & Hartman olde, 2007). Axial coding was the best suitable coding process as partially predetermined codes were used which were derived from previous scientific publications on the same topic. Furthermore, coding was performed according to guidelines by Graneheim and Lundman (2004). Categories, subcategories and themes were determined according to the meaning of the different codes. Analysis was an iterative process, meaning that researchers went back and forth between codes and transcripts during analyses. Analysis was conducted independently by the two researchers, who subsequently discussed findings and reached consensus on discrepancies in their findings. Through discussion they reached agreement themes, categories and sub-categories.

3.5 Ethical considerations

This study was carried out in accordance with the Declaration of Helsinki ensuring that participation was solely voluntarily for participants at all times and that the interest of the FGD participants always prevailed over that of the interest of the study (WMA, 2013). It was explained to the participants that withdrawal from the study was possible at any given moment, without having to provide a reason. Risks and benefits of participation were balance. No incentives were provided; except for refreshments and drinks during the FGDs.

Ethical approval for the study was acquired from the Ethics Office at the UNRWA headquarters in Amman, Jordan. Written and verbal consent was obtained from all participants through the use of an Informed Consent Form (ICF). The ICF was drafted in English according to the World Health Organization (WHO) template for qualitative studies (WHO, 2017) (see Annex 5). The form was subsequently translated into Arabic (see Annex 6). During FGDs, participants were given numbers instead of names, so as to ensure anonymity for all participants. Participants were provided with a telephone number of a local health care worker/policy maker which they could refer to if they had questions once the FGD was over. In transcripts, all names of people, locations or organisations which could identify people, were omitted to keep this information confidential. Recordings, transcripts and translations were stored digitally and are only accessible by the PI using a password. Participants were informed that the recordings will be destroyed after 52 weeks.
4. Results

This chapter presents the findings of FGDs conducted during this study. This chapter starts with a brief description of the sample that was retrieved. Subsequently, findings are presented according to theme and category. In addition, findings were analysed by location and participant group. In general, five themes emerged from the transcripts: culture and traditions; availability of information, health care providers; financial situation, and health status. Each theme comprises a certain number of categories, which are presented according to the themes.

4.1 Study sample

A total of 84 people participated in 12 FGDs (see Table 2); forty (40) females, twenty seven (27) males and seventeen (17) health workers.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Urban HC</th>
<th>Rural HC</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female (age 18-50)</td>
<td>18</td>
<td>22</td>
<td>40</td>
</tr>
<tr>
<td>Male (age 21 – 67)</td>
<td>15</td>
<td>12</td>
<td>27</td>
</tr>
<tr>
<td>Contraceptive users</td>
<td>16</td>
<td>19</td>
<td>35</td>
</tr>
<tr>
<td>Health workers</td>
<td>7</td>
<td>10</td>
<td>17</td>
</tr>
</tbody>
</table>

The mean age of HCUs was 38; the oldest participant was 77 years old, the second eldest participant was 67 years. From the urban HCUs, half of the male participants and half of the female participants indicated to be using contraception. From the rural HCUs, the vast majority of the female participants indicated to use contraception, whereas the vast majority of the male participants stated not to be using contraception.

Professions among the health workers were staff nurses (3), practical nurses (3), doctors (3), midwives (2), clerks (2), lab technicians (2) and one doorkeeper. The doorkeeper did not say anything during the FGD, she was merely present.

4.2 Culture and traditions

Husband and family opposition

Husband or family opposition was frequently mentioned by FGD participants as being a major barrier to the use of contraception. Husband or family opposition means that, as expressed by participants, that women feel the need to use contraception, but that men or other family members of the husband or family-in-law of the woman would not agree with the couple using contraception. Sometimes it was mentioned that the husband would not only disagree but also not allow his wife to use contraception, as explained by a participant while carrying out the prioritisation exercise:
'I put it [the prioritization sticker] here because first and foremost, it's the husband's opinion that will matter. He decides. If he agrees then we will use family planning. If he doesn't agree then we will not use family planning.'
(Female, rural, 29 – 49 years)

During six out of the eight times that the prioritization exercise was carried out in the different FGDs, husband opposition was rated the first or second most important barrier to the use of contraception. In the two other FGDs in which husband opposition was not rated first or second most important barrier, husband opposition was rated third or fourth most important.

In comparison with rural HCUs, urban HCUs spoke less about husband opposition as a barrier to the use of contraception. Urban HCUs spoke more about health workers not wanting to provide contraception, which is expanded upon later.

Health workers expressed uncertainty on their role of providing contraception. Women ask them to provide (or remove) contraceptive methods, with or without the woman having her husband’s consent. Health workers expressed that in such cases the feared for the woman being in trouble for doing something without her husband’s consent. Health workers seemed to feel a dilemma between fulfilling the women’s request with respect to contraception, and preventing the women from getting in trouble as a consequence of doing something without their husband’s consent, as expressed by a health worker:

'We are in a society, that.... we told you before that the social norms are very important, the husband sometimes doesn’t know that she takes family planning, the mother in law doesn't know that she takes family planning, so we are afraid that we might cause the woman problems.'

(Health Worker, urban)

Compared to men, women more often mentioned husband opposition as a barrier to using contraception than men. Men use a number of arguments to explain their desire to have many children. They said that their family would oppose the use of contraception and would put pressure on them to continue having children. Different arguments are used by family members of the husband (his siblings or parents) to pressure the husband to continue having children. These arguments are explained below.

The tradition of pride and gender roles

Pride and the continuation of traditions were frequently mentioned as reasons for having many children and not using contraception. Many HCUs indicated that in general, community members and family members would enjoy more respect and earn pride when they would have more children. As one man commented:
'Yes, from the family, from the family, the father will feel pressured, that for example, 'you have to have kids', 'you have to have kids', 'have kids for pride'.

(Male, urban)

Pride is linked to the opposition of husbands to the use of contraception. Men expressed that pressure is put on them when the community thinks they do not have enough children. Men indicated that family members would shame them if they would not have many children. Family members would look negatively upon men and women who do not have enough children, as expressed by this FGD participant:

‘His sister and his close relative, meaning his brothers, they would say 'you are useless', and 'and your wife is so-and-so. If your wife was a good wife she would have given you four or five children. Look at that man’s wife, god bless her, she has six or seven children'. There is a lot of pressure and all this pressure is from the family.’

(Male, rural)

Men also often expressed that earning pride through having many children is part of their culture. They expressed that they want to uphold this tradition. Furthermore, men expressed that having children was linked to their role as man in the family and society. HCUs expressed that family members would shame men if they would not uphold with their role of having many children.

Compared to men, women less often expressed pride or related factors such as shame or jealousy as a reason for having children. However, some women indicated experiencing pressure from family-in-law for having more children. Participants expressed that pressure is asserted on women to fulfil their gender role of having many children.

Gender preferences

Another important reason according to FGD participants for not using contraception and continuing to have children was the preference for having male children instead of female children. This was mentioned often by both male and female HCUs. It was said that it was important to have male children as compared to having female children. Participants said that if a couple would have children but no male children, they would continue having children until they had a boy. Women said that they were pressured by family-in-law to continue having children if they did not have a boy yet, as expressed by this participant:

‘This is what they did to me! What I mean is that at first I had three girls. After that they kept saying they wanted a boy, my mother-in-law most of all. After three
Girls, I had a boy, and after the boy I had another girl, and then they wanted a brother for the boy and so after ten years I had another boy.’

(Female, urban, 29 – 49 years)

Participants explained that it was important to have boys instead of girls because a family with boys earns more respect and pride within the family or community. Also, it was frequently mentioned that once a couple would have a boy, this boy would need a brother. All categories of FGD-participants agreed that having male children was an important reason for couples not to use contraception but instead to continue having children.

Family and clan survival

During FGDs, it was often mentioned that if the husband was his parent’s only child, than that would be a catalyst for couples to have children. Reason for this was ensuring survival of the family and family name in combination with a society with strong patrilineal traits. Survival of the family was deemed very important, depending in this case only on one family member and passed on through male descendants. Participants expressed that only having one son was not believed to be enough to ensure survival of the family and family name. Therefore, men without siblings can be a catalyst for having children, as expressed by this participant:

‘They are afraid that because he is an only child, that if anything happens to him their family, their family name, the family of his father and his grandfather will cease to exist. And they want the family to grow larger, so as to preserve the family, to preserve the family. Nothing more.’

(Male, rural)

Survival of the family was also expressed as an important reason for husbands not to use or to allow the use of contraception. This was more expressed by female HCU’s than by male HCU’s and more expressed by urban HCU’s than by rural HCU’s. No health workers spoke about the husband being the only child in his family as a reason for couples to have more children and not to use contraception.

In addition, not only family survival, but also clan survival and survival of the population was mentioned to be important and a reason for people not to use contraception. For both clan and population survival participants said it was important to have a large nuclear family, so that in the case that family members would die, the clan would not cease to exist. It was mentioned that small clans (clans with a low number of members) had the least chances of survival. Furthermore participants said that clashes between clans or even within families mostly occur in an environment of people living very close to each other in places such as refugee camps or when families live together in the same house.
Disapproving cultural beliefs

Some participants mentioned that their religion does not allow the use of contraception. Also, participants mentioned that some community members hold cultural beliefs which do not permit the use of contraception. Participants themselves, however, who said to have the same religion, expressed to belief that religion does allow the use of contraception. Such disapproving cultural beliefs on the use of contraception did not seem to be widely accepted or playing an important role in whether or not people would use contraception.

