Meeting Their Needs:

Results from a Knowledge, Attitudes and Practices (KAP) Survey on Gender-Based Violence and Reproductive Health in the Mafraq and Irbid Governorates, Jordan

A Report from the International Rescue Committee

March 2015

Fieldwork Designed and Conducted by the
Queen Zein Al Sharaf Institute for Development (ZENID)

Draft Prepared by Rachel Schmidt

EXECUTIVE SUMMARY

As of March 2015, UNHCR had registered over 3.7 million Syrian refugees, with an estimated rate of nearly 3,000 refugees arriving daily and over 80,000 people awaiting registration.[1] Women and girls are disproportionately affected by this displacement, but they have historically been at the margins of service provision. Female refugees, as well as vulnerable women and girls in host countries, face daily threats of harassment, high rates of domestic violence, and early or forced marriages. Yet most cases of violence against women and children are unreported or do not receive effective intervention due to social, familial, economic, and legal repercussions.

Because traditional support networks have broken down and many refugee families have been separated, there has been an overall increase in the vulnerability to gender-based violence.[2] The refugee population in Jordan has reached 624,854 as of March 10, 2015.[3] According to UNHCR statistics, the majority of these refugees and other "persons of concern" reside in Mafraq (155,926)[4] and Irbid (141,103)[5] governorates, which have been identified as primary areas of concern.

IRC conducted this survey in collaboration with the Jordanian Hashemite Fund for Human Development (JOHUD). The main objectives of the survey were:

1. To provide baseline information about current knowledge, attitudes and practices regarding GBV and RH issues among the targeted population;
2. To provide information about the level of knowledge regarding the available services and referral pathways for GBV and RH;
3. To determine the source of information and service seeking behaviors regarding GBV and RH issues.

The field data collection process took place from October 4-10, 2014 and surveyed 1,062 people residing in the urban centers of Irbid, Mafraq and Ramtha. Due to resource limitations the survey was not statistically representative, but the results give a general overview of the needs and attitudes of the persons in need living in these areas.

[1] UNHCR. 2015. Syrian Regional Refugee Response: Inter-agency Information Sharing Portal http://data.unhcr.org/syrianrefugees/regional.php. Accessed March 10, 2015.
[2] UNHCR. 2014. Sexual and Gender-Based Violence: Syrian Refugees in Jordan. SGBV Sub-Working Group. Report, March 2014
[3] UNHCR. 2015. Syrian Regional Refugee Response: Inter-agency Information Sharing Portal (by country). http://data.unhcr.org/syrianrefugees/country.php?id=107. Accessed March 10, 2015.
[4] ibid
[5] ibid

Summary of Survey Results

Section 1: Awareness:

Out of all services available, respondents were most aware of health and education services and least aware of recreational services and legal aid, with no significant differences between male and female respondents. Syrians were more aware of cash assistance, food services, and psychosocial services than Jordanians. Out of all respondents, 17% could identify IRC as a service provider. Notably, 40% of Syrians identified IRC as a service provider, especially in health-related services, while only 9% of Jordanians did so.

Section 2: Access and Use of Services

A large majority (over 74%) of respondents had accessed some type of available service in their community, most commonly health services. Females accessed services slightly more than males, and Syrians accessed services more than Jordanians. Of those accessing IRC services, the majority were females over the age of 19, accessing medical doctors. Non-health related services were not as well known and were accessed much less frequently.

Section 3: Service Seeking Attitudes

In terms of services for women, health clinic doctors and health clinic midwives were considered the most important overall. For girls, health clinic doctors, cash assistance and training/awareness were ranked most important. Health mobile teams were consistently ranked least important even though other health services were ranked highly, suggesting either a lack of awareness as to what health mobile teams offer, or the perception that they will not meet pressing needs.

Section 4: Accessibility

Overall perception of accessibility of services offered by all types of providers for women and girls was low, with only general health services ranking high in accessibility. Services for girls were perceived to be even less accessible than services for women. In general, Syrians perceived services as less accessible than Jordanians, and women perceived services as less accessible than men. Psychosocial services were perceived as less accessible than most others. The primary obstacles for women and girls to access services were perceived as: the mixing of men and women, distance to services, not being permitted by family to access services, and being unsure of what the service provides. All of these results suggest the need not only for more services in general, but better separation between men and women, more information on what services do, and increased education in the families on allowing women and girls to access services.

Section 5: Knowledge and Awareness of Gender-Based Violence (GBV)

Respondents felt that violence was fairly common in their communities, listing psychosocial violence as the most common form. Respondents felt that home and school were the most likely locations for physical and psychological violence, and the most likely locations for sexual violence were open public spaces and school. Knowledge of the term “gender-based violence” was very low. Overall, Jordanians ranked violence as more common than Syrians did, suggesting that host communities are feeling vulnerable and in need of support, especially psychosocial support.

Section 6: Knowledge, Attitudes, and Practices Towards Family Planning
In discussions on family planning, the birth control pill and the IUD were the most commonly known forms of preventing pregnancy, but those in the 15-18 age group were much less aware of family planning methods overall. The most commonly used form of birth control was the pill, with the IUD second. In the last twelve months, very few respondents had discussed family planning with a healthcare worker, with females having discussed family planning with health professionals or friends/family markedly less than males. This is a key concern. Men were more likely to get family planning information from a health care worker, while women were more likely to get it from a midwife.

Conclusion
In general, a large percentage of vulnerable people in Jordan appear to be accessing services, especially health services, which are ranked most important overall. IRC was the second most listed NGO by Syrians (17%), after Save the Children by a very small margin, which indicates that name recognition and levels of outreach is fairly good among the refugee population, but low among the host Jordanian population. The results of the survey indicate that IRC is doing a relatively good job in providing health services. However, the quality, access, and range of services could be better tailored in order to fully meet the needs of vulnerable populations. In general, many respondents did not feel that IRC services "met needs", suggesting that overall quality of services is in need of improvement.

Summary of Recommendations

1. Increase separation of men and women at points of service. This was listed as a top obstacle in accessing services, suggesting the need for better and more appropriate separation of the sexes, and more female staff.

2. Improve awareness and access to psychosocial services (for all demographics), as psychosocial violence is perceived as high but access to psychosocial support is perceived as low. Women and girls especially require ways to access this care confidentially.

3. Improve/increase outreach, awareness and child protection programs in schools, as school was consistently perceived as a most likely location for psychological, physical, and sexual violence.

4. Improve health mobile teams, both in terms of quantity or quality. These services were not ranked as very important, very accessible, or as meeting needs. Clearly awareness, access, and quality of health mobile teams are all in need of improvement so that vulnerable people can see their utility.

5. Improve women and girls' access to non-health services, such as social workers, cash assistance and training/awareness. These services were frequently ranked as "very important" for women and girls, but not perceived as very accessible.

INTRODUCTION

As of March 2015, UNHCR had registered over 3.7 million Syrian refugees, with an estimated rate of nearly 3,000 refugees arriving daily and over 80,000 people awaiting registration.[6] Women and girls are disproportionately affected by this displacement, but they have historically been at the margins of service provision.[7] Female refugees, as well as vulnerable women and girls in host countries, face daily threats of harassment, high rates of domestic violence, and early or forced marriages. As a response to many of these threats, families are confining women and girls to their homes, which increases their isolation but does not necessarily make them any safer.[8] In fact, according to recent studies, in Jordan 32-43% of women will experience intimate partner violence over their lifetimes.[9]

Many refugee parents also question the utility of putting their girls in school, and fear for their daughters' safety is exacerbated by overcrowding and financial strain.[10] In addition, the appearance that women and girls may be under-utilizing some services, particularly pre- and ante-natal care, suggests that access issues and other barriers are preventing the most vulnerable from getting the care that they need; reports suggest that wait times can be unacceptably high.[11] Conflict puts pregnant women and their newborns at increased risk of poor health outcomes, due to deteriorating health systems.[12]

Because traditional support networks have broken down and many refugee families have been separated, there has been an overall increase in the vulnerability to gender-based violence.[13] Most cases of violence against women and children are unreported or do not receive effective intervention due to the fear of social, familial, economic, and legal repercussions. The full scale of underreporting is unknown, and the consequences of abuse are manifested in mental and physical injuries to the survivor and her or his family.

The refugee population in Jordan has reached 624,854 as of March 10, 2015.[14] According to UNHCR statistics, the majority of these refugees reside in Mafraq (155,926)[15] and Irbid

---

[6] UNHCR. 2015. Syrian Regional Refugee Response: Inter-agency Information Sharing Portal http://data.unhcr.org/syrianrefugees/regional.php. Accessed February 23, 2015.
[7] International Rescue Committee (IRC). 2014. Are We Listening.. http://www.rescue.org/sites/default/files/page_wrappers/assets/syria/pdf/IRC_WomenInSyria_Report_WEB.pdf. Accessed February 23, 2015.
[8] ibid.
[9] Morse, Diane S. et al. 2012. "An Effect That is Deeper Than Beating": Family Violence in Jordanian Women http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3380071/. Accessed February 23, 2015.
[10] IRC 2014, ibid.
[11] UNHCR 2013. Reproductive Health Services for Syrian Refugees in Zaatri Refugee Camp and Irbid City, Jordan. http://data.unhcr.org/syrianrefugees/download.php?id=4108. Accessed March 7, 2015.
[12] Ibid.
[13] UNHCR. 2014. Sexual and Gender-Based Violence: Syrian Refugees in Jordan. SGBV Sub-Working Group. Report, March 2014
[14] UNHCR. 2015. Syrian Regional Refugee Response: Inter-agency Information Sharing Portal (by Country). http://data.unhcr.org/syrianrefugees/country.php?id=107. Accessed February 23, 2015.
[15] ibid

(141,103)[16] governorates, which have been identified by the Jordanian government and a number of non-governmental organizations (NGOs) as areas of concern due to the large influx of refugees and their increased vulnerability, including to GBV.

While according to IASC Guidelines[17], "all humanitarian personnel should assume and believe that GBV (…) is taking place and is a serious and life-threatening protection issue, regardless of the presence or absence of concrete and reliable evidence", it was previously documented that in armed conflicts in Afghanistan and Sierra Leone, displacement increases the risk of GBV and violence against children.[18] Residents of rural areas, including Jordan's 28 poverty pockets, tend to conform to traditional unequal power sharing and gender roles more rigidly, and poverty often leads to situations in which gender roles are unmet.[19] For example, stress and poverty resulting from unemployment difficulties and therefore unmet gender role expectations can result in husbands taking frustration out on their wives and children, resulting in incidents of domestic violence.[20] Syrian refugee women interviewed by the IRC reported similar trends.[21]

International and national NGOs have taken the lead in providing reproductive health (RH) and GBV services in Syrian communities. Institutions such as the IRC, the Institute for Family Health, and numerous United Nations organizations provide free medical, social, psychosocial, and legal services to GBV survivors. Still, many refugees have reported barriers to accessing healthcare services, such as the lack of female doctors, long distances to clinics, and the inability to access or pay for transportation.[22] Many Syrian refugees and vulnerable Jordanians may also be unaware of GBV and RH service providers in their communities, which compounds practical obstacles. Syrian refugees residing in camps are of particular concern. One study revealed that 83% of Za'atari camp residents were unaware of available GBV services in their communities.[23] Limited access to livelihood opportunities has also increased incidences of survival sex.[24] Some refugees have reported

[16] ibid

[17] Inter Agency Standing Committee. 2005. Guidelines on Gender-Based Violence Interventions in Humanitarian Settings, 2005.

[18] Clark, C. J., Silverman, J. G., Shahrouri, M., Everson-Rose, S., & Groce, N.. 2010. The role of the extended family in women's risk of intimate partner violence in Jordan. *Social Science and Medicine*, Jan; 70(1):144-51.

[19] Morse, Diane S. et al. 2012. An Effect that is Deeper than Beating: Family Violence in Jordanian Women. *American Psychological Association: Families, Systems, & Health, March; 30(1): 19-31. DOI: 10.1037/a00271.*

[20] Morse et al, *ibid*.

[21] IRC 2014, ibid.

[22] UN High Commissioner for Refugees, Report of the participatory assessment UNHCR, Amman December 2012.

[23] UN WOMEN. 2013. Inter-Agency Assessment of Gender-based Violence And Child Protection Among Syrian Refugees In Jordan; With A Focus On Early Marriage. http://www.unwomen.org/~/media/headquarters/attachments/sections/library/publications/2013/7/report-web%20pdf.pdf%29

[24] SGBV Working Group Briefing Note. 2014. Sexual & Gender Based Violence: Syrian Refugees in Jordan. March 2014.

sex-for-aid transactions in the Mafraq governorate,[25] which further exacerbates disengagement with local service providers.

The IRC is strongly committed to ensure that the specific needs voiced by the target population inform the adaptation and evaluation of our interventions. To address these pressing concerns and to get a better understanding of needs, awareness, and barriers to access among vulnerable populations, IRC conducted this survey in collaboration with the Jordanian Hashemite Fund for Human Development (JOHUD).

The main objectives of the survey were:

4. To provide baseline information about current knowledge, attitudes and practices regarding GBV and RH issues among the targeted population;
5. To provide information about the level of knowledge regarding the available services and referral pathways for GBV and RH;
6. To determine the source of information and service seeking behaviors regarding GBV and RH issues.

METHODOLOGY

These research procedures were designed and carried out by the Queen Zein Al Sharaf Institute for Development (ZENID) in an effort to bridge information gaps regarding service seeking behaviors, knowledge, and attitudes toward GBV and RH issues in communities within the Mafraq and Irbid governorates (including Ramtha). Further details about the methodology can be found in Appendix A.

Respondents had to be a resident of the Mafraq or Irbid governorates and be age 15 or older. No other restrictive criteria were set.

Test phase

In order to detect issues that might affect the accuracy of data collection, researchers at ZENID undertook a testing operation in the city of Ramtha (Irbid governorate) and in the towns of Khaldya and Zatry (Mafraq governorate) from September 22 to September 24, 2014. The data, comprising 71 questionnaires (just under 10% of the total sample size) was collected over the course of two days in Mafraq and one day in Irbid. From this test, the questionnaire was determined to be effective, culturally appropriate, and required no modifications.

Sample size allocation and selection method

Due to resource limitations, this survey was not intended to be statistically representative of the entire refugee population. The sample of 1,062 respondents was estimated to provide a reasonably accurate snapshot of the knowledge, awareness and practices in Irbid,

[25] United Nations High Commissioner for Refugees.. 2012. Report of the Participatory assessment, UNHCR, Amman.

Mafraq and Ramtha, but any extrapolations to the entire refugee population cannot be made. Formulas used to calculate the sample can be found in Appendix A.

The study sample was drawn using a three-stage cluster sampling method and ketch table tool to ensure random selection of household members.

30 households in total refused to complete the questionnaire, stating that the study was not relevant to meeting their needs or they did not have enough time to complete the questionnaire.

Implementation phase

The field data collection process took place from October 4-10, 2014. Two teams comprised of 10 trained data collectors were dispersed in Mafraq and Irbid, with each interviewer responsible for completing 7-8 questionnaires each per day. No fees were paid to data collectors until questionnaires were cleared through both manual and electronic checks.

Study Limitations

A number of challenges arose in the process of conducting this study, as follow:

- Researchers faced difficulties in obtaining surveys from the target groups in the target areas, as many household members were not present in their homes at the time the researchers visited.
- Some adults insisted on participating in interviews that were to be conducted with their children. In these cases, the researchers sought questionnaire completion from different households where they could conduct the interviews with children confidentially.

Ethical Considerations on Researching Vulnerable Populations

Ethical considerations were emphasized during the training of the data collectors, as well as throughout the data collection process. Specifically, JOHUD ensured that all data collectors received training on sensitive issue/vulnerable population interview techniques. All participants in this study were involved voluntarily and were fully informed of what their participation entailed, prior to the beginning of discussions. All researchers signed a confidentiality form. All researchers had prior experience and training on GBV, child protection and reproductive health, and on the ethical considerations involved in this type of research. Participants were informed that they could stop at any time, skip any questions, and were encouraged to bring up any questions or concerns they had. Further, all respondents were informed that their choice to participate or not would not affect any support they or their families were receiving from the IRC or from any other service provider. The use of external interviewers further strengthened this message. Finally, the confidentiality and anonymity of participants was ensured by collecting data in private, closed rooms, and by not using names or attributing responses to specific individuals that took part in the survey.

RESPONDENT CHARACTERISTICS

Table 1.1 provides an overview of respondents' major characteristics. The sample was gender balanced, with the majority (74.2%) being Jordanian, reflecting the population overall. The sample was deliberately selected so that half of the respondents were 18 and under. The majority of respondents (54.7%) had received at least some secondary education, while a sizeable number (20%) had only primary schooling. Of the Syrians surveyed, the majority reported being in Jordan for less than six months.

Table 1.1 Respondent Characteristics

Sex	50% female
Age	
15-18	49.5%
19-39	39.5%
40+	11%
Marital status	
Single	61.7%
Married	34.3%
Over 18 when married	73.6%
Blood relation with spouse	63.7%
Education	
No formal education	4.8%
Primary only	19.1%
At least some secondary	54.7%
Post-secondary	13.2%
Number of family members currently in Jordan	
2-4	16.3%
5-8	51%
More than 8	31.4%
Number of family members in same house	
2-4	39%
5-8	50.4%
More than 8	10.6%
Place of residence	
Mafraq	50.6%
Irbid	45%
Ramtha	4.4%
Nationality	
Jordanian	74.2%
Syrian	24.5%
Syrians: number of months in Jordan since most recent arrival	
6 months or less	52.5%
Greater than 6 months	33.5%

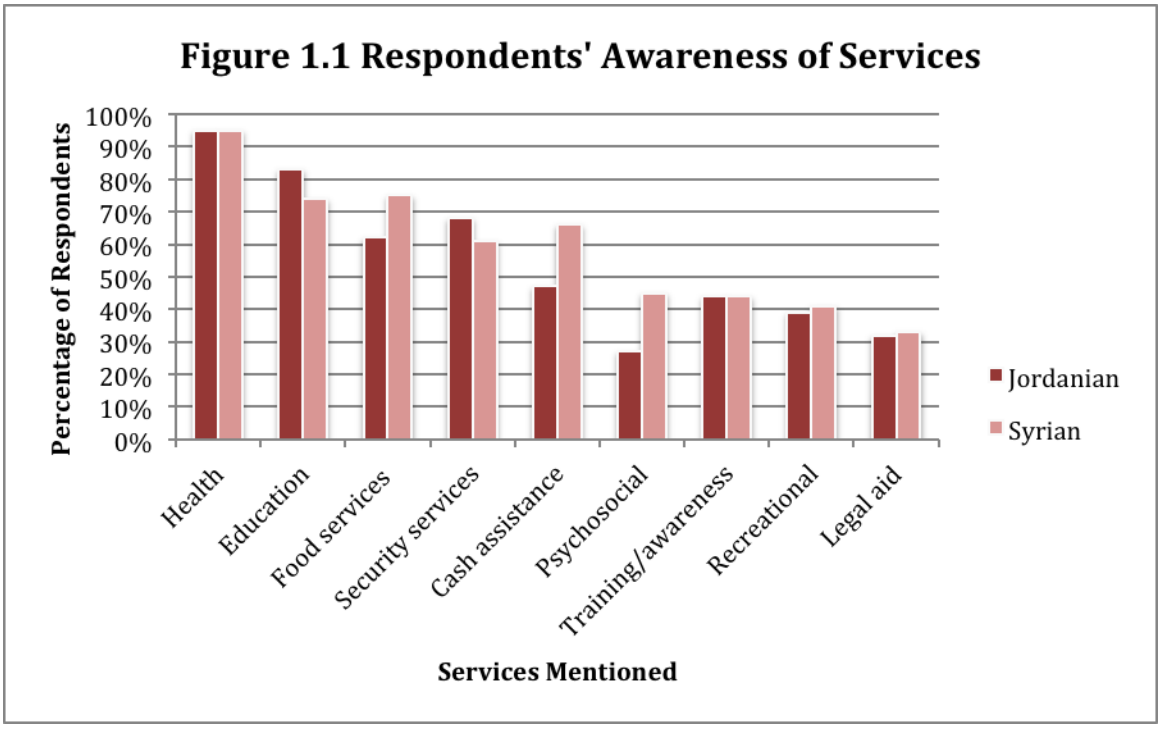
SURVEY RESULTS

Section 1: Knowledge of Available Services

***Summary*: Out of all services available, respondents were most aware of health and education services and least aware of recreational services and legal aid, with no significant differences between male and female respondents. Syrians were notably more aware of cash assistance, food services and psychosocial services than Jordanians. Out of all respondents, 17% could identify IRC as a service provider. Notably, 40% of Syrians identified IRC as a service provider, while only 9% of Jordanians did so.** [26]

Awareness of Services and Providers

To get a general view of respondents' knowledge and awareness, researchers first asked if respondents were aware of any available service in their community, and asked them to list any of which they were aware. Figure 1.1 reflects the percentage of Jordanian and Syrian respondents, who named each service without prompting. There were no significant differences between males and females, or when disaggregated by age group.

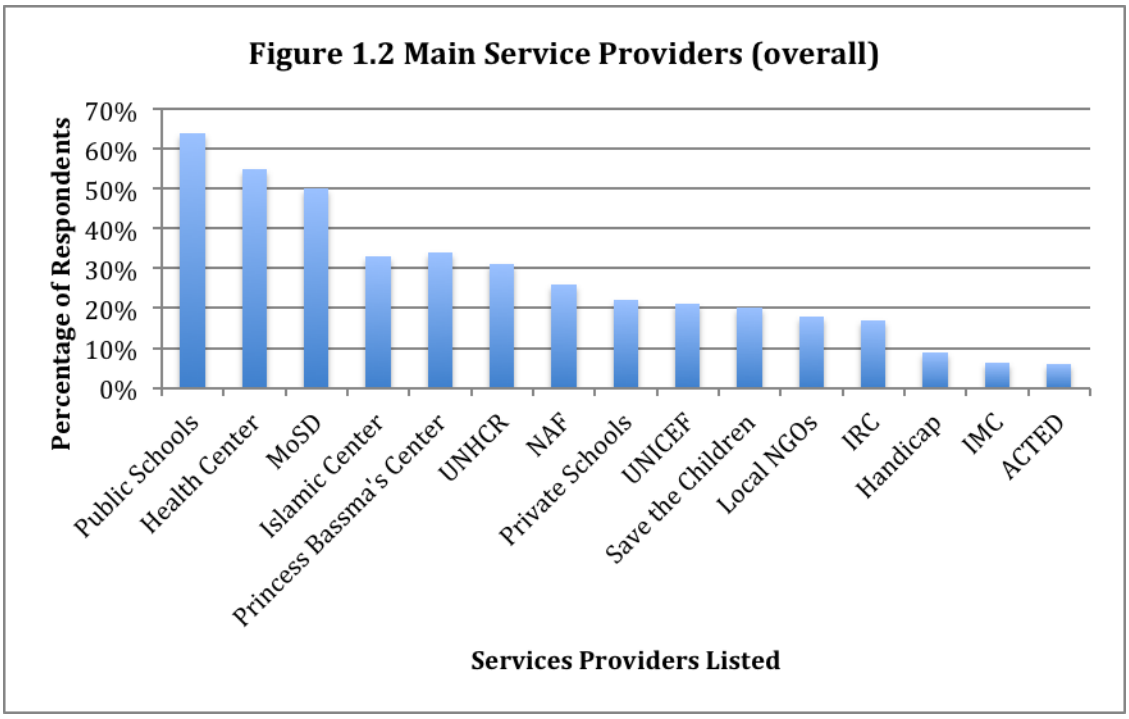


Awareness differences between Jordanians and Syrians were more pronounced when it came to food services, cash assistance and psychosocial services, as illustrated here. For example, 75% of Syrians were aware of food services compared to 62% of Jordanians, and

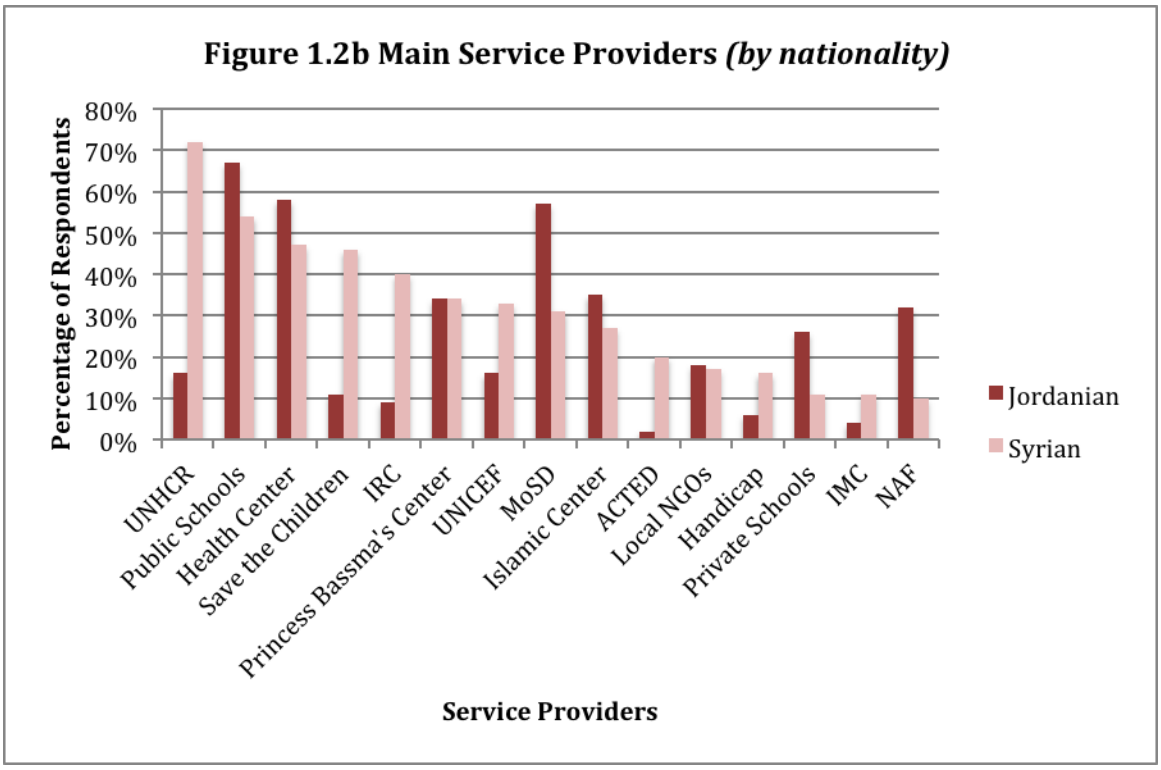
[26] All percentages list represent the valid percent—i.e., the percentage of the respondents that actually answered that particular question. The margin of error is +/- 3.1%.

45% of Syrians were aware of psychosocial services compared to 27% of Jordanians. This may be partly because services like food distributions and cash assistance are primarily available to refugees. But it could also suggest that some Jordanians may not be getting the assistance that they need, or at least are not aware of what is available to them.

Next, researchers asked respondents to list the main service providers in their community. Again, respondents were not given a list, but were simply asked to recall any service providers by name. Figure 1.2a lists the service providers identified by respondents overall. There were few variations in providers listed by males and females—public schools were the highest listed (64%), followed by health centers (55%). Overall, 17% of all respondents listed IRC as a service provider.



When disaggregated by nationality, the differences were more profound (Figure 1.2b). Public schools were still the top listed provider by Jordanians (67%) followed by health centers (58%), but Syrians listed UNHCR most frequently (72%) followed by public schools (54%). In terms of IRC recognition, 40% of Syrians identified IRC while only 9% of Jordanians did so. In fact, IRC (17%) was the second most listed NGO by Syrians, after Save the Children (20%), which could be equivalent due to the margin of error. This indicates that name recognition and levels of outreach is fairly high among the refugee population, relatively speaking. However, if IRC is hoping to also reach vulnerable Jordanians, then there is clearly more work to be done on awareness and name recognition among that population.



When looking at only the age 15-18 demographic, public schools were listed with the highest frequency (males 65%, females 66%) followed by health centers (55% both sexes) and MoSD (males 47%, females 46%). There were no significant differences between males and females, with 20% of adolescent females and 15% of adolescent males naming IRC as a service provider.

IRC as a Service Provider

Out of the 17% that identified IRC as a service provider (N=182), they were then asked to name which services IRC provides. Most named primarily health services (72% of males and 76% of females) as a service that the IRC provides, as shown in Table 1.2. What is very positive is that general health services were quite well known; however, other services were known by only a very small percentage, indicating that awareness and information about IRC services outside of general health needs improvement. Reproductive health services in particularly were particularly poorly known, as were recreational activities.

Table 1.2 Awareness of Services that IRC Provides

Type of Service	Males	Females	Jordanians	Syrians
General health services	72%	76%	72%	81%
Psychosocial services	3%	4%	2%	4%
Training/awareness	3%	4%	3%	4%
Reproductive health services	0%	1%	0%	2%
Cash assistance	4%	8%	8%	4%
Recreational activities	1%	0%	1%	0%

Section 2: Access and Use of Services

<u>Summary</u>: A large majority (77%) of respondents had accessed some type of available service in their community. Females accessed services slightly more than males, and Syrians accessed services more than Jordanians. Of those accessing IRC services, the majority were females over the age of 19, accessing medical doctors.

In this section, researchers assessed respondents' access and use of services. First, respondents were asked if they had ever used services available in their community. By nationality, 74% of Jordanians and 83% of Syrians said yes. There were no significant differences between males and females.