However, some participants did believe that contraception is not allowed. During discussions, participants holding this belief were attacked by other participants who had the same religion, as this part of a discussion illustrates:

‘R1: There isn't a fatwa which says that family planning is forbidden.
R2: Family planning is forbidden and is not allowed by religion, do you understand? It's not allowed.
R1: There isn't a fatwa which says that it's forbidden.’ (Repeated in a hushed tone)
(Male, urban)

In addition, there seemed to be some confusion amongst participants on the working mechanism of contraception. Some different views were held on the working mechanism of contraception. Some participants believed that contraception prevents pregnancy whereas other participants believed that contraception prevents any future pregnancy. Participants believing that contraception prevents any future pregnancy also believed that religion does not allow birth limitation:

‘R1: We are back now to the subject of birth-limitation, and birth-limitation is forbidden.
R2: No, no this is not limitation.
R3: I didn't not limit, I am content-
R2: See, you beat me to saying that. No, no that's because you are saying that it's birth-limitation when it's not.’
(Men, urban)

Furthermore, men seemed much more preoccupied with whether or not religion approves the use of contraception as compared to women. The role of religion in the use of contraception was an important topic during group discussions with male HCUs, whereas this topic was barely touched upon during FGDs with female HCUs. During FGDs held in the rural HC, when participants explained that religion does not allow the use of contraception, it was emphasized that men can marry multiple wives and thereby still have many children, but not put a large burden on only one woman. By marrying and having children with multiple wives, better circumstances would be created for both the woman and the child. However, this belief was not widely shared among participants.
Furthermore, one health worker from the rural site mentioned that in the community people believe that religion does not allow the use of contraception, confirming what other HCUs mentioned during FGDs.

Finally, it seemed that contraception was associated with certain unwanted behaviour such as adultery. Participants explained that women could engage in sex outside of marriage without their husband knowing as they would not get pregnant because of the use of contraception. One participant explained:

‘R1: You were a university student and you have been to a university, right?  
Translator: Yes.  
R1: Look at what we have now, because of birth-limitation and family planning, which exists there], now we have let in a lot of bad things, most important of these is adultery.’

(Male, rural)

Some participants explained that contraception is especially introduced for people who engage in adultery or sex without marriage. They condemned such behaviour and looked negatively upon the use of contraception.

**Mistrust towards contraception and its providers**

Some male HCUs from the rural setting indicated that they lack trust in contraceptive methods and in people who provide the methods. They said that this lack of trust could discourage the use of contraception. Participants indicated that they had a lack of trust in contraceptive methods for a number of reasons. The first reason is that contraceptives are provided for free, unlike for example medication for cancer. Participants did not understand why contraception is provided for free and became suspicious because of that. Also, participants were suspicious of contraception about the high number of contraceptive methods available as well as of the high number of side effects accompanied by each method.

**Children’s rights**

A large number of participants said that contraception was used for birth spacing to provide children with their rights. Participants explained that with rights they meant that the parents or mother were able to raise the children well. They explained that through birth spacing, parents would have more time to spend with their children so that children would not need to play in the streets for example and parents could give them enough attention. One HCU explained:

‘They use family planning because, as the other participant said, because of the closeness in age, meaning that they don’t like to have their children consecutively.'
It has to be that they have a child every three years, to raise them, to take care of them, and to give them attention in that period of time between each child.’

(Female, rural, 18 – 28 years)

All participants, rural and urban, male and female, emphasized the opportunity of providing children with their rights through using contraception and practicing birth spacing.

Family problems

Birth spacing, as participants explained, would not only provide children with their rights, but would also allow for a happier family and couple-life. By practicing birth spacing, couples have more time for each other and would have fewer fights between each other. Also if the couple lives with their family-in-law, they would have a more peaceful living situation if they would use contraception and practice birth spacing, as two participants explained in this quote:

‘R1: But after four or five kids, it’s either that he’ll get bored with her or she’ll get bored with him. By the end of the day, she’ll be exhausted from all the noise, and cannot wait until she gets to sleep. She’ll be really tired I swear. So when her husband wants to get married again, I encourage him to go and get married because I swear he’ll get bored and she’ll get bored. I have experienced this.
R2: There is no time for her to even sit down with her husband and-
R1: There isn’t, there is no time.’

(Female, rural, 29 – 49 years)

The desire to have a more harmonious family life was mentioned by all HCUs as an opportunity when using contraception and practicing birth spacing. Health workers did not discuss this topic.

4.3 Information about contraception

Some categories of codes are related to information about contraception which people have or do not have. This means that the information that people have or do not have plays a role in whether or not people use contraception. The different factors are presented below.

Fear of side effects

Participants frequently mentioned side effects in relation to the use contraception. Participants spoke about side effects, citing information they obtained from friends or family members. Participants explained that the information they had on side effects plays a role in deciding whether or not to use contraception. Compared to speaking about experiences of side effects, participants relatively more discussed side effects which were heard of through relatives or friends, like by this woman:
‘And I am not going to use the IUD so that I wouldn’t get health problems and then my husband would stop loving me. And I am not going to use the injections so that those things won’t happen. And I am not going to use anything because I am afraid. I am afraid that I’ll go crazy or become fat like a cow.’

(Female, rural, 18 – 28 years)

The most feared side effect was infertility. Many participants mentioned that fear of infertility was a reason for people not to use contraception. Both male and female HCUs frequently mentioned fear of infertility as an important factor in whether or not to use contraception. Health workers indicated that stories which community members share with each other on the side effects of contraception are not always based on facts, as commented by this participant:

‘The reason people don’t use family planning is because there are many women who fear that if they started using a family planning method after the first pregnancy and then wanted to get pregnant again, that she might not be able to get pregnant directly and she’ll fear that this delay in getting pregnant is caused by using family planning. This is a belief that the women spread amongst themselves. They say to each other ‘don’t use family planning methods because it will delay your pregnancy’.’

(Health worker)

Furthermore, some participants, especially male HCUs and health workers from the urban site, mentioned that community members have little knowledge on sex and contraception and the working mechanism of sex and contraception. They indicated that this is related to whether or not people use contraception. They also said that especially young people or people who enjoyed little education do not use contraception.

**Traditional contraception**

HCUs from the rural site said they use the traditional method of withdrawal to avoid pregnancy. They said these methods are sufficient if one wants to avoid pregnancy. Especially participants from the rural site mentioned using the withdrawal method.

In addition, HCUs from the rural site indicated to use the lactational amenorrhea method (LAM) until their child would be two years old. They said that their religion prescribes women to use the LAM for two years after child birth. The believe that their religion dictates that the LAM is to be used until two years after child birth was widely spread amongst participants who strongly hold on to it, as explained by a participant:
‘In our religion, in Islam, it’s said that women should breastfeed for two years. The Islamic family planning is for two years. As she breastfeeds for two years, this is family planning in our religion. After two years the woman gets pregnant and has a child.’

(Male, rural)

Solely HCUs, both male and female, from the rural site mentioned using traditional methods or the LAM for two years after child birth. No HCUs from the urban site or health workers mentioned the use of withdrawal or the LAM for two years.

4.4 Health care providers

Some factors mentioned by participants playing a role in the use of contraception are related to health workers, health care providers, HCs or the health system. These factors are presented below.

Lack of resources and staff

A few factors influencing the use of contraception are related to a lack of staff or resources at the HC. Participants mention that they experience long waiting times at HCs before being able to see a health worker. Long waiting times were experienced and mentioned both by health workers and women from the rural and urban sites.

In addition, participants mentioned that health workers have little time to provide HCUs with information and counselling on contraception. This was only mentioned both by health workers and women from the urban site, like one health worker commented:

‘And the heavy workload also affects other family planning methods, for example pills. When we want to give them to someone, we ask that person all the information we need, but we don’t give the patient enough information. What I mean is that it’s important to us that the patient is given the right family planning method, but we don’t have time to give them information about it.’

(Health worker)

Furthermore, health workers emphasized the lack of qualified staff. Health workers from the urban HC emphasized the lack of training. Health workers from the rural site stressed the lack of a gynaecologist at their HC.

Unwillingness to provide

During an FGD with female HCUs from the urban site, a few examples were given in which health workers were unwilling to provide contraception services, as demanded by HCUs. The roles of local health workers, HCs and the health system were only discussed in FGDs with women at the urban
site. During further FGDs, this topic was exchanged by another question, as explained in the Methodology section.

An example which women gave was health workers’ unwillingness to provide contraception if a woman had only had one child (instead of more children):

‘Translator: Does the age play a role in the provision of contraception? If she is young or old?
R1: No, it’s doesn’t... But after the first baby they refuse, after the second baby they will insert it.’