Next, respondents were asked to specify which service provider they had accessed for each service. Figure 2.1a illustrates respondents that identified IRC as the service provider that they had accessed.

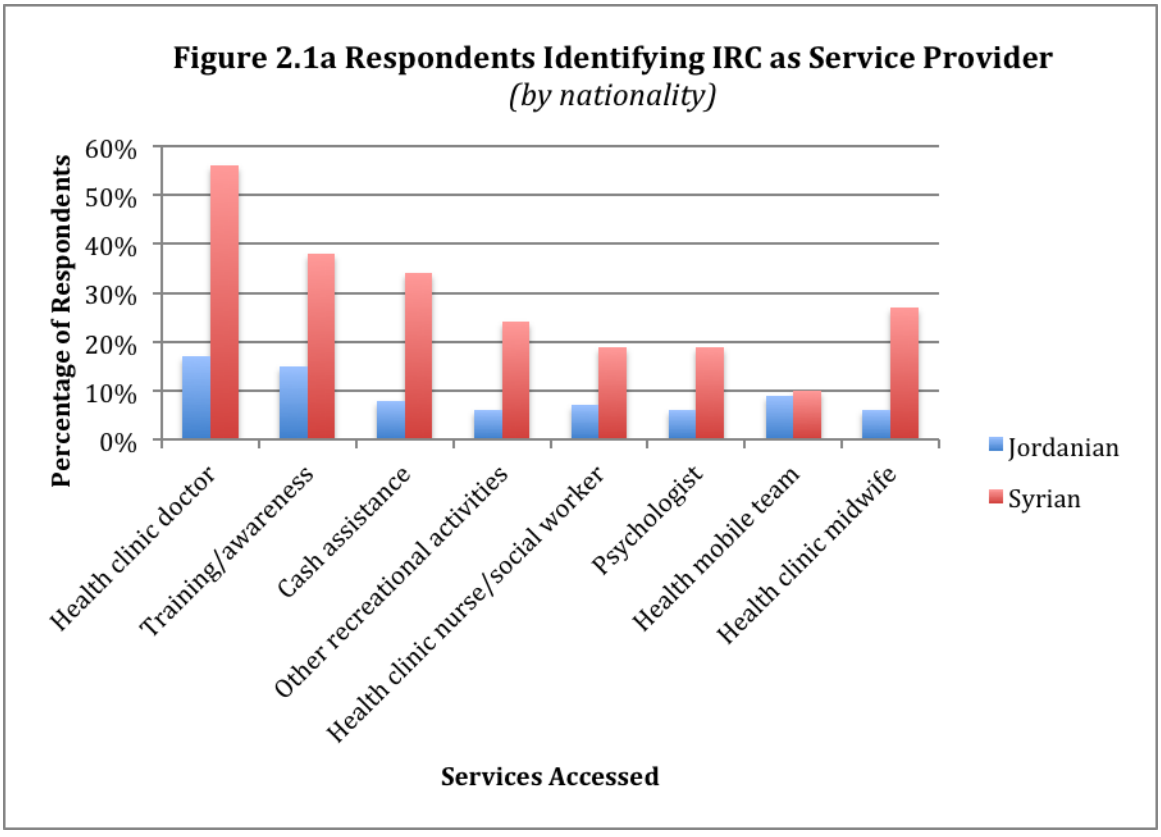


Figure 2.1a shows that Syrians accessed IRC services far more than Jordanians. For example, 32% of females over 19 who had visited health clinic doctors identified IRC as the service provider, while only 26% of males said the same. Similarly, 56% of Syrians accessing health clinic doctors identified IRC as the service provider, while only 17% of Jordanians did the same. For training/awareness sessions, 38% of Syrians had used IRC for

while only 15% of Jordanians had done so, and 34% of Syrians accessed IRC cash assistance, compared to only 8% of Jordanians. Disaggregating by sex and age, males 15-18 were the least likely to have used IRC services, and women age 19 and up were the most likely. The only exception to this was in accessing psychosocial services, where 10% of boys listed IRC as the service provider and only 5% of girls did so, but it is possible that this small difference could also be due to a reluctance to admit accessing such services, or this could simply be due to the margin of error.

Table 2.1 Respondents That Identified IRC as Their Service Provider (by age/sex)

IRC Service	Male 19+	Female 19+	Male 15-18	Female 15-18
Health clinic doctor	26%	32%	20%	31%
Training/awareness	21%	25%	15%	24%
Cash assistance	15%	17%	12%	17%
Other recreational activities	14%	11%	7%	12%
Health clinic nurse/social worker	10%	14%	9%	9%
Psychosocial services	10%	14%	10%	5%
Health mobile team	10%	13%	8%	7%
Health clinic midwife	10%	20%	7%	11%

Respondents were then asked if the IRC services they had accessed had "met needs", "partially met needs", or "did not meet needs". Table 2.2 shows the percentage of respondents who said the services met their needs, while Table 2.3 shows the overall results for all three responses. IRC recreational activities were most likely to have met needs (61% of males, 54% of females). Health mobile teams were the least likely to have met needs (see Table 2.2). Note that because some of the frequencies in certain categories were so small, these percentages must be interpreted with caution, especially those regarding Jordanians, as so few actually accessed IRC services. Therefore it is more meaningful to look at the spectrum of best to worst, rather than at exact percentages.

Table 2.2 IRC Services that "Met Needs"

Service	Male	Female	Jordanians	Syrians
Other recreational activities	61%	54%	100%*	51%
Psychosocial services	53%	39%	57%	36%
Training/awareness	47%	51%	49%	49%
Cash assistance	49%	42%	30%	51%
Health clinic doctor	43%	41%	30%	48%
Health clinic nurse/social worker	37%	33%	38%	34%
Health clinic midwife	32%	51%	46%	45%
Health mobile team	23%	40%	33%	27%

**Note that this figure reflects only four out of four Jordanians who accessed IRC recreational services.*

Table 2.3 shows the overall results for all three ranking options, with health mobile teams, psychosocial services and health clinic midwives receiving the highest numbers of respondents saying that the services "didn't meet needs". Further investigation is required to determine exactly *why* needs are not being met in these areas, and how to improve services.

Table 2.3 IRC Services that "Met", "Didn't Meet", or "Partially Met" Needs

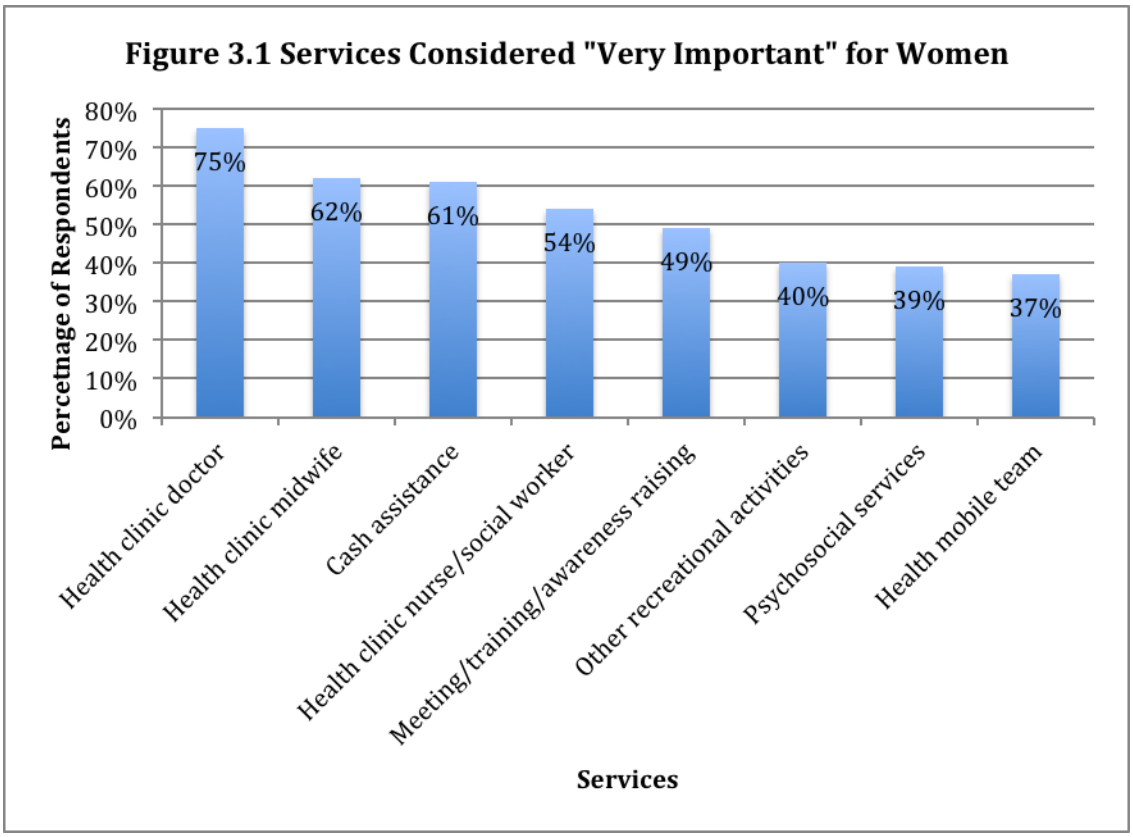
Service	Didn't Meet Needs	Partially Met Needs	Met Needs
Other recreational activities	21%	21%	57%
Psychosocial services	29%	25%	46%
Training/awareness	24%	26%	49%
Cash assistance	21%	34%	45%
Health clinic doctor	18%	39%	42%
Health clinic nurse/social worker	22%	37%	35%
Health clinic midwife	28%	27%	45%
Health mobile team	38%	30%	32%

Section 3: Service Seeking Attitudes

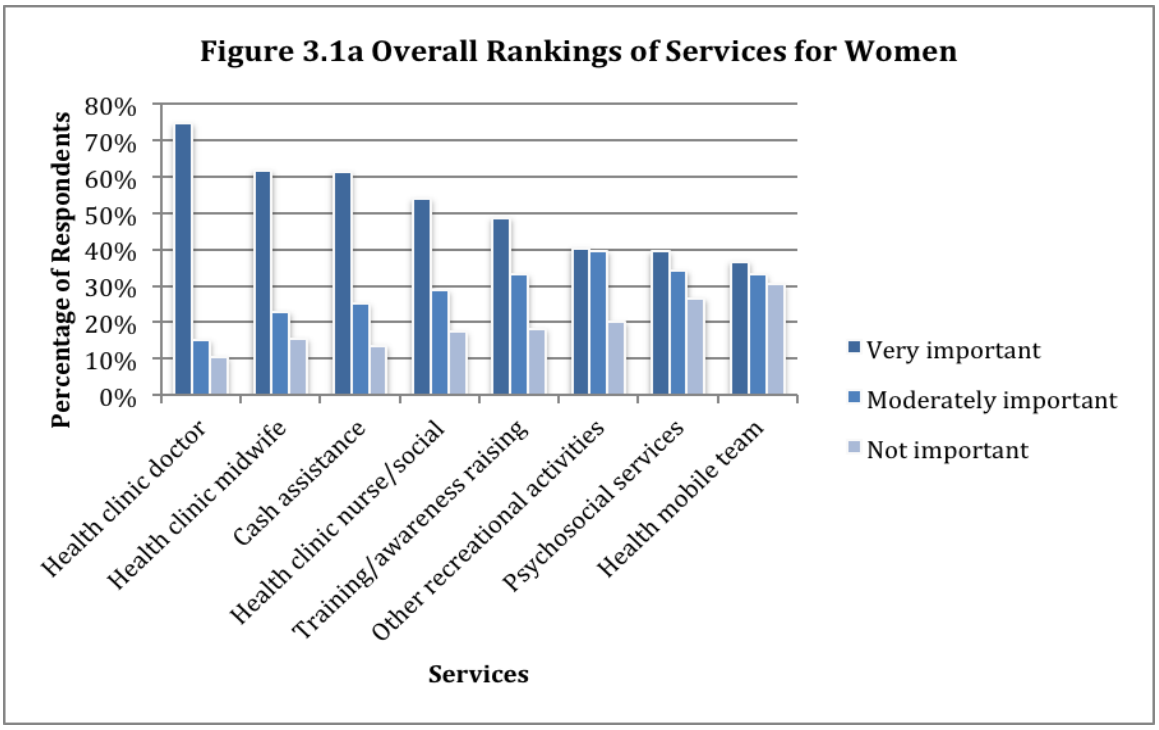
<u>Summary</u>: In terms of services for women, health clinic doctors and health clinic midwives were considered the most important by all respondents. Regarding services for girls, health clinic doctors, cash assistance and training/awareness were ranked most important. The primary obstacles for women and girls to access services were perceived as: the mixing of men and women, distance to services, not being permitted by family to access services, and being unsure of what the service provides.

Researchers then explored questions related to respondents' attitudes about certain services and how important they were specifically for girls and women. The options they

were given were: “very important”, “moderately important”, and “not important”. Figures 3.1 and 3.2 illustrate how many respondents overall listed various services as “very important” for women and girls, respectively. It is important to note that less than 1% of the 15-18 age group responded to this question, so these results are a reflection of the adult respondents’ attitudes to the importance of services.

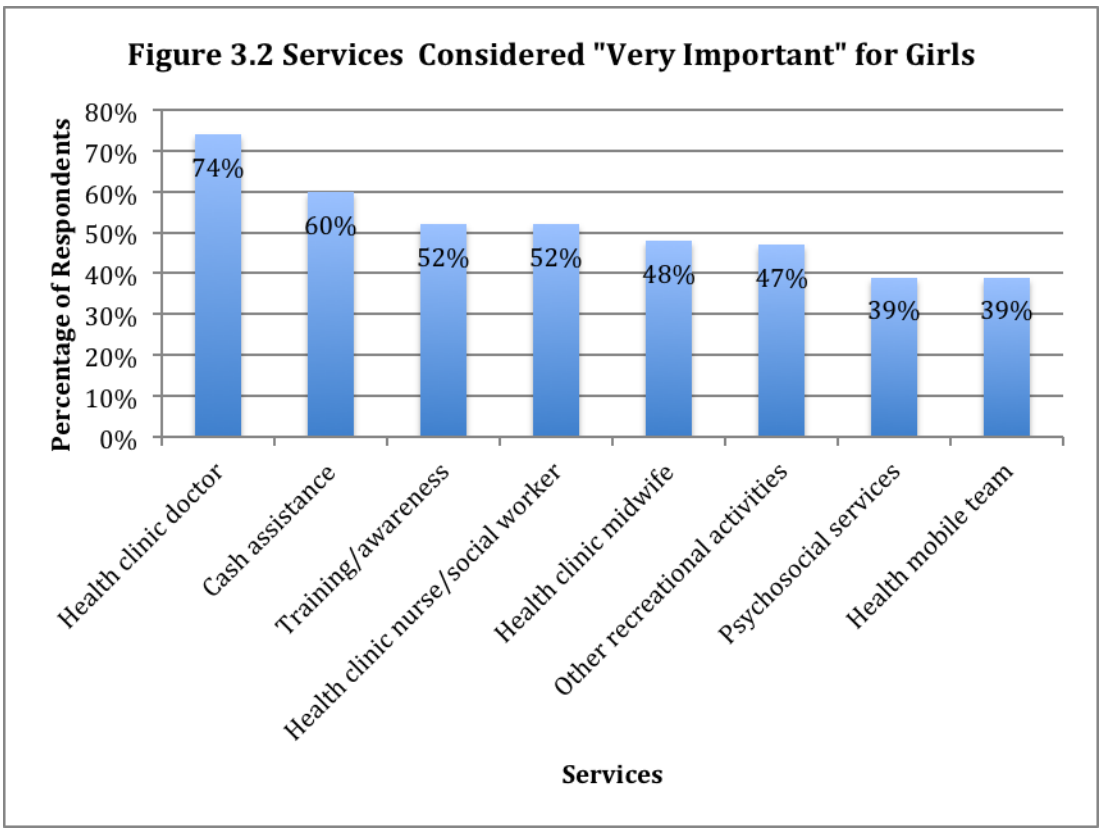


As Figure 3.1 shows, respondents ranked health clinic doctors as “very important” most often. There were no significant differences between male and female, except in health clinic midwives, where 67% of males and 57% of females ranked them as “very important.” There weren’t any notable differences between Jordanians and Syrians aside from cash assistance, where 69% of Syrians ranked it as “very important” and 59% of Jordanians did so.