(Female, urban, 29 – 49 years)

Home visits
Participants told about a certain incentive that are provided in their community by an aid organisation and which encourages people to use contraception. Health workers conduct home visits to speak about and provide contraceptives. HCUs from the urban site and health workers from both sites spoke about these home visits. Participants mentioned that health workers make repeated visits to encourage people to use contraception. Participants said that people actually start using contraception, encouraged by those visits. They furthermore view these visits as positive and mention that contraception provided through those health workers are for free. One HCU explained:

‘After that female health worker came to my house, I went to get an IUD inserted and the health worker had already told me when I should go to have it inserted for free. Without her information I would have had it inserted for 80 JD, it would have cost me a lot, including the check-up. That health woman was a gift from God. So when I went, there was a woman setting next to me who wanted to have her baby and then get an IUD. I told her about the health woman and I took her number and I told her that I’d call the health woman for her. By God she prayed for me and the health worker told me ‘I will go to that woman wherever she is. I will go to her’.’

(Female, urban, 18 – 28 years)

Quality of products
Participants also discussed the difference in quality of products provided at private/governmental health care providers or at UNRWA HCs. Views amongst participants differed on whether quality at UNRWA HCs was better or not as good as quality of products at other HCs (private or governmental). Some HCUs mentioned that the quality of products (medication/contraceptives) at UNRWA HCs is less than at other HCs. Health workers, however, mentioned that HCUs perceive the quality of products and services at UNRWA HCs as better than that of non-UNRWA HCs.
4.5 Low household income

Participants mentioned a low household income as both hindering and amplifying the use of contraception, as described below.

Location of the health centre

The location of the HC was mentioned by participants to play a role in the decision of using contraception. Participants mentioned that the location of the HC, where contraception is to be obtained, would be far from the house of some HCU. If they use another method than the IUD, HCU will have to attend the HC once every few months. Participants indicated that the cost of traveling to the HC once every few months could be a barrier to the use of contraception for some people, like one health worker explained:

‘The financial situation, it also stops people from accessing family planning. If they live far away and they don’t have the money to come to the health centre, for example if they live in Sahab [town near Amman]. Some people are afraid. They would tell you they cannot come every month to the health centre to get family planning’. They do not have the money for transport. For some people spending just a dinar or even two dinars means a great deal to them and has a great impact on their budget, a great effect on them.’

(Health worker)

Location of the HC as a financial factor was mentioned during FGDs with both HCU and health workers in both the urban and rural site.

Also, often women are the ones taking care of the children. It will be difficult for them to travel to the HC as they have to either leave the children home or have to bring them along to the HC which can be quite a challenging situation.

Health and education of children

When speaking of the opportunities of contraception and birth spacing, the topic participants mainly spoke about was the ability to provide children with the children’s rights. This means providing their children with good education, health care and attention. Participants mentioned that through birth spacing and the use of contraception they were able to provide their children with good health care and a good education. With good education they mainly meant high school or university, as UNRWA primary schools are free of charge for eligible refugees. One woman commented:

‘What happens is that it'll be easy for the mother to raise them. As her first child will get older and then she’ll start raising the second one, so they will be given their right in education, especially when it’s time for them to go to university.'
When you have them consecutively it’ll be hard to get them both to university at the same time. When the university is for three and four years, it will be hard to send two to university at the same time. But like this, once the first one finishes university, it will be the other’s turn.’

(Female, rural, 29 – 49 years)

Both HCUs from the urban and rural site frequently mentioned the opportunity of providing their children with their rights through the use of birth spacing and contraception. Health workers did not speak about this opportunity.

Women can work

Some participants mentioned that by using birth spacing and contraception, the mother is enabled to work. Traditionally, the mother takes care of the children while families have more children. However, so as to enable the mother to work, one can use contraception and practice birth spacing so the mother will only need to take care of fewer children at the same time. Participants explained:

‘R1: So she will have one or two children, so she'll have the time for her job, she'll have to put them in a day-care if she has a lot of children.
R2: That's right, that's right.
R1: But when she has just one or two children, then she'll be able to leave them with her family, or her husband’s family. She will find that they are enough. But when she has a lot of children, she will be unable [to do so]. [If] she's an employee she doesn't have the time for them, so she will have to use the contraceptive.’

(Female, rural, 29 – 49 years)

The opportunity of enabling women to work through contraception was solely mentioned by female HCUs and a health worker from the rural site.

4.6 Women’s health

Side effects

Experiences of side effects of contraceptives were discussed by participants during the FGDs. However, women who had experienced side effects themselves did not indicate that side effects stopped them from using contraceptives. Rather, they expressed to change method or to settle with the side effects they experienced.

Some health workers mentioned that women whom they met through their work experience side effects from contraceptives and therefore might decide not to use contraception. One health worker explained:
The side effects of the contraceptive, the IUD, and the other family planning methods, this is an important barrier, one that stops them from using family planning.’

(Health worker)

Mental and physical health of mother

Participants frequently spoke about the mental and physical health of the mother as a reason for using birth spacing or contraception. They mentioned that spacing births had the chance to improve both the mother’s physical and mental health as she would be taking care of fewer children at the same time. One woman commented:

‘The second thing is that the mother will have physical and mental rest. Because of family planning she will rest mentally. She will rest mentally and physically.’

(Female, urban, 29 – 49 years)

Compared to male HCUs, female HCUs more elaborately spoke about the physical and mental benefits of practicing birth spacing. Male HCUs mentioned this opportunity less often and merely spoke about the benefits for the general health of the mother, they did not distinguish between the physical and mental health of the mother. Health workers barely mentioned the benefit of birth spacing on the health of the mother.
5. Discussion and conclusion

In this chapter, an interpretation of findings will be given. First, the aim of this study is presented, followed by a brief summary of result of the study. Subsequently, an interpretation will be given for the main results. Then, the results will be compared with findings of previous research. After that, the limitations of this study will be discussed that should be taken into consideration when learning about the results of this study. Next, the recommendations are presented for future studies and policy on improving access to contraception. The chapter finishes with a brief tentative conclusion following the findings of this study.

5.1 Key findings

This study aimed to understand socio-cultural barriers and opportunities to ensuring access to contraception for Palestinian refugees in Jordan. This was done through conducting FGDs with both male and female HCUs and health workers from a rural and urban setting. By conducting these FGDs it became apparent that HCUs generally are aware of the possibility of and working mechanisms of contraception. Participants emphasized to view contraception as a tool to practice birth spacing. Especially some cultural factors seem to play a role ensuring access to contraception for Palestinian refugees in Jordan. Five different themes emerged from analyses which play a role: culture and traditions, information about contraception, health care providers, low household income and mother’s health.

Compared to the other four themes, the theme of culture and tradition was discussed most during FGDs. Culture and traditions seemed to be the main barrier as compared to the other mentioned barriers. Firstly, women indicated wanting to use contraception, but their husbands or family-in-law would not want them to do so for various reasons. Reasons participants cited for husbands and family-in-law not wanting women to use contraception were mainly for pride and to maintain traditional gender roles. Traditional gender roles would dictate women to provide their husbands with children and dictate men to have a ditto wife. Men and women with little children would be stigmatized, which functions as a barrier accessing contraception. Furthermore, men were discussing the role of religion in relation to contraception. However, religion did not seem a barrier for men to use contraception as they strongly feel the need to use contraception for some financial reasons. Some traditional features also provide an opportunity using contraception. Participants mentioned that they wanted to use contraception and practice birth spacing so as to be able to give enough attention to their children while raising them. Also so as to have a more harmonious family life, participants indicated wanting to space births by using contraception.

For women, the main barriers to the use of contraception were its side effects which they heard of from relatives or friends. Especially the fear of infertility was widely spread and an important barrier for women to use contraception. Fear of infertility might be linked to the pressure women experience from their husband and family-in-law to provide their husband with children. Crucial here is to note that women who had actually experienced side effects said that those side effects did not influence their decision on the use of contraception. Side effects of contraception only influenced women’s decisions if the information on the side effects came from other people instead
of their own experiences, indicating the opportunity for counselling to provide correct information on side effects. Furthermore, the use of the LAM for two years after child birth seemed to be widely accepted and used by people in the rural community. Participants said that use of the LAM for two years after child birth was prescribed by their religion.

According to participants, access to contraception was not only influenced by features pertaining to HCU, but also by features to health workers and the HCs. Participants mostly mentioned the lack of resources and staff to be a barrier to accessing contraception. Long waiting times and brief contact time with health workers were mentioned to be a barrier to accessing contraception. Interesting is the role of health care providers in providing access to contraception. Participants mentioned the unwillingness of health workers to provide contraception in certain cases. Throughout the FGDs, health workers expressed their doubts on how to act in a situation in which a woman asked for contraceptive services, but the husband or family-in-law did not approve. Health workers indicated to feel a dilemma between meeting the woman’s request on the on hand, and not meeting the women’s request but preventing them from getting into trouble with their husbands or family-in-law on the other hand. Participants spoke positively about people who conduct home visits to provide contraception. Participants viewed such visits as beneficial and encouraging the use of contraception.

Interestingly, participants explained that a low household income could both be an opportunity as well as a barrier for the use of contraception. For people living far from the HC, a low household income could be a barrier to attend the HC once every few months. However, most participants viewed a low household income as an amplifying factor to use contraception. Contraception and birth spacing would enable parents to provide their children with good education and health care. In addition, through the use of contraception, the wife would be enabled to work while having children.