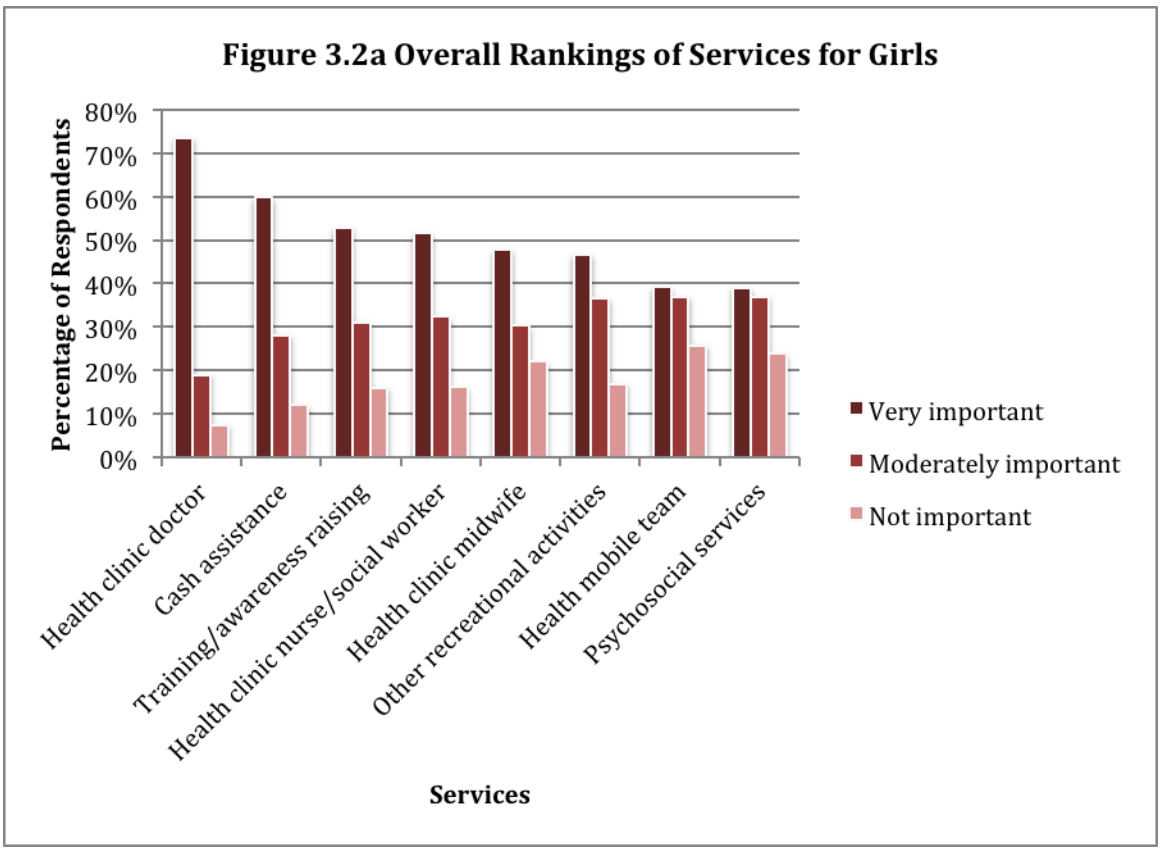
As shown in Figure 3.1a, the services most frequently ranked as "not important" were psychosocial services (27%) and mobile health services (30%). This result is concerning, considering that respondents ranked psychological violence against women to be the most common form of violence (see Figures 5.1 and 5.2). Recreational activities were ranked as "not important" by 20% of respondents, training/awareness by 18% and health clinic/social workers by 17%. All other services were ranked as "not important" by less than 15% of respondents.

Figure 3.2 shows which services were ranked as "very important" for girls. As noted above, it is important to recognize that these answers may have varied considerably if more respondents from the 15-18 demographic had responded. As it stands, these answers reflect the attitudes of the adult population. Predictably, health clinic doctor was ranked as "very important" the most often (74% overall; Jordanians 76% and Syrians 66%), with cash assistance as second, and training/awareness as third. Most of the percentage differences here are quite small, so services that are close in ranking may not be statistically different. It is more revealing to look at the top and bottom end of the spectrums to see what ranked most and least important. Notably, Syrians ranked cash assistance (68%) and training/awareness (64%) as "very important for girls" more frequently than did their Jordanian counterparts (58% and 53% respectively).



In both figures, health mobile team ranked the least important or equal to psychosocial services, even though other health concerns (doctors, nurses, midwives) ranked highly. This may indicate either a lack of awareness as to what a mobile health team can offer, or a perception that the mobile health teams do not meet their most pressing needs, as indicated in Table 2.2. It could also be because other health services are close enough that respondents do not require health mobile teams; further investigation would be required to determine the exact reasons.

As shown in Figure 3.2a, the services most often ranked as "not important" for girls were psychosocial services (24%) and health mobile teams (26%). All other services were ranked as "not important" by 7-16% of overall respondents. This result is promising, as it indicates that, in general, respondents thought that most services were very important or at least moderately important for girls. However, as with women, it indicates that much more awareness and education around psychosocial services is warranted.



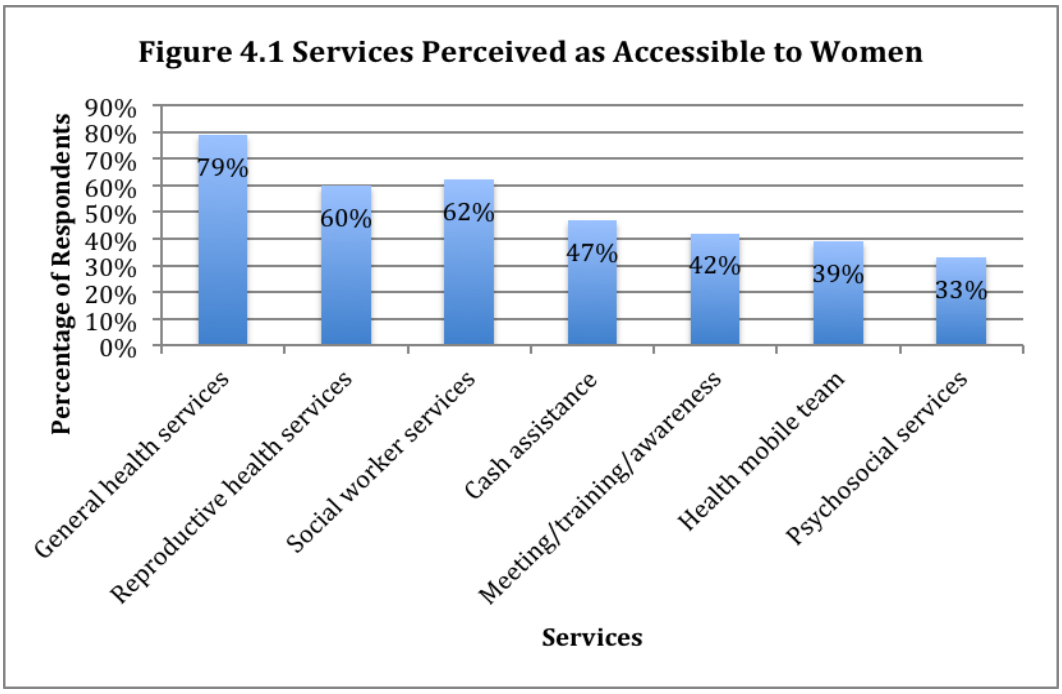
Section 4: Accessibility

<u>Summary</u>: Overall perception of service accessibility from all service providers for women and girls was low, with only general health services ranking high in accessibility. Services for girls were perceived to be even less accessible than services for women. In general, Syrians perceived services as less accessible than Jordanians, and women perceived services as less accessible than men.

Next, researchers questioned respondents about the perceived accessibility of services. They asked respondents if the services listed in the previous section (see Figures 4.1 and 4.1) were accessible to girls and women. Figures 4.1 and 4.2 show the level of respondents who answered, "Yes" to the question, **"Do you think [xxx] service is accessible to women/girls? (Yes/No)."**

As illustrated in Figure 4.1, in general the opinion that services were accessible was fairly low across all demographics, with the exception of general health services. In fact, only general health services, reproductive health services and social worker services reached over 50% in affirmative responses. There were no notable differences between men and women except in reproductive health, where 65% of men and 54% of women felt they were accessible.

A few notable differences appeared when disaggregated by nationality (Figure 4.1a): 67% of Syrians and 82% of Jordanians thought that general health services were available. For reproductive services, 67% of Jordanians and 54% of Syrians thought they were available. For social worker services, Jordanians (65%) ranked them more accessible than Syrians (51%); for health mobile teams Syrians (28%) ranked them as less accessible than Jordanians (28%). Conversely, more Syrians (40%) than Jordanians (31%) ranked psychosocial services as accessible.



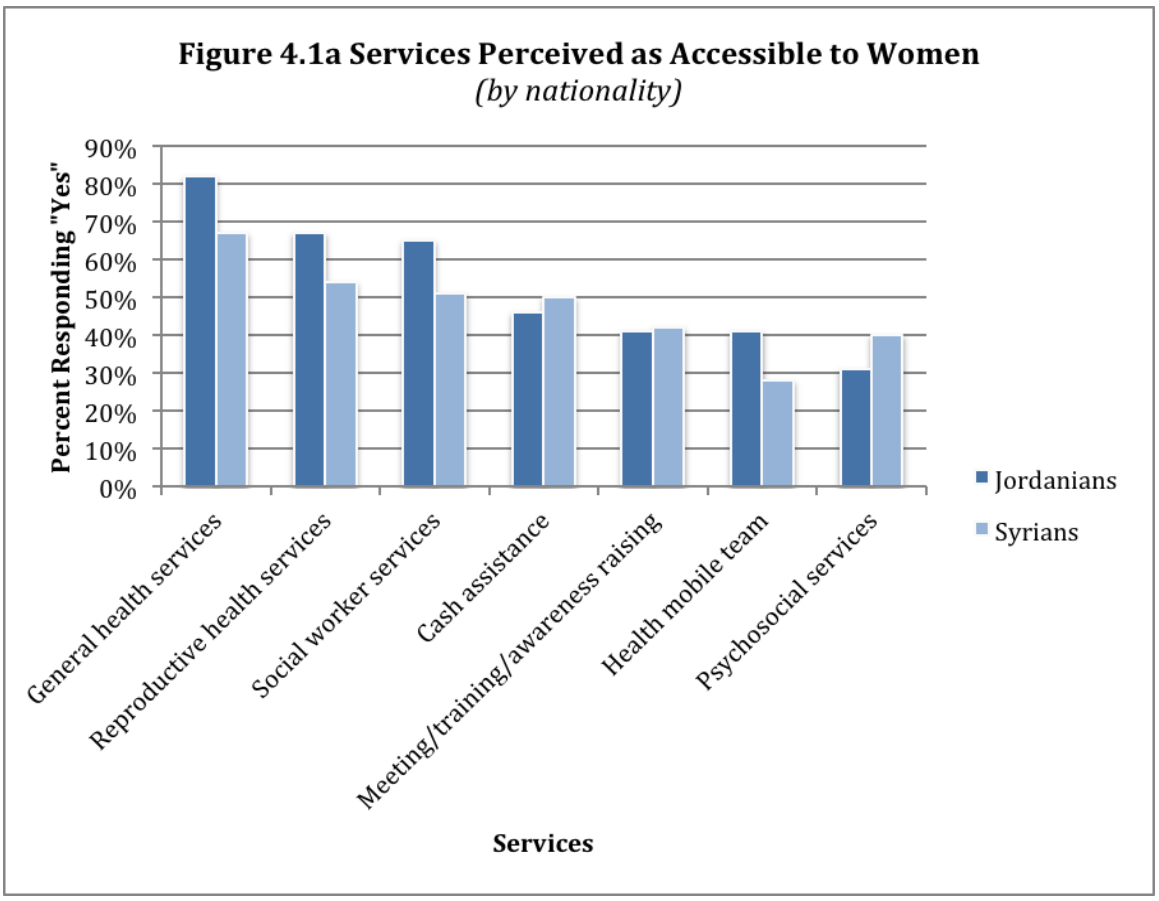
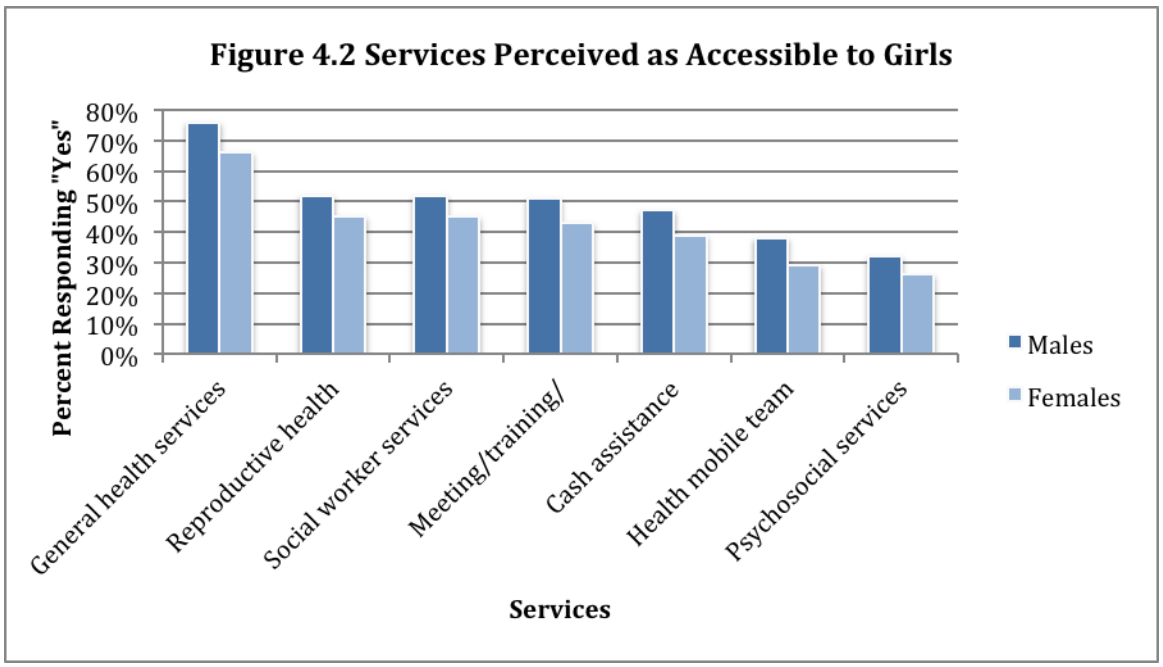


Figure 4.2 illustrates the answers to the same question as pertaining to girls. There were slightly more differences between men and women than in Figure 4.1, so they are disaggregated by sex. As with Figure 3.2, these answers may have varied if respondents from the 15-18 age bracket had been asked this question. In general, however, perception of accessibility was even lower for girls, with almost all affirmative responses (except general health services) being at 50% or lower. The main differences between men and women were in general health services (76% of males, 66% of females) and health mobile teams (38% of males, 29% of females).