The health of women was seen as both an opportunity and barrier to the use of contraception. Health workers mentioned that some women would cease to use contraception because of the side effects they experienced. No HCU, however, mentioned that they stopped using contraception because of the side effects. The only HCU who spoke about side effects they had experienced explained that they either accepted the side effects or switched to another method. At the same time, the health of women was seen as an opportunity for using contraception. Participants explained that it is tough for women to have many children consecutively, both physically and mentally. They said that by spacing births, a woman would be enabled to recover physically and mentally. Also, if women have fewer children simultaneously to take care of, they would experience less stress and it would be physically less challenging. As such, wanting to improve women’s health could be an opportunity for the use of contraception.

Overall, there is a great opportunity for the use of contraception. Both men and women are aware of the methods and there is a great willingness to access these. Participants especially mention the use of contraception as a tool to practice birth spacing. Nonetheless, participants expressed that the opposition of husbands or family-in-law, and fear of side effects hinder people from accessing contraception. Main reason for men to oppose the use of contraception is a strong attachment to traditional gender roles in the community. Opportunities for accessing contraception were mainly motivated financially.
5.2 Previous research

Certain findings of this study are in line with research that was previously conducted on access to contraception in Jordan. This study found that husband or family opposition was an important barrier. A recently conducted survey within the UNWRA found that husband opposition was the reason for not using contraception for 19.7% of women who were interviewed, confirming that husband opposition is an essential barrier to accessing contraception by Palestinian refugee women in Jordan.

In addition, a study conducted by Petro-Nustas and al-Qutob found that cultural features such as pride and stigmatization of the use of contraception play a role in the use of contraception. These findings are similar to those presented in this study. Studies of Youssef (2005) and Petro-Nustas and al-Qutob found that preference for boys was negatively associated with the use of contraception. Also in this study revealed that preference for having boys motivated people to continue having children.

Cultural beliefs and the use of contraception were also mentioned in other studies conducted in Jordan (Mahadeen et al., 2012; Sueyoshi & Ohtsuka, 2010). This study found that that disapproving cultural beliefs were hardly present amongst HCUs and did not seem to be a barrier to accessing contraception. These findings are in line with findings presented by Mahadeen et al. They found that disapproving cultural beliefs on contraception only played a role for <1% of interviewed women in whether or not they used contraception.

Also the lack of knowledge, especially on side effects of contraception, was found in two other studies that were conducted in Jordan (Albsoul-Younes et al., 2003; Petro-Nustas & Al-Qutob, 2002). Both studies report that the use of traditional methods is associated with misconceptions and fear about side effects of modern contraception. Our findings confirm these results, indicating the possible magnitude that a lack of knowledge in accessing contraception. The studies of Albsoul-Younes and Petro-Nustas indicate that the use of traditional methods was motivated by unjust fear of side effects.

A study of Al-Qutob and Nasir (2008) found that health workers feel they deliver suboptimal quality of care due to the high working load. This is in line with findings of this study in which health workers said that they were experiencing a high work load and HCUs complain about short contact time with their health workers and long waiting times for HCUs.

Also, a motivation for using contraception found in this study was so as to take good care of the children and provide them with their rights. Participants in FGDs argued that because of their low household income, they were not able to provide for many children, motivating them to practice birth spacing and use contraception. Participants were very united in commenting that people would use contraception to be able to provide their children with their rights and to raise their children well. It was interesting to note that participants continuously used the same words to describe this motivation. A study conducted by Sueyoshi and Ohtsuka (2010) also found that people using contraception was associated with the motivation of taking good care of the children, confirming the opportunity for the use of contraception that this provides.

Lastly, this study reported that the desire to preserve or improve the woman’s mental and physical health could be an opportunity for the use of contraception. This finding confirms findings of the study by Mahadeen et al. (2012), who found that 95% of women report that the use of contraception is beneficial for women’s health.
Some findings of this study appear to contradict findings of previous studies. Mahadeen et al. report no financial obstacles to the use of contraception whereas this study found that traveling to the HC once every few months might be a financial barrier to some HCUs to the use of contraception.

Finally, this study also yielded new results. New results include a strong fear of infertility as a consequence of using contraception as felt by female HCUs. The UNRWA review presented different results, indicating that fear of side-effects was not a major barrier to access contraception. A different research strategy might explain this difference in findings as the UNRWA assessed reasons for not using contraception whereas seeks to understand barriers to the use of contraception.

Another result not reported on by other studies was the mistrust towards providers of contraception, expressed during this study. An explanation for this might be that contraception for participants of this study is provided through an international organisation, as opposed to through local organisations in the case of the other studies.

Furthermore, participants mentioned that the desire of people to improve their lives and living situation if they were living with their extended family, might be an opportunity to practice birth spacing and use contraception so that the living situation would be less chaotic as there would be fewer children. In addition, participants explained that working women also provide an opportunity to practicing birth spacing and using contraception, so that the woman will have to take care of fewer children at the same time. Finally, participants mentioned that home visits by health workers encouraged and enabled people to use contraception. No other previous research on contraception conducted in Jordan reported on such initiatives.

This study is unique for that it incorporated both male and female HCUs as well as health workers. It provides a deeper understanding behind the opposition of husbands and family (-in-law) and suggests opportunities for the use of contraception.

5.3 Study limitations

This study has some limitations which impact the credibility, transferability, dependability and conformability of research findings (Lincoln & Guba, 1985). Firstly, throughout the process of the research it became apparent that some participant groups had an agenda during the course of the FGDs which might have jeopardized the credibility of the research findings. Health workers and HCUs from the rural site wanted the UNRWA to employ a gynaecologist at their HC so that women could have an IUD inserted. Also female HCUs (18 – 28 years) mentioned during FGDs that with a group of women they had put a suggestion in the suggestions box at the HC asking for a gynaecologist. During analysis of results, this bias was taken into account. Also the use of a translator during the FGDs might have weakened the credibility of results (Lucassen & Hartman olde, 2007; Noyes et al., 2011). So as to mitigate the impact, a translator was selected who shared the same background as participants and assisted throughout all FGDs.

Both credibility and transferability of findings might be jeopardised because of the sampling method adopted during this study. Participants were selected through opportunistic purposive sampling, increasing chances that the researcher and the translator influenced this selection process, thereby influencing the representativeness and transferability of findings. In addition, as participants were
selected from HCs, results regarding the location of the HC as a barrier to accessing contraception might not be well represented in this study.

In addition, dependability of results might be compromised as the topic of the provision of contraception through health workers was only discussed in three out of twelve FGDs.

Finally, credibility of findings might be compromised as FGDs were conducted within UNRWA premises (i.e. UNRWA HCs) (Lucassen & Hartman olde, 2007; Noyes et al., 2011). As FGDs were conducted in UNRWA HCs, participants might have felt less free to express their opinion as they are dependent on the UNRWA for their health care and often also for other services. As such, participants might have provided the researcher with socially desirable answers.

5.4 Recommendations

Future research should continue exploring the role of health workers in the provision of contraception, as during this study this was only touched upon during a three out of twelve FGDs. It is important to look further into the role of health workers to better understand the potential misconception between HCU and health workers. Furthermore, so as to have better transferable results, it is important to use sampling methods.

Also, it is crucial to further explore themes which this study highlighted and which had not been highlighted yet in the literature. For example, in previous research, the location of the HC as a barrier to accessing contraception in Jordan was not widely present. Also in the UNRWA survey, this was not taken into account. To get a better understanding of the role of the location of the HC it is essential to assess the magnitude of this factor.

Likewise, it is recommended to assess the magnitude of the fear of side-effects (especially fear of infertility). This fear seemed to be widely spread amongst HCU, both male and female and appeared to be an important factor for people in their decision on whether or not to use contraception. As especially the fear of infertility did not always seem correctly justified, it is recommended to assess the magnitude of the fear of infertility, so as to be able to improve counselling on contraception. The same accounts for the mistrust in providers of contraception (both the system as well as the health workers) that was expressed during FGDs of this study.

When it comes to the provision of contraception, more resources are needed to improve and ensure access to contraception for Palestinian refugees in Jordan. More resources are needed to explore the magnitude of certain findings of this study, to increase contact time between health workers and their patients and to train staff. When training health workers on reproductive health counselling focus should be on the dilemma felt by health workers between what they perceive as to be beneficial for the women and the demands of the women. It seems that this creates a misunderstanding between health workers and HCU. In addition, it is recommended during counselling to provide information on the correct use of the LAM as this study indicates that incorrect beliefs on the use of the LAM are spread amongst community members in both sites (WHO, 1996). Also, strongly held fear for infertility because of contraception should be addressed during counselling. Furthermore, during counselling health workers could emphasize through birth spacing, parents will be able to take good care of their children and provide them with their rights when it comes to education and health care.
5.5 Conclusion

Increased maternal mortality among Palestinian refugees in Jordan urges for immediate action to prevent future maternal deaths. Especially young pregnant women are at risk of maternal morbidity and mortality. In addition, pregnancy patterns also affect infant health. Women who practice short birth spacing have a higher risk of adverse outcomes for their infants. Clearly, pregnancy patterns influence maternal- and infant health. Modern contraception can prevent unwanted pregnancies and thereby improve maternal- and infant health. By increasing access to contraception, maternal- and infant health can be improved. So as to improve access to contraception, it is essential to comprehend what factors play a role in access to contraception in the context of the Palestinian refugees in Jordan. This study explored current barriers and opportunities to accessing contraception among Palestinian refugees in Jordan. Results of this study show that husband or family opposition motivated by cultural norms and traditions; and fear of side effects play a role in accessing contraception by Palestinian refugees in Jordan.