The only notable differences by nationality were in general health services, where only 58% of Syrians asserted that they were accessible to girls, compared to 74% of Jordanians. This indicates a perception among a significant portion of refugees in the areas surveyed that girls may not be able to access the health services they need.

The overall low responses indicates that many of those surveyed do not feel that, aside from general healthcare, services are available or accessible to them, especially in terms of cash assistance, training/awareness, health mobile teams and psychosocial services. This result suggests a need to improve accessibility, remove perceived obstacles and increase awareness of how and where services can be accessed.



When asked if respondents felt that *women* faced obstacles when accessing these services, 32% of all respondents said yes, with no significant differences when disaggregated by sex or nationality. When asked if *girls* faced obstacles when accessing services, 36% of respondents said yes (again with no significant differences when disaggregated). This is an interesting result, as it indicates that even though accessibility is perceived to be fairly low, it may not always be due to perceived obstacles.

As Table 4.1 indicates, for women, the mixing of men and women was perceived as the biggest obstacle to accessing general health services (40%), while distance was a bigger obstacle for recreational services (25%), health mobile teams (23%) and training/awareness (22%). Fear of being recognized/stigmatized was primarily only a concern in terms of accessing psychosocial services (12%). The biggest noted obstacle for each service is highlighted in yellow in the table below. Obstacles that were rarely mentioned are not listed here, such as not being allowed to leave the house, which didn't appear to be a notable concern for women's access. Numbers listed are the percentages of respondents who felt that the obstacle was relevant to that particular service.

Table 4.1 Primary Obstacles for Women Accessing Services (numbers are %)

Obstacles	General health	Reproductive health	Health clinic nurse/ social workers	Health mobile teams	Psychosocial services	Cash assistance	Recreational activities	Training/awareness
Mixing of men and women	40	12	11	7	7	4	15	15
Lack of female service providers	14	16	6	9	5	11	11	11
Not permitted by family to access services	3	12	19	12	19	16	14	19
Services are too far away	21	23	16	23	16	16	24	22
The behavior of services providers is inappropriate	4	7	13	7	6	5	3	2
Low quality of services	6	7	7	4	4	8	4	2
The services don't meet women's needs	2	6	4	6	1	7	4	2
Not sure of what the service does	5	12	15	22	21	19	15	14
Fear of being recognized/ identified/ stigmatized	--	2	2	4	12	5	3	4

For girls, Table 4.2 illustrates the biggest obstacles mentioned overall, with the highest in each category highlighted in yellow. As with women, mixing of men and women was the biggest obstacle noted for general health services (36%), but was also a commonly listed obstacle in accessing reproductive health (23%) and awareness/training services (18%). Not being permitted by family members was also a key issue for girls, especially for accessing social workers (15%), psychosocial services (15%) and recreational activities (19%). Finally, a location too far away was the most frequently listed obstacle in accessing social workers (15%), health mobile teams (18%), and cash assistance (17%).

When looking only at the 15-18 female demographic, the most common obstacles listed by girls themselves were: not being permitted by their families (in accessing social workers [16%], health mobile teams [22%] and awareness/training [24%]), distance from services (especially in accessing general health [33%] and reproductive health [41%]) and fear of stigmatization (when accessing psychosocial services [22%]). Interestingly, the only

category in which mixing of males and females was the top concern for girls themselves was in accessing recreational activities (27%), but it was still a significant concern in accessing health services (30%).

Table 4.2 Primary Obstacles for Girls Accessing Services (numbers are %)

Obstacle	General health	Reproductive Health	Health clinic nurse/ social workers	Health mobile teams	Psychosocial services	Cash assistance	Recreational activities	Training/awareness
Mixing of men and women	36	23	14	8	3	5	17	18
Lack of female service providers	15	17	5	4	7	11	7	8
Not permitted by family to access services	8	13	15	13	15	14	19	15
Not allowed to leave house	7	9	7	9	9	11	14	12
Services are too far away	22	20	15	18	14	17	16	17
The behavior of services providers is inappropriate	5	7	9	4	3	6	2	3
Low quality of services	3	7	10	10	8	6	6	11
The services don't meet women's needs	1	4	6	7	4	3	3	2
Not sure of what the service does	1	8	11	13	12	8	8	8
Fear of being recognized/ identified/ stigmatized	<1	4	3	6	18	13	5	2

These results indicate that approximately one third of all respondents feel that barriers to services exist, and the most significant barriers noted across all services were: mixing of men and women, lack of female service providers, they were not permitted by family members, services were too far away, or they were unsure what the service was.

Section 5: Knowledge and Awareness of Gender-Based Violence (GBV)

***Summary*: Respondents felt that violence was fairly common in their communities, listing psychological violence as the most common form. Respondents felt that home and school were the most likely locations for physical and psychosocial violence, and the most likely locations for sexual violence were open public spaces and school. Knowledge of the term "gender-based violence" was very low.**

The next section asked respondents about their perceptions of based violence in their communities. Respondents were asked, "**To what extent do you think that violence is prevalent in your community, and how often do you think it occurs in the following categories?"** As Figure 5.1 shows, psychological violence was perceived as the most common type of violence against both males and females under 18, with physical violence second most common. Sexual violence against boys was least often ranked as "very common". Perceptions on the first two types of violence were fairly uniform across demographics (with 58-66% saying both were "very common"). There were no notable differences in male and female responses. There was a bigger gap between Jordanians' and Syrians' perceptions of sexual violence: 38% of Jordanians felt that sexual violence against girls was "very common" while 27% of Syrians felt the same. The gap for sexual violence against boys was even greater, with 34% of Jordanians feeling that sexual violence against males under 18 was "very common", while only 19% of Syrians felt that it was.

When disaggregated by age, the 15-18 demographic did not have any significant differences in responses.

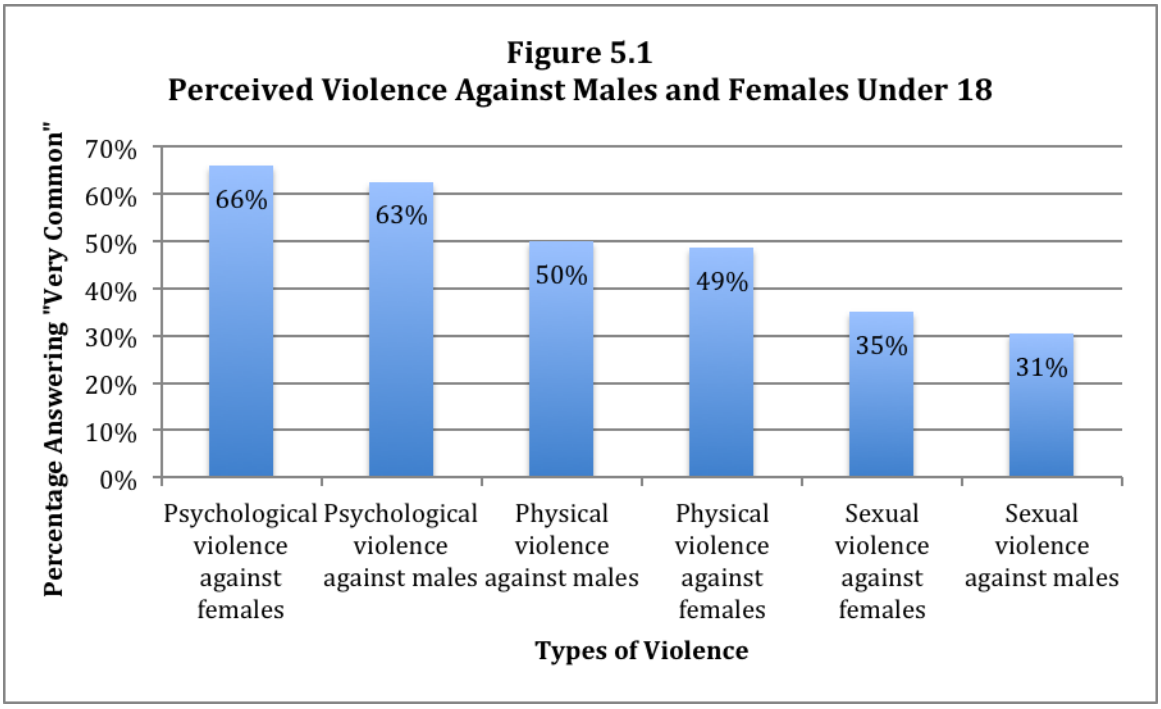
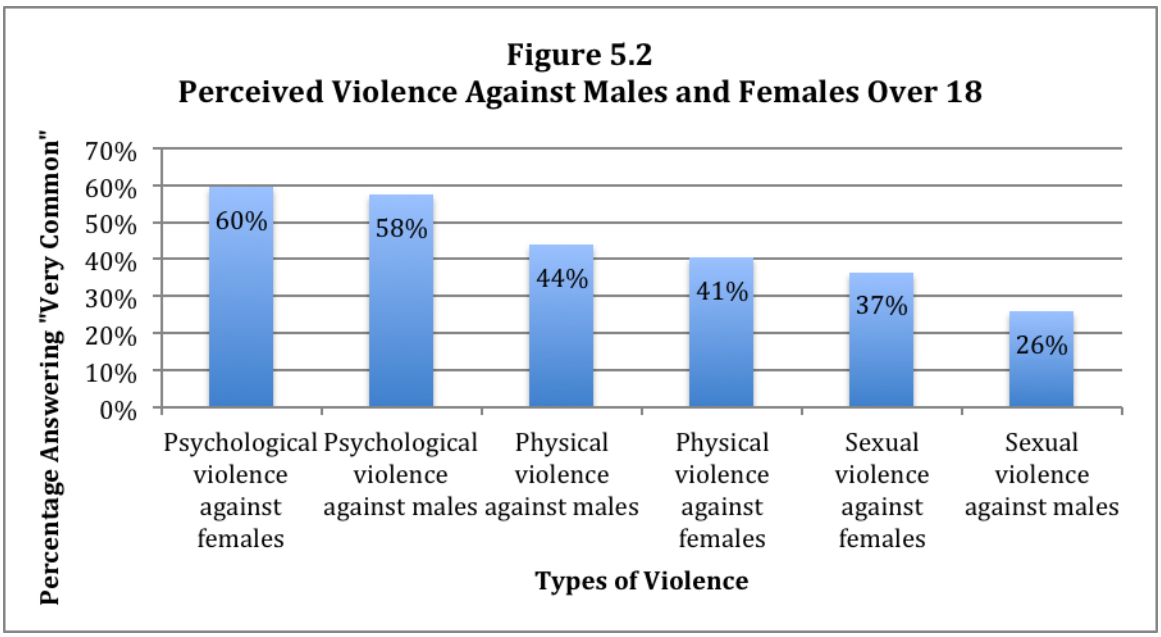


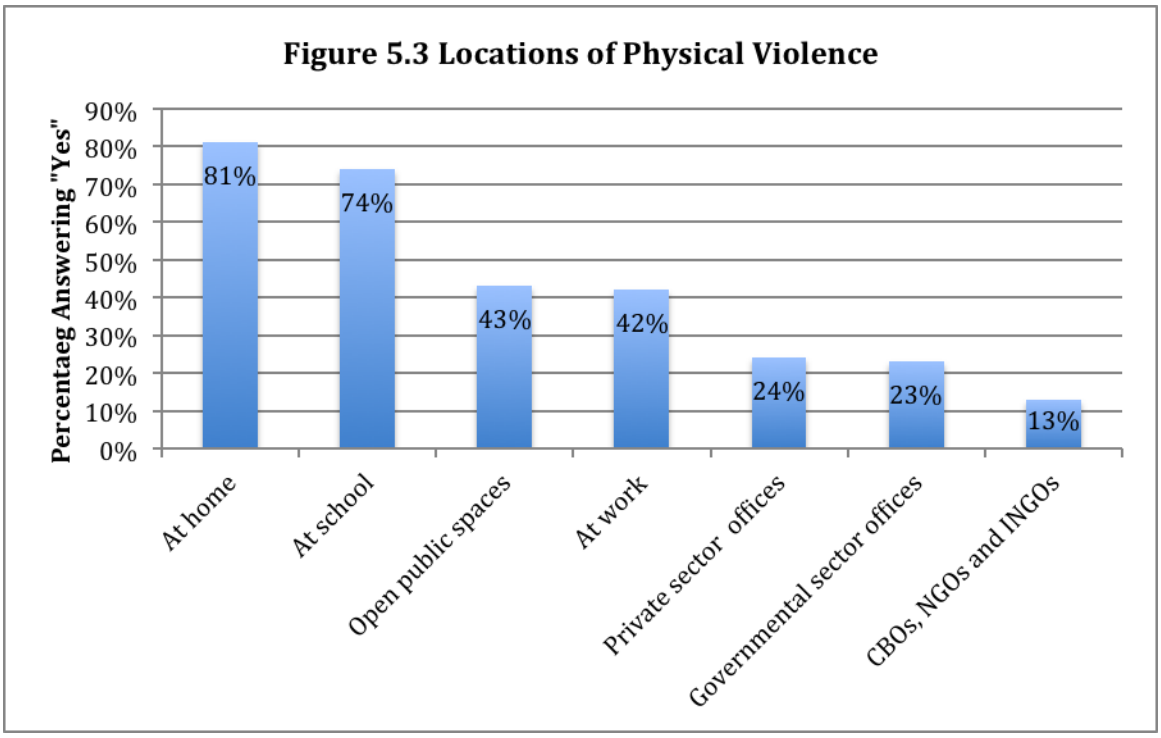
Figure 5.2 shows perceptions of violence against males and females over 18. As the chart indicates, sexual violence against adult males is again perceived as the least common type of violence. That said, it is still reported as "very common" by 26% of overall respondents, which is a sizeable percentage considering how rarely this type of violence is reported. In this category, psychological violence is again reported as most common for both males and females. While there were no marked differences between males and females, Syrians' perceptions are lower than Jordanians' perceptions: 49% of Syrians think psychological violence against males is "very common" while 60% of Jordanians think the same. With physical violence against males, 32% of Syrians think it is very common while 48% of Jordanians think the same. With sexual violence against males and females, the gaps are similar: 27% of Syrians and 39% of Jordanians think sexual violence against females is very common, while 18% of Syrians and 28% of Jordanians think sexual violence against males is very common.