Findings indicate that there is room to improve access to contraception. Therefore, future research should aim to understand the magnitude of findings of this study and policy should address husband or family opposition and the fear of infertility through improved counselling methods.
References


Kitzinger, J. (1994). The methodology of Focus Groups: the importance of interaction between
research participants. Sociology of Health & Illness, 16(1), 141–9889.


Annexes

1. Invitation script

Hello________________

UNRWA would like to invite you to a meeting to discuss access to family planning. It doesn’t matter if you use family planning or not. Instead, we are trying to gain a deeper understanding of the situation here in Wehdat/Kraymeh. From previous research we know that there might be some challenges when accessing family planning. However, we know this from research conducted in countries such as Iran, Kenya or Turkey. No research has been done in Jordan on this topic. This is why we want to do this research and report to UNRWA so they can improve the family planning services.

You will be joined in this group discussion with other female/male Palestinian refugees from Wehdat/Kraymeh. It will take approximately 2 hours of your time, refreshments will be provided. Would you be willing to attend?

The meeting will be held at 10AM, on [DATE] at Wehdat/Kraymeh Health Center.

Kindly make a note of this date and time.

Contact #: Dr. [NAME OF DOCTOR]: [TELEPHONE NUMBER OF DOCTOR]

We look forward to seeing you.
2. **FGD-Guide health care users**

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**Introduction**

“Hello everyone, welcome to our focus group. Our names are [NAME OF TRANSLATOR] and [NAME OF PRINCIPAL INVESTIGATOR], and we will be the facilitators for this focus group. I will moderate and [NAME OF TRANSLATOR] will translate. But before we start we would like to go through the informed consent forms that we will give you.”

[Give out ICFs]

**Introduction**

I am [NAME OF PRINCIPAL INVESTIGATOR], working for the UNRWA. I am doing research on access to family planning. I am going to give you information and invite you to be part of this research. Please take the time you need to decide whether you want to participate in this research. If you have a question, please ask me to stop and I will take time to explain. If you have any questions later you can ask them of me or of dr. [NAME OF DOCTOR] ([E-MAIL ADDRESS]).

**Purpose of the research**

This study is to evaluate and improve the family planning services of UNRWA. From previous research we know that there might be some barriers when accessing family planning. However, we know this from research conducted in countries such as Iran, Kenya or Turkey. No research has been done in Jordan on this topic. This is why we are here to do this research and to report to UNRWA so they can improve the family planning services.

**Type of research**

Your participation comprises taking part in a group discussion. We will do some exercises and ask you to share your opinion and thoughts on family planning. We will not ask you to share personal beliefs, practices or stories and you do not have to share any knowledge that you are not comfortable sharing. We will end by giving you the opportunity to ask questions or to prompt anything you feel should be added to the discussion.

If you are OK with this, the discussion will be tape-recorded, but no-one will be identified by name on the tape. The tape will be stored digitally. The information recorded is confidential; no-one except [NAME OF PRINCIPAL INVESTIGATOR] and [NAME OF TRANSCRIBER] will have access to the tapes. The tapes will be destroyed after 52 weeks.

**Risks**

There is a risk that you share personal information, or that you feel uncomfortable talking about some topics. We do not wish for this to happen. You do not have to answer questions or take part in
the discussion if you feel the question(s) are too personal or if talking about them makes you uncomfortable.

**Benefits**
There will be no direct benefit to you, but your participation is likely to help us find out more about how to improve access to family planning.

**Reimbursements**
You will not be provided any incentive to take part in this research. Refreshments are provided.

**Confidentiality**
We will ask you and others in the group not to talk to people outside the group about what was said in the group, which is common practice in research. You should know, however, that we cannot stop or prevent participants who were in the group from sharing things that should be confidential. We will not be sharing information about you to anyone outside of the research team.

**Sharing the results**
Results will be shared with relevant policy makers at the UNRWA so that they may learn from the research. Results will be shared more broadly through publication in a scientific journal and with the funding agency (Share-Net International) based in Amsterdam, the Netherlands.

**Right to refuse or withdraw**
Your participation in this research is entirely voluntarily. You may stop participating in the group discussion at any time that you wish.

**Who to contact**
If you wish to ask questions later, you may contact dr. [NAME OF DOCTOR] [PHONE NUMBER OF DOCTOR]. This proposal has been reviewed and approved by the UNRWA Ethics Office in Amman, which is committed to ensure research participants are protected from harm. If you wish to find out more about the Ethics Office, contact [NAME], [PHONE NUMBER].

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**Part II: Certificate of Consent**
I have been invited to participate in a group discussion about access to family planning.
I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and questions I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this research.”

[Signing of ICFs]

“So, this study is to evaluate and improve the family planning services of UNRWA. From previous research we know that there might be some barriers when trying to access family planning. However, we know this from research conducted in countries such as Iran, Kenya or Turkey. No research has been done in Jordan on this topic. This is why we are here to do this research and to report to UNRWA so they can improve the family planning services. Furthermore, it is important to know that during this discussion we are to respect each other’s opinions and responses—there are no wrong answers, and all answers are worth discussing and learning from. Disagreements might arise, this is OK. Please do not argue but inform us about your disagreement.
To enable us to listen and to help the translator, we would like you to speak one by one and to not interrupt each other - we will do our best to ensure everyone’s opinion is heard. Are there any remaining questions? During the discussion it will be my task to ask questions but at the end of the discussion there will be room for questions you’re your side again.”

Warm-up
“Now that you have heard some information about this focus group discussion we would like to start with a name round. We will do this by using this object, a [IUD FOR FEMALE PARTICIPANTS/CONDOM FOR MALE PARTICIPANTS]. I will give this to one of you and you can tell us your name and briefly discuss what comes into mind when holding this condom. Then you give this to the next participant. Are there any questions? If not, we will start.”

[Moderator starts]

Exercise 1: Perceptions on family planning
Participants are prompted to express their perceptions on family planning.

“We will now turn to family planning specifically. We would like to prompt you to think of family planning. Please try to see what is good and what is less good about family planning. What do you like and what do you like less about family planning? Take 2 post-its and put them in front of you. Write something that you like about family planning on 1 post-it and something you like less about family planning on the other post-it. There are no wrong answers. I will give you four minutes to think about this and will let you know when time is over. Is this clear to everyone?”

[AFTER 4 MINUTES]

“Ok, is everyone ready? I would like to start by asking you [NUMBER OF PARTICIPANT] if you could mention the two you have on your post-its and if you could paste them onto the mind map.”

Probing questions
“Can you explain why you have selected those two? Are there any specific examples you can think of? Is there anyone who has something similar to these two examples? Is there anyone who has something very different? Now that we have selected all those nice examples, I would like to ask you if there is anything that we might have forgotten to write down.”

Exercise 2: Community barriers
Participants are asked to think of two specific socio-cultural barriers among people in this community (i.e. Wehdat) to accessing family planning. They are prompted to place their post-it notes on a mind map, around the centre idea of “barriers”. Participants are asked to describe and go into further detail on why they chose the sources they chose.

“Now, we would like you to think of family planning and why people here in Wehdat would use it and why they might not use it. Please take two post-its and put them in front of you. Think about two examples of reasons for using or not using family planning and write them down on the post-its, one per post-it. There are no wrong answers. I will give you five minutes to think about this and will let you know when time is over. Is this clear to everyone?”

[AFTER 5 MINUTES]
“Ok, is everyone ready? I would like to start by asking you [name] if you could mention the two you have on your post-its

While listening to the answers, [NAME OF TRANSLATOR] writes down the mentioned barriers on the whiteboard.

Probing questions
“Can you explain why you have selected those two? Are there any specific examples you can think of? Is there anyone who has something similar to these two examples? Is there anyone who has something very different?
Now that we have selected all those nice examples, I would like to ask you if there are any barriers we might have forgotten to write down.”

List of potential barriers/opportunities (based both on previous literature and FGDs)
  - Experienced side-effects;
  - Lack of knowledge on family planning (including misunderstandings about side-effects and fear of infertility);
  - Disapproving cultural beliefs;
  - Opposition of husband and/or family in law;
  - Low perceived risk of pregnancy;
  - Belief that a large nuclear family will bring prosperity;
  - Preference for male children;
  - Perception that the health centre is mainly for women;
  - Gender/sex of the health worker;
  - Financial concerns (location of the health centre);
  - Joint decision making;
  - Counselling of both (man and wife);
  - Education;
  - Religion of health worker;
  - Location of the Health Centre;

Prioritization
Participants are given two stickers: pink, and yellow. They are prompted to use these stickers to prioritize the barriers on the whiteboard, based on which barriers they think are most important.