These results are interesting, possibly indicating that Syrians feel relatively safer than their Jordanian counterparts, or are less keen to report their sense of vulnerability to violence. More qualitative data is needed to know the exact reasons. From a programming perspective, these results suggests that some Jordanians may need psychosocial support just as much as Syrians do, especially when compared to Figures 4.1 and 4.2, which indicate that psychosocial support is the least accessible type of service, and the most likely to generate fears of stigmatization (as shown in Tables 4.1 and 4.2).

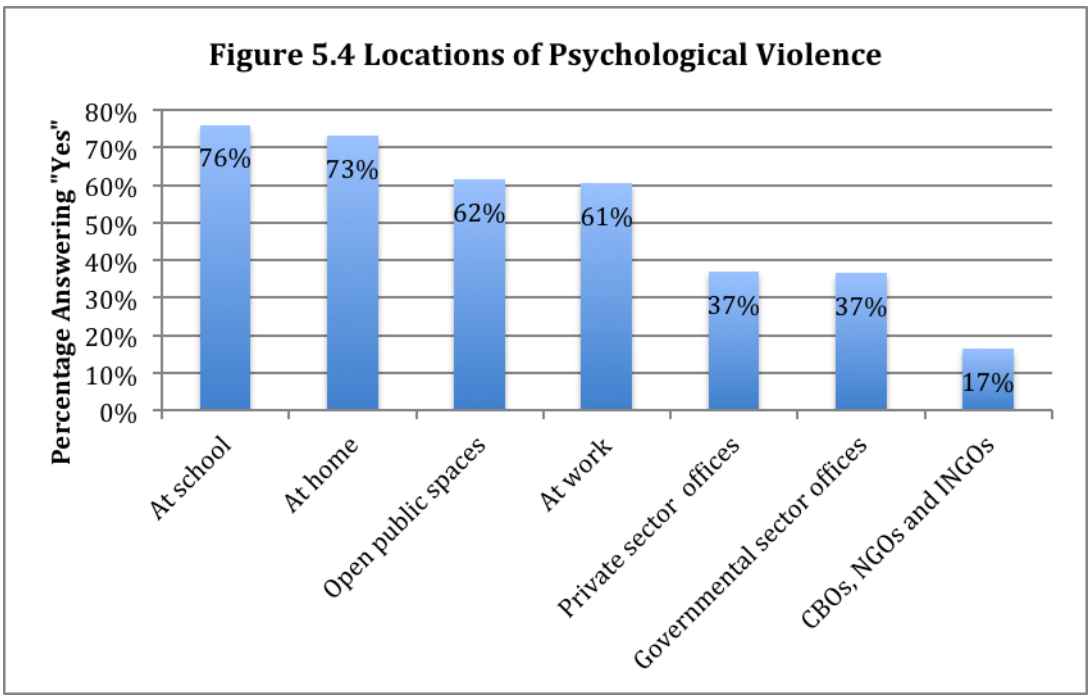
Next, researchers asked respondents to note where they felt that violence was most common. They were asked the following question: "**From the following places, where do you think the risk of violence is more prevalent?"** And then they were presented with a list of locations as shown in Figure 5.3. Respondents were asked to answer "Yes", "No", or "I don't know" to each location for each type of violence. Figures 5.3-5.5 show the "Yes"

answers to each location and type of violence, and Table 5.1 specifically lists answers from males and females in the 15-18 age bracket.

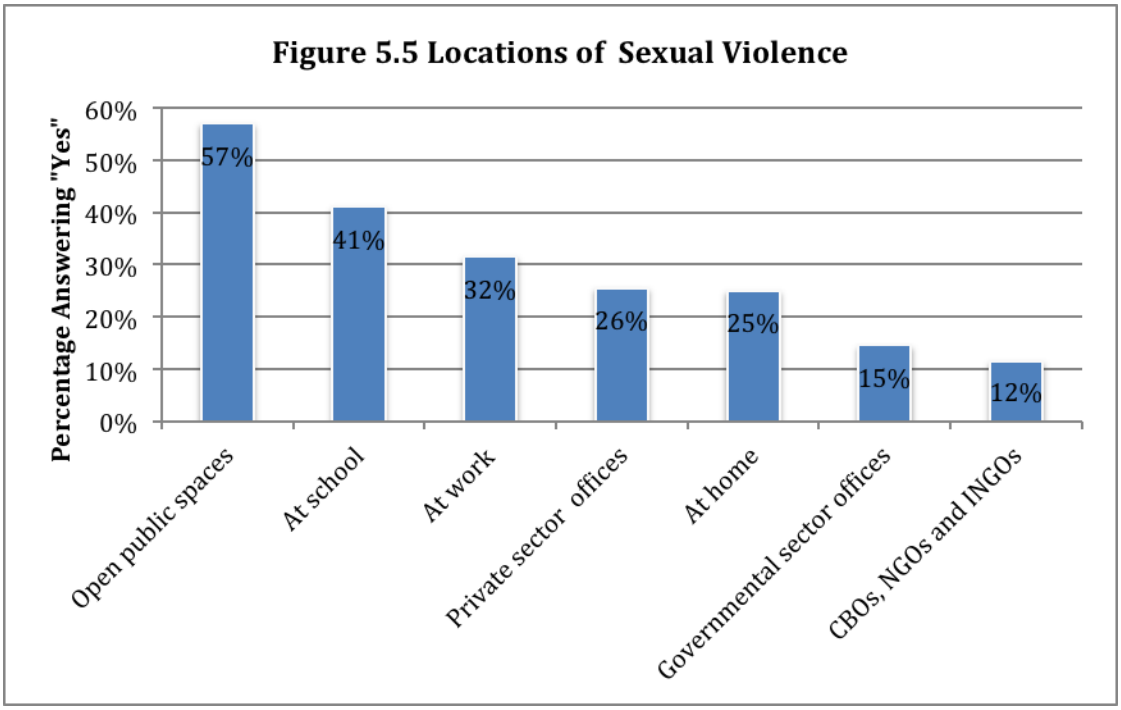


For physical violence, the home was the most listed location (81%), followed by school (74%). There were no notable differences when disaggregated by sex or nationality, except in terms of governmental offices (Jordanians 26%, Syrians 15%) and private sector offices (Jordanians 25%, Syrians 18%). These gaps may be due to the fact that Jordanians are more likely to be working in these places, but may also be because Syrians are hesitant to point out violence in places that they may be relying on; the same could be said for the low reporting of violence at CBOs, NGOs and INGOs. It is impossible to know without further research.

In terms of psychological violence, Figure 5.4 shows that 76% overall thought that it was most common at school, followed by home at 73%. There were no notable differences by age or sex, but by nationality, 63% of Jordanians thought psychological violence was common at work, compared to 53% of Syrians. Similarly, 40% of Jordanians thought psychological violence was common at private sector offices, compared to 26% of Syrians.



In terms of sexual violence, open public spaces were the most frequently listed (57%), followed by school (41%). The only notable difference for sexual violence in terms of disaggregated data was in government offices, where 17% of Jordanians felt it was common, compared to 9% of Syrians.



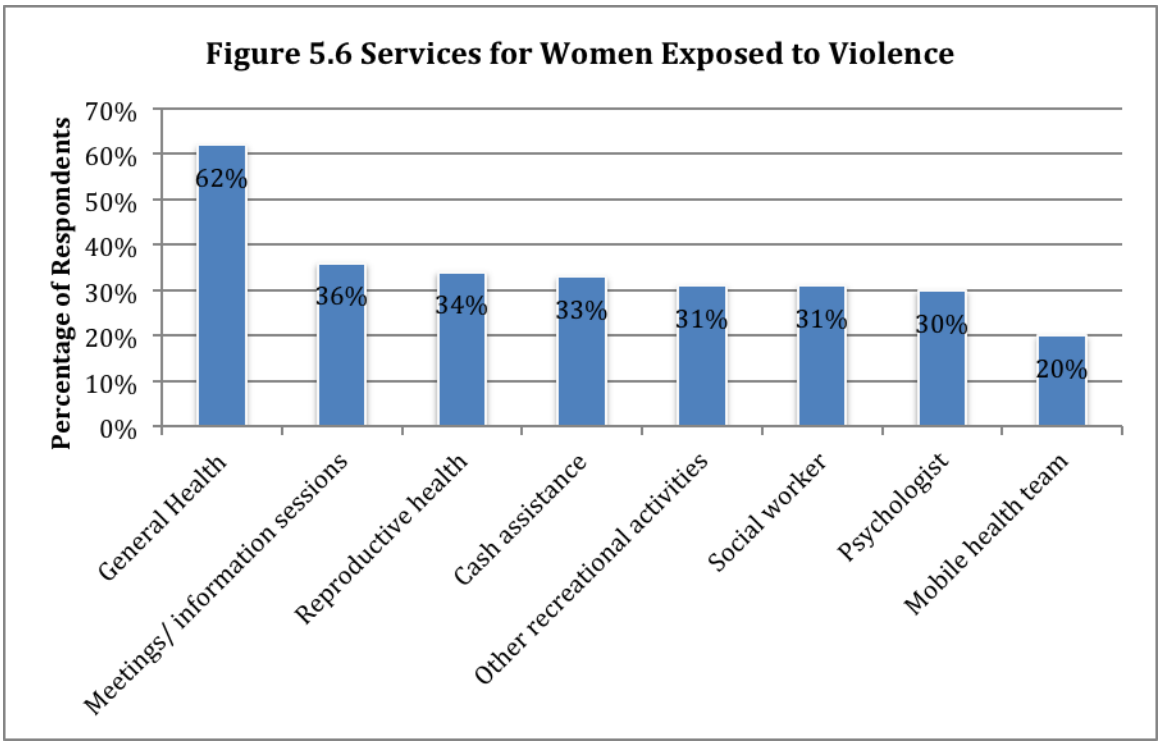
Gender-Based Violence

Respondents were then asked if they had ever heard the term "gender-based violence." Only 20% of females ages 15-18 and 19% of females 19 and up answered "Yes" to that question. Similarly, 19% of males 15-18 and 20% of males 19 and up answered "Yes". When disaggregated by nationality, only 19% of Jordanians recognized the term while 25% of Syrians did so. Overall, the large majority of respondents were not familiar with this term.

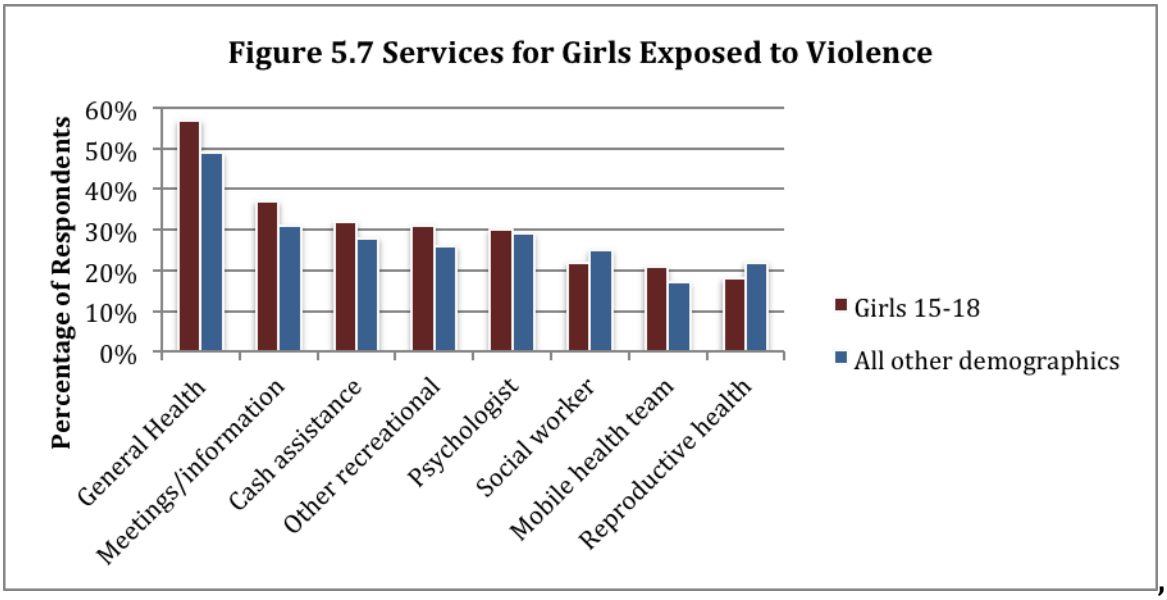
Of the approximately 200 respondents who had heard the term, the most common answer as to what constitutes violence against females was physical violence (43% of males and 33% of females) or psychological violence (22% of males and 32% of females). Only 4% of males and 3% of females said sexual violence as an example of violence against females.

Next respondents were asked to identify sources of support for women exposed to violence. They were first asked, **"If a woman is exposed to any type of violence, are you aware of any available services in your community that can provide her with support?"**

Figure 5.6 illustrates what types of services respondents indicated were available to women exposed to violence. The most common response, by far, was general health services, listed by 62% overall. Most of other services had frequencies between 30-36%, with the exception of mobile health teams, which were listed by approximately 20% of all respondents. Notably, Syrians listed psychologists (40%), recreational activities (38%) and cash assistance (41%) in greater frequency that their Jordanian counterparts (30%, 28% and 28%, respectively), which may indicate that Jordanians aren't as aware of these services, or that some simply are not available to them.