“The next exercise is about what you think is the most significant barrier. As you can see, on the whiteboard we have written down the barriers that you mentioned earlier. We would like to ask you to take 2 coloured stickers: pink and yellow. Each colour represents a different number of points (pink; most important--2 points, yellow; second most important--1 point). We will give you 2 minutes to place the stickers onto the reasons you think are important. I am kindly asking you to do this assignment without conversation and make choices by yourself only. Is this clear to everyone?”

Exercise 3: Health worker barriers
Participants are asked to think of two specific reasons that might exist among health workers for not prescribing family planning methods. They are prompted to place their post-it notes on a mind map, around the centre idea of “barriers”. Participants are asked to describe and go into further detail on why they chose the barriers they chose.
“We will now turn to the role of health workers specifically. We would like you to think of barriers that might exist among health workers to prescribing family planning methods. What might be a reason for a health worker not to provide family planning to a patient?” *(For example because someone is not married yet, or because someone is below the age of 18)* Be aware that there are no wrong answers, all answers are worth hearing. Please take two post-its and write one example on one post-it. I will give you three minutes to think about this and will let you know when time is over. Is this clear to everyone?”

**[After 3 minutes]**

“Ok, is everybody ready? I would like to start by asking you [NUMBER OF PARTICIPANT] to mention the two you have on your post its and if you could paste them onto the mind map.”

**[Probing questions]**

“Can you explain why you have selected those two? Are there any specific examples you can think of? Is there anyone who has something similar to these two examples? Is there anyone who has something very different? Now that we have selected those nice examples, I would like to ask you if there are any barriers we might have forgotten to write down.”

**Wrap-up**

“We are nearly finished with this discussion. Do you have any questions before we close?”

**[Answer potential questions]**

“We have now come to the end to this focus group discussion. We would like to thank you all for your time and participation; it was very nice to hear all of your perspectives regarding this topic. Please feel free to take anything remaining from the refreshments.”
Introduction

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**Who to contact**
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I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and questions I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this research.”

**[Signing of ICFs]**
“So, this study is to evaluate and improve the family planning services of UNRWA. From previous research we know that there might be some barriers when trying to access family planning. However, we know this from research conducted in countries such as Iran, Kenya or Turkey. No research has been done in Jordan on this topic. This is why we are here to do this research and to report to UNRWA so they can improve the family planning services.
Furthermore, it is important to know that during this discussion we are to respect each other’s opinions and responses—there are no wrong answers, and all answers are worth discussing and learning from. Disagreements might arise, this is OK. Please do not argue but inform us about your disagreement.
To enable us to listen and to help the translator, we would like you to speak one by one and to not interrupt each other - we will do our best to ensure everyone’s opinion is heard. Are there any remaining questions? During the discussion it will be my task to ask questions but at the end of the discussion there will be room for questions you’re your side again.”

Warm-up
“Now that you have heard some information about this focus group discussion we would like to start with a name round. We will do this by using this object, an IUD. I will give this to one of you and you can tell us your name and briefly discuss what comes into mind when holding this condom. Then you give this to the next participant. Are there any questions? If not, we will start.”

[Modemator starts]

Exercise 1: Patient barriers
Participants are asked to think of two specific socio-cultural barriers among patients to accessing family planning. They are prompted to place their post-it notes on a mind map, around the centre idea of “barriers”. Participants are asked to describe and go into further detail on why they chose the sources they chose.

We will now turn to family planning specifically. We would like to prompt you to think of socio-cultural barriers that might exist among patients for accessing family planning methods. Please take two post-its and put them in front of you. Think about two examples of socio-cultural barriers that might exist among patients for accessing family planning and write them down on the post-its, one per post-it. There are no wrong answers. I will give you five minutes to think about this and will let you know when time is over. Is this clear to everyone?

[After 2 minutes]
Ok, is everyone ready? I would like to start by asking you [name] if you could mention the two you have on your post its and if you could paste them onto the mind map. You can put them anywhere on the map and if you think they belong to a post-it already on the map you can group them. [Probing questions] Can you explain why you have selected those two? Are there any specific examples you can think of? Is there anyone who has something similar to these two examples? Is there anyone who has something very different?
Now that we have selected all those nice examples of barriers, I would like to ask you if there are any barriers we might have forgotten to write down.

[After 4 minutes]
“Ok, is everyone ready? I would like to start by asking you [name] if you could mention the two you have on your post-its and if you could paste them onto the mind map.”

Probing questions
“Can you explain why you have selected those two? Are there any specific examples you can think of? Is there anyone who has something similar to these two examples? Is there anyone who has something very different?
Now that we have selected all those nice examples, I would like to ask you if there is anything that we might have forgotten to write down.”

List of potential barriers/opportunities (based both on previous literature and FGDs)
- Experienced side-effects;
- Lack of knowledge on family planning (including misunderstandings about side-effects and fear of infertility);
- Disapproving cultural beliefs;
- Opposition of husband and/or family in law;
- Low perceived risk of pregnancy;
- Belief that a large nuclear family will bring prosperity;
- Preference for male children;
- Perception that the health centre is mainly for women;
- Gender/sex of the health worker;
- Financial concerns (location of the health centre);
- Joint decision making;
- Counselling of both (man and wife);
- Education;
- Religion of health worker
- [add more if appropriate];

**Exercise 2: Health worker barriers**

*Participants are asked to think of two specific barriers among health workers to providing access to family planning. They are prompted to place their post-it notes on a mind map, around the centre idea of “barriers”. Participants are asked to describe and go into further detail on why they chose the barrier they chose.*

We will now turn to the role of health workers specifically. We would like you to think of barriers that might exist among health workers to providing access to family planning. What might be a reason for a health worker not to provide family planning to a patient? But be aware that there are no wrong answers, all answers are worth hearing. Please take two post-its and write one example on one post-it. I will give you five minutes to think about this and will let you know when time is over. Is this clear to everyone?

[After 2 minutes]

Ok, is everybody ready? I would like to start by asking you [name] to mention the two you have on your post its and if you could paste them onto the mind map. You can put them anywhere on the map and if you think they belong to a post-it already on the map you can group them.

While listening to the answers, [TRANSLATOR] writes down the mentioned barriers on the whiteboard.

*Probing questions*

“Can you explain why you have selected those two? Are there any specific examples you can think of? Is there anyone who has something similar to these two examples? Is there anyone who has something very different? Now that we have selected all those nice examples, I would like to ask you if there are any barriers we might have forgotten to write down.”

*Prioritization*

*Participants are given two stickers: pink, and yellow. They are prompted to use these stickers to prioritize the barriers on the whiteboard, based on which barriers they think are most important.*
“The next exercise is about what you think is the most significant barrier. As you can see, on the whiteboard we have written down the barriers that you mentioned earlier. We would like to ask you to take 2 coloured stickers: pink and yellow. Each colour represents a different number of points (pink; most important--2 points, yellow; second most important--1 point). We will give you 2 minutes to place the stickers onto the reasons you think are important. I am kindly asking you to do this assignment without conversation and make choices by yourself only. Is this clear to everyone?”

[After 2 minutes]

“I would like you to briefly expand upon your top rankings and why you chose them.”

[7 minute Break]

Exercise 3: Solutions

Participants are asked to think of strategies to overcome barriers that were mentioned during the second exercise. Barriers are written on the whiteboard.

“In the second exercise we talked about barriers to accessing family planning among the community here (and we discussed barriers that you deem most significant). We would like you to pair up with someone. Then, please pick one barrier that is written on the whiteboard and try to come up with a solution to overcome this barrier. Please write or draw what you are thinking of (this can be more than one thing) on a post-it.

We will give you 5 minutes for this and then discuss our findings.”

[After 7 minutes]

“Is everybody done? Now we would like you to tell us which barrier you chose and explain the solution that you were thinking of. Please put the solution on the map and explain your solution.

Thank you all for your ideas and solutions to these barriers. As you can see there are some people who chose to [example] as a solution to overcome barriers, and others who chose to [example].”

Wrap-up

“We are nearly finished with this discussion. Do you have any questions before we close?”

[Answer potential questions]

“We have now come to the end to this focus group discussion. We would like to thank you all for your time and participation; it was very nice to hear all of your perspectives regarding this topic. Please feel free to take anything remaining from the refreshments.”
4. **Transcription protocol**

**Text format**

Transcribe all focus group discussions (FGDs) using Calibri 11-point font, with one-inch margins on all sides and justification of the text on both sides. Use 0 points of spacing after and before paragraphs, use enter.

**Archival #**

Each FGD has its own archival number indicating the location of the event (i.e. Amman New Camp or Kraymeh), the type of event (i.e. focus group discussion) and the focus group sample. The first 3 letters of the archival # indicate the location. Amman New Camp is indicated as: ANC; Kraymeh is indicated as: KRM. The following 3 letters indicate the type of event. All events in this study were focus group discussions, and are indicated as: FGD. The last letters indicate the focus group sample. There are 5 focus group samples:

1. The pilot including females aged 29 – 49 years indicated as: Pilot
2. Females 29 – 49 years indicated as: F29-49
3. Females 18 – 28 years indicated as: F18-28
4. Males 18 years and above indicated as: M18+
5. Healthcare workers indicated as: HCW

For example, the focus group discussion held at Amman New Camp with women aged 18 to 28 years old would be archived under the following name: ANCFGDF18-28.

**File name**

Start the file name of the transcript always with the archival number of the focus group discussion, followed by a space and Transcr. For example: KRMFGDHW Tanscr

**Interview Transcript Header**

Label all FGD transcripts with the following header at the top of the document in bold font, completed according to the FGD which is being transcribed in the document. Use TABs between the two columns of details to space (just as it is done in this example). Use 10 points of spacing after a paragraph in the header (see example). Place a ½ points top border above the header and a ½ points bottom border underneath the header:

<table>
<thead>
<tr>
<th>Archival #:</th>
<th>Site:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus group sample:</td>
<td># Participants:</td>
</tr>
<tr>
<td>Date of Interview:</td>
<td>Moderator:</td>
</tr>
<tr>
<td>Translator:</td>
<td>Transcriber:</td>
</tr>
</tbody>
</table>
Press ‘enter’ twice after the header, leaving a single blank line between the header and the focus group transcript.

**Participant ID**

Before the transcript of each response or question, identify the speaker using the Participant ID, preceded and followed by a double pound sign (##). For example ##ANCFGDF18-28_1##.

The Participant ID for each individual in the focus group is the archival number from the focus group discussion, followed by ‘_1’ for the participant with the participant number 1 in the focus group discussion. (For example archival number KRMFGDM18+ becomes Participant ID KRMFGDM18+_1 for Participant 1 of the focus group discussion, KRMFGDM18+_2 for Participant 2, and so on.)

For focus group participants who cannot be readily identified on the recording, type the archival number from the recording/focus group discussion, followed by _UNKNOWN. For example KRMFGDM18+_UNKNOWN would mean unidentifiable participant for the focus group discussion with the archival number KRMFGDM18+.

Should the moderator speak, indicate this using the abbreviation MOD. For example KRMFGDM18+_MOD. Should the translator speak, indicate this using the abbreviation TRANS. For example KRMFGDM18+_TRANS.

**Indicating the Start of a New Recording File**

Indicate the start of a new recording file by typing ‘START OF RECORDING_FILE 1’. Be sure to use capital letters. For example:

```plaintext
##KRMFGDM18+_5##
Transcript
```

**Indicating End of Focus Group Discussion**

Press ‘Enter’ twice after the last line of focus group transcript text, leaving two blank lines. Type END OF INTERVIEW in capital letters on the last line of the transcript to indicate that the interview session had ended. For example:

```plaintext
##KRMFGDM18+_1##
Transcript

END OF INTERVIEW
```
Transcribing Contents of Recordings

Transcribe all recordings verbatim (that is, word-for-word, exactly as words were spoken). Transcribe all parts that are spoken in Arabic. This means that the parts spoken by the translator and the focus group participants. English spoken parts of the interview do not need to be transcribed.

Indicate all nonverbal or background sounds in parentheses. This includes laughter, sighs, coughs, clapping, snipping of fingers, pen clicking, car horn, birds, et cetera. For example: (short sharp laugh), (group laughter), or (police siren in background).

Do not ‘clean up’ the transcript by removing foul language, slang, grammatical errors, or misused words or concepts.

Transcribe any mispronounced words exactly as the interviewer or participant pronounced them. If a transcribed mispronunciation risks causing problems with the reader’s comprehension of the text, use the following convention: [/word as it would correctly be pronounced/]. For example:

I thought that was pretty pacific [/specific/], but they disagreed

Standardize the spelling of key words, blended or compound words, common phrases, and identifiers across all focus group transcripts.

Transcribe all fillers, sounds that are not standard words but that do express some meaning. For example: hm, huh, mm, mhm, uh huh, um, mkay, yeah, yuhuh, nah huh, ugh, whoa, uh oh, ah, or ahah.

Transcribe repeated words or phrases. For example:

I went to the clinic to see, to see the nurse.

Transcribe truncated words (words that are cut off) as the audible sound followed by a hyphen. For example:

He wen- he went and did what I told him he shouldn’ve.
Unclear speech

Indicate recording segments that are difficult to hear or understand on the transcript. For words or short sentences, use [inaudible segment]. For example:

The process of identifying missing words in a recorded interview of poor quality is [inaudible segment].

For lengthy segments that are difficult to hear or understand, or when there is silence because no one is talking, record this information in square brackets. Also provide a time estimate for the information that could not be transcribed. For example:

[Inaudible: 2 minutes of interview missing].

Overlapping speech

Indicate overlapping speech (when multiple participants are speaking at the same time) that is difficult to separate and assign to individual speakers by typing [cross talk]. Resume transcription with the first speech that can be attributed to an individual.

Pauses

Mark brief pauses with periods or ellipses ( . . ). Brief pauses are breaks in speech lasting two or three seconds. They often occur between statements or when the speaker trails off at the end of a statement. For example:

Sometimes, a participant briefly loses . . . a train or thought or . . . pauses after making a poignant remark. Other times, they end their statements with a clause such as but then . . .

Pauses longer than 3 seconds by typing (long pause). For example:

Sometimes the individual may require additional time to construct a response. (Long pause) Other times, he or she is waiting for additional instructions or probes.

Questionable Accuracy

Indicate that a word or phrase may not be accurate by typing the questionable word between question marks and parentheses. For example:
I went over to the ?(clinic)? to meet with the nurse to talk about joining up for the study.

**Sensitive Information**

When an individual uses his or her own name during the discussion, replace the name with the appropriate Participant ID. For example:

```plaintext
##ANCFGDF29-49_3##

My family always tells me, ‘ANCFGDF29-49_2, think about things before you open your mouth’
```

```plaintext
##ANCFGDF29-49_1##

Hey ANCFGDF29-49_2, don’t feel bad; I hear the same thing from mine all the time.
```

If an individual uses the names of people, locations, organization, etc., identify them by typing an equal sign (=) immediately before and after the sensitive information. For example:

```plaintext
##ANCFGDF29-49_1##

We went over to =John Doe’s= house last night and we ended up going to =O’Malley’s Bar= over on =22nd Street= and spending the entire night talking about the very same thing.
```
Informed Consent Form for beneficiaries of UNRWA health centres who were invited to participate in research on access to family planning

**Principal Investigator:** N Gerritsma  
**Sponsor:** Share-Net International, the Netherlands

This Informed Consent Form has two parts:  
- Information Sheet (to share information about the study with you)  
- Certificate of Consent (for signatures if you choose to participate)

You will be given a copy of the full Informed Consent Form.

**Part I: Information Sheet**

**Introduction**  
I am Noortje Gerritsma, working for the UNRWA. I am doing research on access to family planning. I am going to give you information and invite you to be part of this research. Please take the time you need to decide whether you want to participate in this research. This consent form may contain words you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have any questions later you can ask them of me or of Dr. [NAME OF DOCTOR] ([E-MAILING ADDRESS OF DOCTOR]).

**Purpose of the research**  
Family planning can prevent unwanted pregnancies, reduce the number of abortions, and lower the amount of deaths due to complications during pregnancy or labour. We want to find ways to give more people a choice in family planning. We believe that you can help us by telling us what you know about family planning and how family planning is delivered. We want to learn what different reasons are for people to use or not to use family planning.

**Type of research**  
You will be asked to participate in a discussion with 6 – 8 other [PEOPLE OF THE SAME PARTICIPANT CATEGORY] registered with [NAME]-health centre. This discussion will be guided by Noortje Gerritsma.  
The group discussion will start with me, providing an introduction to this research and giving you the opportunity to ask questions about this research. Then we will do some exercises about family planning. We will not ask you to share personal beliefs, practices or stories and you do not have to share any knowledge that you are not comfortable sharing. We will end by giving you the opportunity to ask questions or to prompt anything you feel should be added to the discussion.  
The entire discussion will be tape-recorded, but no-one will be identified by name on the tape. The tape will be stored digitally. The information recorded is confidential; no-one except N Gerritsma and the transcriber (to be identified) will have access to the tapes. The tapes will be destroyed after 52 weeks.

**Risks**  
There is a risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics. However, we do not wish for this to
happen. You do not have to answer any question or take part in the discussion if you feel the question(s) are too personal or if talking about them makes you uncomfortable.

Benefits
There will be no direct benefit to you, but your participation is likely to help us find out more about how to improve access to family planning in this community.

Reimbursements
You will not be provided any incentive to take part in this research. Refreshment will be provided.

Confidentiality
We will ask you and others in the group not to talk to people outside the group about what was said in the group. We will ask each of you to keep what was said in the group confidential, which is common practice in research. You should know, however, that we cannot stop or prevent participants who were in the group from sharing things that should be confidential. We will not be sharing information about you to anyone outside of the research team.

Sharing the results
Results will be shared with relevant policy makers at the UNRWA so that they may learn from the research. Results will be shared more broadly through publication in a scientific journal and with the funding agency (Share-Net International) based in Amsterdam, the Netherlands.