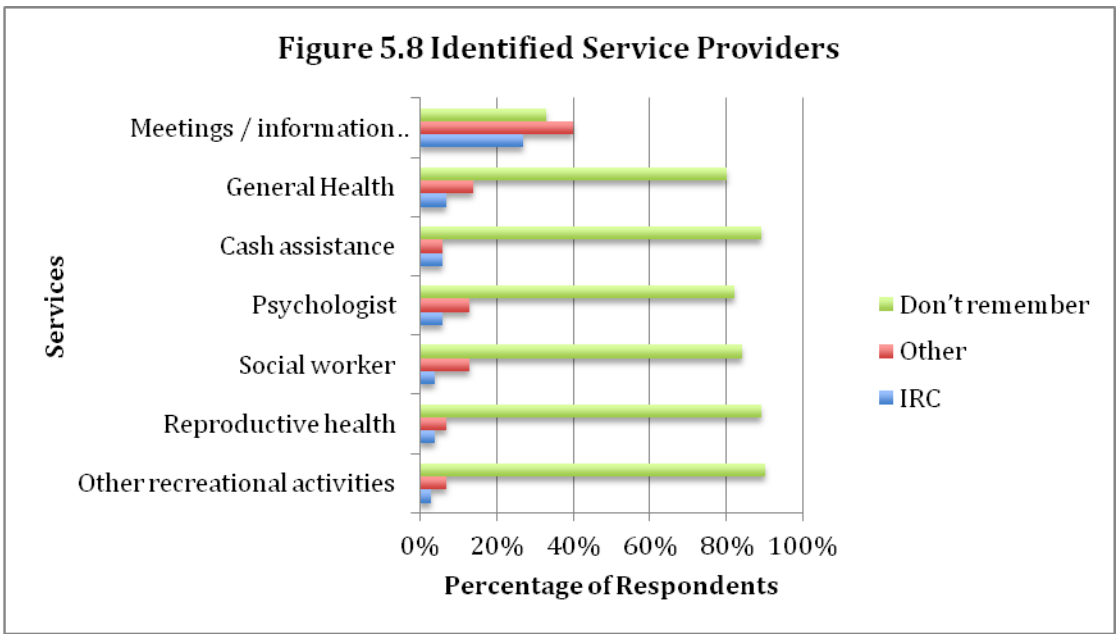
For girls facing violence, general health was again the most commonly listed source of support. Figure 5.7 disaggregates female responses into ages 15-18 compared to all other demographics (where there were no notable differences) to get a more accurate picture of how girls view these services.



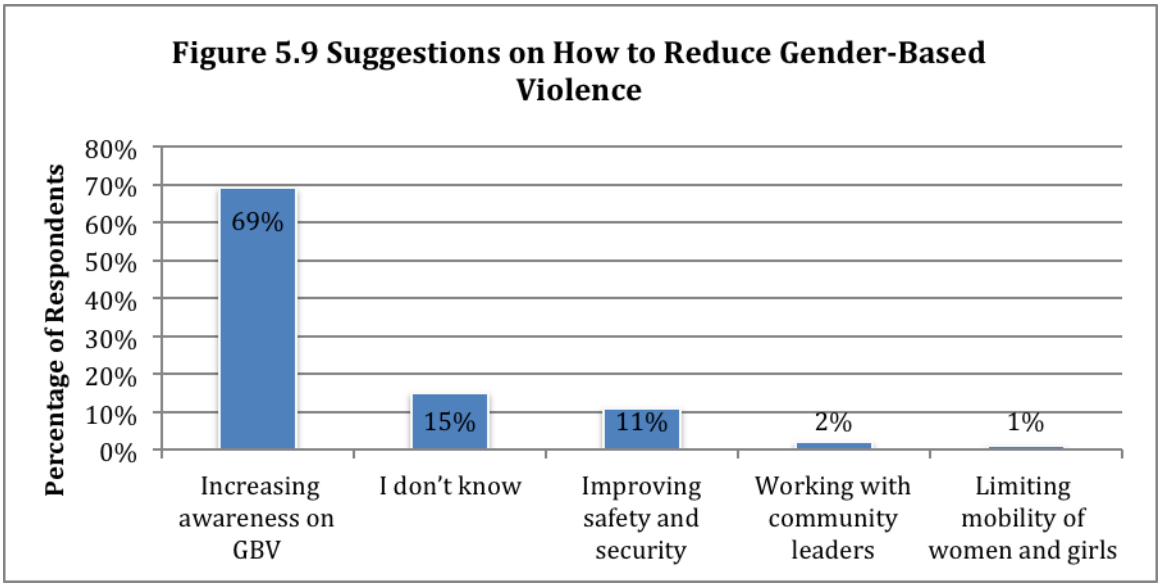
As with women, general health services were identified as the primary service for girls facing violence, and highest among Syrians (58%) and girls 15-18 (57%), compared to 49%

overall. As with services for women, Syrians ranked psychosocial support (38%) and cash assistance (40%) notably higher than their Jordanian counterparts (26% for both services).

Next, respondents were asked to name which particular service providers could offer specific types of support. Very few respondents could actually recall specific service providers that could help women and girls. The only category in which respondents recalled IRC with any significance was in awareness/training services (27%) but this must be interpreted with caution, as the number of people answering in this particular category was very low (N=94). In all other categories, 7% or less recalled IRC as a service provider and 80% or more could not recall a specific service provider at all. This is important to keep in mind when considering that 17% of the entire sample could name IRC as a service provider—it may simply be because many do not retain the name of their service provider in general.



Researchers then asked respondents to provide suggestions on how to reduce gender-based violence. Figure 5.9 shows the most commonly provided answers, with increasing awareness on GBV as the most prominent suggestion (69%). The second most common response was "I don't know" (15%) followed by improving safety and security (11%). There were no significant differences when disaggregated by age, sex or nationality.



The next question asked about attitudes towards forms of gender-based violence. Table 5.1 shows that overall, respondents were not accepting of harmful practices such as marriage of a female under 18 or violence against women or girls. Yet there is still work to be done: 15-19% of respondents were still supportive of underage marriage for various reasons, as listed below. Also, approximately one-third of all respondents agreed that if a women or girl is being hit, it should remain a family matter and no one outside the family should interfere. This suggests a need for greater education and outreach around domestic violence, especially considering that the home is perceived as the most common location of physical and psychological violence. This type of outreach should target both males and females, so that all members of the family are better educated and aware of services. While this is perhaps an obvious suggestion, many programs addressing the prevention of gender-based violence only target females, and thus do not have the full effect that they could if they engaged the entire family.

Community leaders and religious elders should also be brought into these discussions, wherever feasible and only if it does not exacerbate the situation, to aid in the spreading of awareness and service information. The results displayed in Table 5.1 indicate that the sample population is less open to harmful gender-based discriminatory practices than might be assumed.

Table 5.1 Attitudes Towards Gender-Based Violence

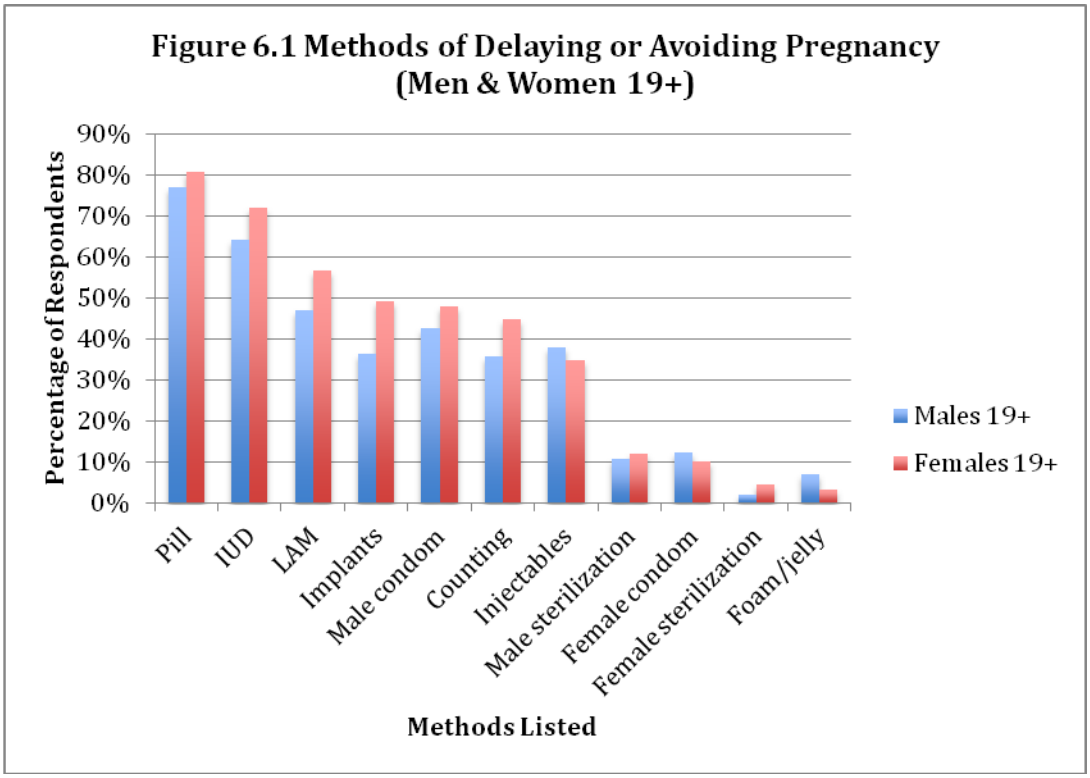
Statement	Agree	Disagree	Refuse to answer
Marriage of a female under the age of 18 is an acceptable way to protect the family's honor	15%	74%	1%
Marriage of a female under the age of 18 is an acceptable way to protect the girl	19%	66%	1%
Marriage of a female under the age of 18 is acceptable to help solve the financial problems of the family	18%	66%	1%
Marriage of a female under the age of 18 for financial reasons is acceptable	19%	65%	1%
Marriage under the age of 18 can negatively affect the health of a female	65%	17%	1%
Marriage of a female under the age of 18 can negatively affect the psychological wellbeing of a girl	69%	15%	1%
Marriage of a female under the age of 18 can negatively affect the community	62%	17%	1%
A husband and wife should make decisions together about how money will be spent in the household	73%	17%	1%
Only men should decide on how money will be spent in the household	24%	61%	1%
Only women should decide on how money will be spent in the household	8%	75%	1%
All family members should contribute to the decision on how money will be spent in the household	53%	29%	1%
Violence against women is acceptable under certain circumstances	16%	60%	3%
Violence against girls is acceptable under certain circumstances	17%	58%	3%
If a woman is being hit, this is a family matter and no one outside the family should interfere	28%	41%	3%
If a girl is being hit, this is a family matter and no one outside the family should interfere	31%	36%	3%
If a woman exposed to violence she will seek help from a trusted person	57%	14%	3%
If a girl exposed to violence she will seek help from a trusted person	58%	14%	3%
If a woman is exposed to violence she will seek help from a specialized service provider	49%	15%	4%
If a girl is exposed to violence she will seek help from a specialized service provider	44%	15%	3%

Section 6: Knowledge, Attitudes, and Practices Towards Family Planning

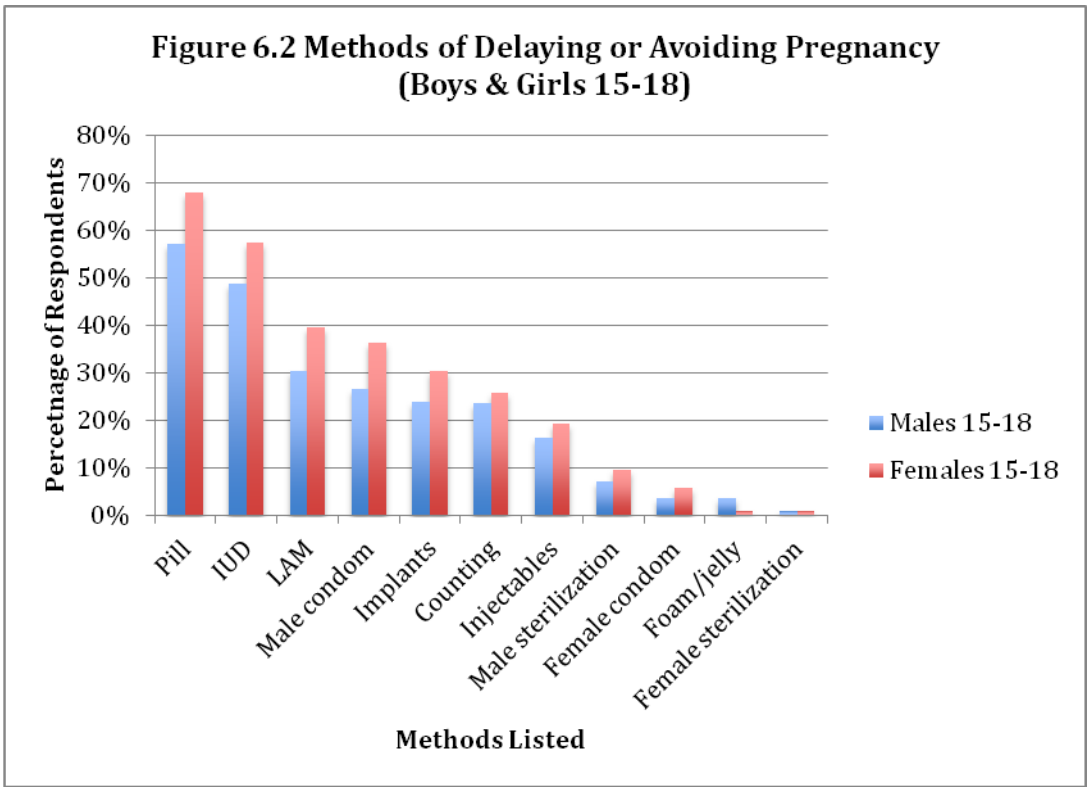
Summary: In discussions on family planning, the birth control pill and the IUD were the most commonly known forms of preventing pregnancy, but those in the 15-18 age group were much less aware of family planning methods overall. The most commonly used form of birth control was the pill, with the IUD second. The most common locations for respondents to obtain birth control were government hospitals or health centers. Men were more likely to get family planning information from a health care worker, while women were more likely to get it from a midwife.

The final section of the survey related to questions around pregnancies and family planning. Researchers asked respondents what ways they had heard of to prevent or delay pregnancy. Figure 6.1 and 6.2 show responses of "Yes" (they had heard of the method) disaggregated by age and sex.

The highest listed birth control method was the pill (77% of men, 81% of women, 68% of girls, 57% of boys), but when comparing Figures 6.1 with 6.2, those in the 15-18 age group were much less aware of all methods in general. The biggest differences in men and women were in implant devices (49% of women, 36% of men) and Lactation Amenorrhea Method (LAM), with 47% of men aware of this method and 57% of women. Overall, females in all age groups were more aware of birth control methods than males, which is not surprising but does suggest that more family planning education and awareness needs to be targeted at men, and especially young men, given the results in Figure 6.2.