Right to refuse or withdraw
Your participation in this research is entirely voluntarily. You do not have to take part in this research if you do not wish to do so. You may stop participating in the group discussion at any time that you wish. I will give you the opportunity at the end of this group discussion to review your remarks, and you can ask to modify or remove portions of those from the recording.

Who to contact
If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact dr. [NAME DOCTOR] [TELEPHONE NUMBER OF DOCTOR]. This proposal has been reviewed and approved by the UNRWA Ethics Office in Amman, which is committed to make sure research participants are protected from harm. If you wish to find out more about the Ethics Office, contact [NAME OF OFFICER], [TELEPHONE NUMBER OF OFFICER].

Part II: Certificate of Consent
I have been invited to participate in a group discussion about access to family planning. I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and questions I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this research.

Print Name of Participant__________________

Signature of Participant ___________________

Date ___________________________

  Day/month/year
Statement by the translator and researcher:
I have to the best of my ability made sure that the participant understands that the following will be done:
1. Group discussion for about one and a half hour on access to family planning here in the community;
2. The discussion will be tape-recorded without people being identifiable by name;
3. Results of the study will be shared with policy makers and other interested people and in scientific journals.

I confirm that the participant was given the opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this Informed Consent Form has been provided to the participant.

Name of translator _______________________

Signature of translator _______________________

Date ___________________________
         Day/month/year

Name of researcher _______________________

Signature of researcher _______________________

Date ___________________________
         Day/month/year
استمارة الموافقة المستنيرة للمشارك في بحث عن إمكانية الوصول إلى خدمات تنظيم الأسرة

الباحثة الرئيسية: نورتشا خيرتسما
راعي البحث: ش رنت العالمية ، هولندا

استمارة الموافقة المستنيرة تتكون من جزئين:

- صحيفة معلومات (لمشاركةكم بمعلومات عن هذه الدراسة)
- وثيقة الموافقة (لتوقيع إذا اختتمتم المشاركة)

سوف يتم إعطائكم نسخة من إستمارة الموافقة المستنيرة كاملة.

الجزء الأول: صحيفة المعلومات

المقدمة

أنا نورتشا خيرتسما وأعمل لدى الأروروا. أجري بحثاً حول إمكانية الحصول على خدمات تنظيم الأسرة. سوف أقوم بإعطائكم معلومات وسأدعوكما لتكونوا جزءاً من هذا البحث. الرجاء أخذ الوقت الكافي لإتخاذ القرار حول ما إذا أردتم المشاركة في هذا البحث. إذا نفيكم أي سؤال، أرجو بأن تطلبهوا من الوقوف وأنا ساعطي الوقت الكافي للشرح. في حال كان لديكم أي أسئلة بعد ذلك يمكن لكم أن تطرحوها على الدكتور مصطفى عمورة ([EMAILING ADDRESS OF CHIEF AREA OFFICER]).

هدف البحث

إن هذه الدراسة تهدف إلى تقييم وتحسين خدمات تنظيم الأسرة في الأروروا. نحن نعلم من الأبحاث السابقة أنه قد يوجد هناك بعض العقبات عند المحاولة للحصول على تنظيم الأسرة. ولكن، نحن حصلنا على هذه المعرفة عن طريق أبحاث أجريت في بلدان أخرى كإيران، كينيا، وتركيا. لم يتم إجراء دراسة على هذا الموضوع في الأردن من قبل. ولذا نحن هنا لإجراء هذا البحث ورفع تقرير عنه إلى الأروروا، ذلك حتى يتمكنوا من تحسين خدمات تنظيم الأسرة التي يقدمونها.

نوع البحث

تشمل مشاركتكم في هذا البحث على المشاركة في نقاش جماعي.

 deferred treatment: منكم منكم شاركتنا أروروا وأفكراك حول موضوع تنظيم الأسرة. نحن لنطلب منكم أن شاركونا معنا إذا أجريتكم شخصية أو أشارتنا الخصوصية أو الأفكار الخاصة بكم وأنت ليس علينا أن تشاركنا بآية معرفة لا تساعرون بالراحة جالسونا بها. سوف ننهي هذا بإعطائكم الفرصة لطرح الأسئلة أو لطرح أي أمر تشعرون بأنه يجب إضافته للنقاش.

إذا وافقت على هذا، سيتم تسجيل التحقيق على شريط، ولكن لن يتم التعريف بالإسم عن أي أحد في هذا التسجيل. سيتم تخزين هذا الشريط رقمياً. المعلومات التي سنستلمها ستكون سرية; لن يستطيع الوصول إليها أي أحد عدا نورتشا خيرتسما والباحث (سيتم تعريفه). سيتم تدبير التسجيلات بعد 52 أسبوع.
المخاطر

يوجد مخاطرة بأن تصبحوا نحن microbes شخصية من غير قصد، أو أنكم قد تشعرون بالراحة جبال الحديث عن بعض المواضيع. ولكن، لن تحتر نحنرغب في حدوث ذلك. ليس عليكم الإجابة على الأسئلة أو المشاركة في النقاش إذا شعرتم أن الأسئلة شخصية جدا أو إذا كان الحديث فيها يشعركم بعدم الراحة.

المتوقع

لن يوجد مناقع مباشرة لكم، ولكن من المرجح أن تشارككم مساعدتنا على معرفة المزيد عن كيفية تحسين تنظيم الأسرة.

التعويضات

لن يتم تقديم أي محفزات لدفعكم للمشاركة في هذا البحث. سيتم تقديم المزادات.

السرية

ستطلب منكم ومن الحاضرين في هذه المجموعة بأن لا تحضروا مع أشخاص آخرين من خارج هذه المجموعة عن ما تم الحديث عنه في هذه المجموعة. وهذا من الممارسات الشائعة في البحث ولكن يجب الأخذ في عين الاعتبار أننا لا نستطيع إيقاف أن منع المشاركين في هذه المجموعة من مشاركة الأمور التي يجب المحافظة على سريتها. لن نقوم بمشاركة المعلومات الخاصة بكم مع أي أحد خارج فريق البحث.

مشاركة النتائج

سيتم مشاركة نتائج هذا البحث مع ذوي الصلة من القائمين على صنع السياسات في الأوروبا عن طريق إجتماع سيعقد بعد الإنتهاء من البحث وذلك حتى يستفيدون من البحث. النتائج سوف يتم مشاركتها على نطاق أوسع من خلال نشرها في مجلة علمية وأيضاً مع المنظمة الممولة شير- نت العالمية، التي مقرها في أمستردام، في هولندا.

حق الرفض أو الانسحاب

مشاركتكم في هذا البحث هي طوعية كليا. يمكن لكم التوقف عن المشاركة في النقاش الجماعي في أي وقت ترغبون به.

جهة الاتصال

إذا رغبتم في طرح الأسئلة لاحقا، يمكن لكم التواصل مع الدكتور مصطفى عمورة [TELEPHOPNE NUMBER]. هذا المقترح تم مراجعته والموافقة عليه من قبل مكتب الأخلاقيات - الاندروفا في عمان. والذين هم على ال常识 للحصول على أن المشاركين محرومون من أي آذى إذا رغبتم في معرفة المزيد عن مكتب الأخلاقيات، يرجى التواصل مع ليد ناكنغر [TELEPHOPNE NUMBER].
الجزء الثاني: وثيقة الموافقة

لقد تم دعوتى للمشاركة في نقاش جماعي حول إمكانية الحصول على خدمات تنظيم الأسرة. لقد قمت بقراءة جميع المعلومات المدرجة أعلاه، أو قد تم قرائتها لي. لقد أعطيت لي الفرصة لطرح الأسئلة حول هذه المعلومات وقد تم الإجابة عليها بشكل مرضي. أنا أوافق طواعية على المشاركة في هذا البحث.

اسم المشارك:

توقيع المشارك:

التاريخ:
اليوم/الشهر/السنة

تصريح من قبل المتزجم:

لقد بذلت قصارى جهدي في الحرص على أن المشاركة قد فيهم أنه سيتم القيام بالاتي:

1. نقل جماعي مدة ساعة ونصف تقريباً عن إمكانية الحصول على خدمات تنظيم الأسرة في المجتمع.
2. سيتم تسجيل النقاش على شريط وذلك بدون التعريف عن المشاركين بالاسم;
3. سيتم مشاركة نتائج هذا البحث مع صانعي السياسات وأي أشخاص اخرون من ذوي الاهتمام وفي مجالات علمية.

أنا أؤكد أنه تم إعطاء المشاركين الفرصة لطرح الأسئلة عن الدراسة، وأن كل الأسئلة التي طرحها من قبل المشاركين قد تم الإجابة عليها بشكل صحيح وعلى أكمل وجه من مقدري. أنا أؤكد أن الفرد المشارك لم يتم إجباره على الموافقة على المشاركة، وأن الموافقة قد أعطيت طوعياً وحرية تامة.

تم تقديم نسخة من استمارة الموافقة المستثيرة هذه إلى المشارك.

اسم المترجم:

توقيع المترجم:

التاريخ:
اليوم/الشهر/السنة
اسم الباحث

توقيع الباحث:

التاريخ: ____________________
اليوم/الشهر/السن