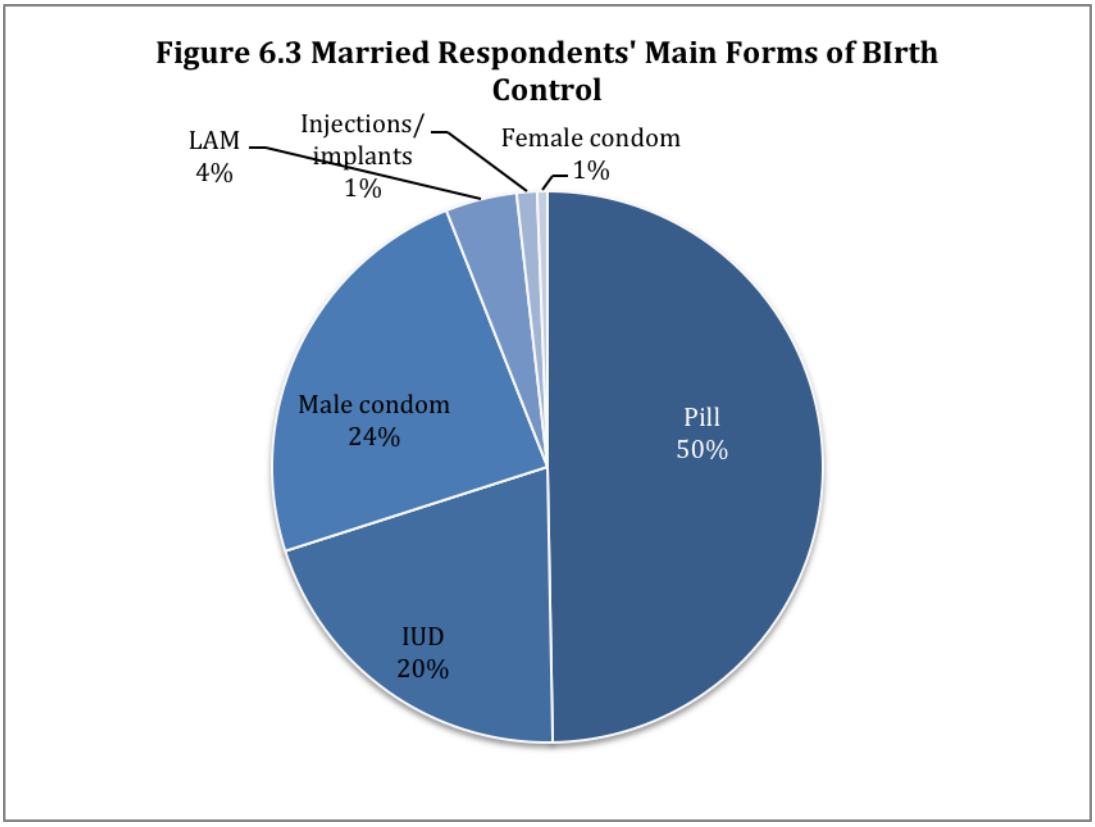
Of particular concern is the seeming lack of awareness of the male condom in the age 15-18 demographic, not only for preventing pregnancy for also for sexually transmitted diseases. Only 36% of girls and 27% of boys ages 15-18 were aware of this method. In the 19+ age group, awareness was better but still relatively low, with 48% of women and 43% of men aware of this method.



These results suggest that a sizeable percentage of the vulnerable populations in the targeted areas are not aware of appropriate methods or options to delay or prevent pregnancies.

When disaggregated by nationality, the biggest differences of awareness were regarding the male condom (Jordanians 37%, Syrians 29%), implants (Jordanians 37%, Syrians 30%), counting (Jordanians 35%, Syrians 27%) and injections (Jordanians 27%, Syrians 19%).

Next, researchers asked married respondents what was the main form of birth control they were currently using, and where they had obtained it. Approximately 46% of married respondents were using some form of birth control. Figure 6.3 shows that the birth control pill was the most frequently named main method (50%), with the male condom second (24%), and the IUD third (20%).



When asked where they obtained their main method of birth control last, the majority had obtained their preferred method at government hospitals, health centers, or family planning clinics. (See Table 6.1) Very few obtained their birth control from mobile health clinics, field workers, or community based organizations.

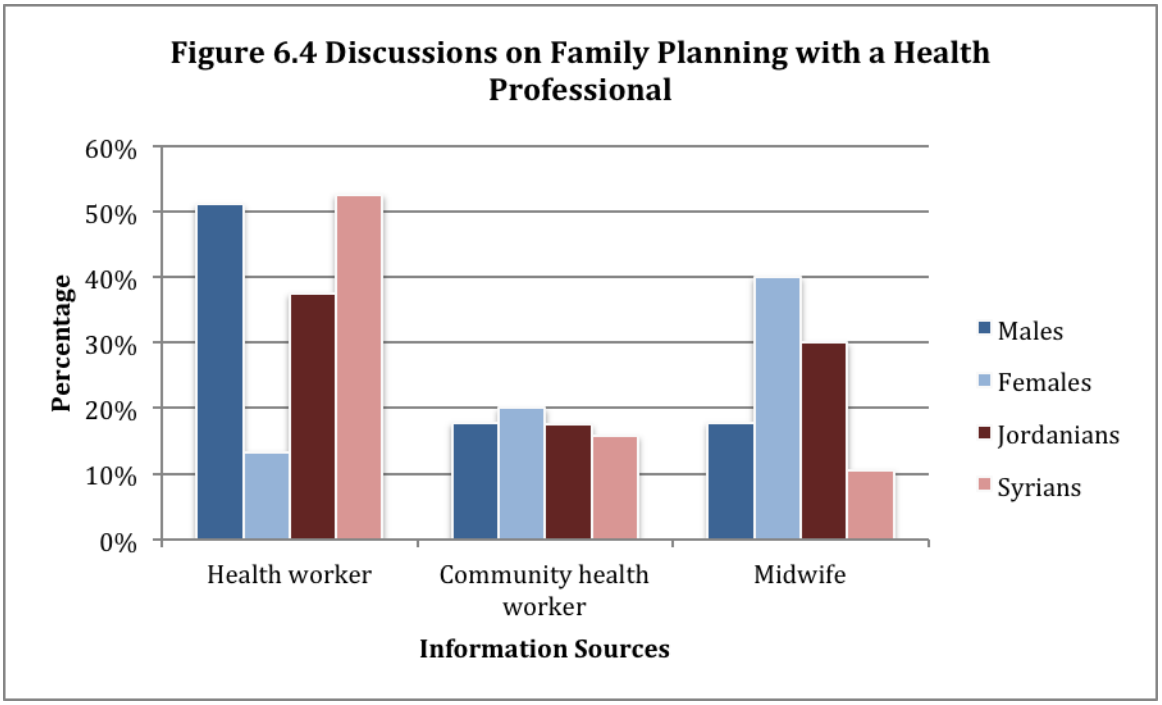
Table 6.1 Locations for Obtaining Main Form of Birth Control

Location	Pill	IUD	Male condom	Injections, implants
Government hospital	56%	32%	8%	67%
Government health center	16%	33%	68%	4%
Family planning clinic	22%	28%	3%	8%
Mobile health clinic	1%	3%	n/a	n/a
Field worker	1%	1%	n/a	n/a
Community based organization/distributor	5%	2%	n/a	4%
Private hospital/clinic	n/a	n/a	n/a	n/a
Pharmacy	n/a	1%	21%	8%
Friend/relative	n/a	n/a	1%	n/a

Sources of Family Planning Information

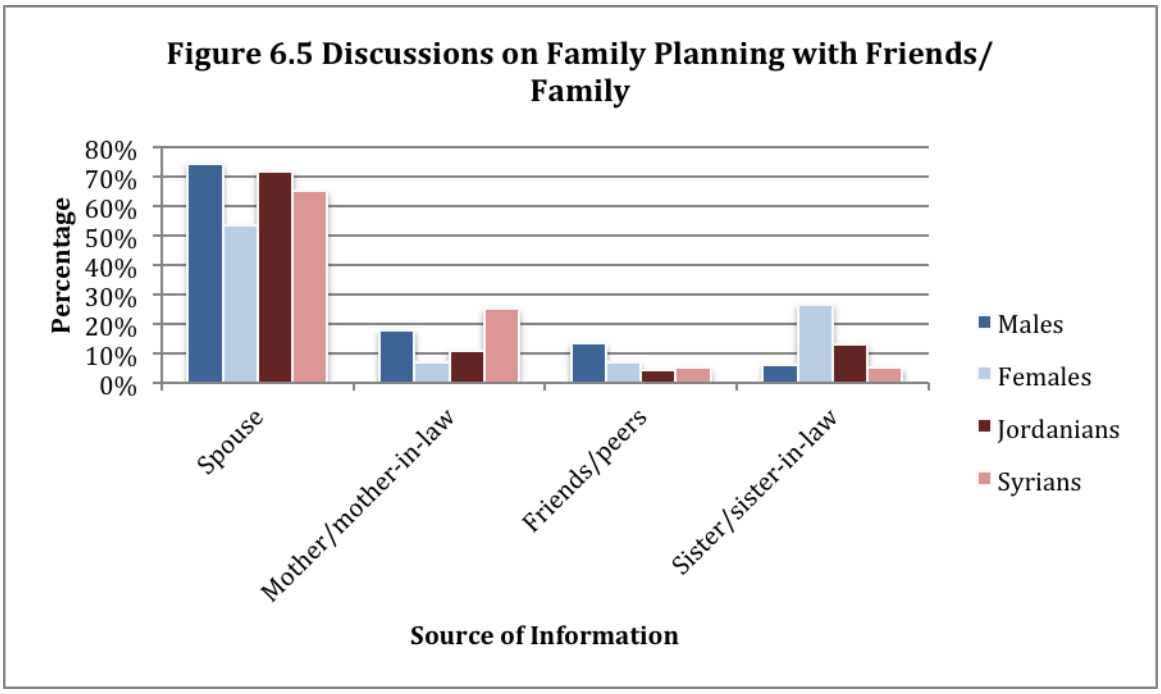
Researchers then discussed information on family planning methods, asking first, "**In the last 12 months have you discussed family planning with a health worker either in the health unit or in the community**?"

The majority of respondents had not discussed family planning with a health worker, with 27% of males and only 8% of females saying yes. The discrepancy here between males and females is quite striking, and should be considered in future planning around reproductive health. Because no qualitative data was collected here, it is difficult to know *why* women discussed it so much less with health professionals than men did. The discrepancy was similar with discussing family planning with friends and family, with 39% of males saying they had but only 9% of females saying the same. This is concerning and warrants further investigation and discussion, as it does not appear that married women are discussing family planning very much at all. By nationality, only 15% of Jordanians and 24% of Syrians said yes. This question was only asked of married respondents, so only 32 respondents between ages 15-18 that answered this question. Of that sample, only four (13%) said yes and all were males. No married female between the ages of 15-18 said they had discussed family planning with a health worker. Though this sample is very small and no major inferences can be made, it indicates a need for further investigation in this area on the family planning knowledge for women in general, and especially for underage married girls.



Out of the sample that had discussed family planning, they were then asked with whom they discussed it. Figure 6.4 shows that men were more likely to have discussed family

planning with a health care worker (51% compared to women at 13%),[27] while women were far more likely to have discussed it with a midwife (40% compared to men at 18%). Syrians were also more likely to discuss family planning with a health care worker (53%) than Jordanians (38%), while Jordanians were much more likely to discuss it with a midwife (30%) than Syrians (10%).[28] Across all four demographics, 16-20% had discussed family planning with a community health worker.



This sample was then asked if they had decided to use family planning as a result of the conversation. For men, 76% said yes while 73% of females also said yes. By nationality, 78% of Jordanians and 68% of Syrians said yes. So while the decision to use family planning was similar between males and females, there was some discrepancy between Jordanians and Syrians, even though a greater proportion of Syrians said they had engaged in a family planning discussion.

The most common reason given for a "no" answer (i.e., they did not use family planning as a result of the discussion) was that respondents were already using some form of family planning (47%), but the second reason was fear of using family planning (33%), followed by being currently being pregnant (7%) and wanting a child/trying to conceive (13%). The questionnaire did not ask specifically *what* respondents were scared of, but this result suggests a greater need for raising awareness and providing proper education on family planning and the inherent risks and benefits.

[27] To be interpreted with caution, as only 15 females and 45 males answered this question (i.e., 13% is 2/15).
[28] Again, this must be interpreted with caution due to the very small sample size. Only 19 Syrians answered this question.

Lastly, researchers asked respondents if they had discussed family planning with other people in their household or community. Figure 6.5 shows the most common answers, with spouse being the most common answer by far (75% of males, 53% of females, 72% of Jordanians, 65% of Syrians). Females were the most likely demographic to discuss it with a sister or sister-in-law (27%), while Syrians were most likely to speak to a mother or mother-in-law (25%). What is interesting is the discrepancy between men and women regarding talking to their spouses. This might indicate that men and women have different perceptions on what counts as discussing family planning with a spouse, or that men and/or women are misrepresenting themselves.

CONCLUSION

In general, a large percentage of vulnerable people in Jordan appear to be accessing services, especially health services, which are ranked most important overall. IRC was the second most listed NGO by Syrians, after Save the Children, which indicates that name recognition and levels of outreach is fairly good among the refugee population. The biggest demographic accessing IRC services was women ages 19 and up. However, many respondents do not feel that IRC services are meeting their needs, and many feel that there are obstacles, especially for women and girls, in accessing services. There is a pervasive agreement that violence is high, especially at home and at school, with psychological violence ranked the most common type of violence. There are also some striking differences between Syrian and Jordanian awareness of services (especially in terms of psychosocial services and awareness of IRC in general), suggesting there are gaps in IRC's ability to reach host populations. Finally, very few respondents had engaged in family planning discussions with healthcare professionals, and while some forms of birth control were well known, others were not, especially in the age 15-18 demographic, where lack of knowledge was especially concerning.

The results of this survey indicate that IRC is doing a relatively good job in providing health services compared to other non-governmental agencies in the sample areas. However, overall awareness of IRC was low across the surveyed population. Also, the quality, access, and range of services could be better tailored in order to fully meet the needs of vulnerable populations. In general, many respondents did not feel that IRC services "met needs" (especially psychosocial services and health mobile teams), suggesting that overall quality of services is in need of improvement. More research is required here to know where the services failed them and how they could be improved.

Of particular concern is that even though 40% of respondents felt that psychosocial services were very important (compared to 25% ranking them as not important), they were perceived to be one of the least accessible services, and one of the least likely IRC services to have met needs. Yet psychosocial violence at home and at school was perceived to be the most common type of violence. This points to an acute need not only for more psychosocial care, but also for better awareness and education on what psychosocial services can provide, and efforts to take away the stigma attached to such care.

Also, 62% of respondents felt that health clinics midwives were very important for women, but key obstacles to accessing reproductive health was the distance to services, and also a lack of female service providers.

Some of the main obstacles that came up in this survey can be addressed by providing more female service providers and separating men and women appropriately, and by trying to provide more access points so that those in need do not feel they are so far away. Because not being sure of what the service actually provided was a factor in all services except

general health and reproductive health, there appears to be a need to educate vulnerable people as to what is available to them and how it can help.

Another top concern is the lack of awareness of the term gender-based violence, even though the vast majority agreed that increasing awareness is the best way to combat GBV. Also concerning is the fact that one-third of respondents felt that if a girl or woman is being hit, the matter should be kept within the family is especially concerning.

Finally, very few women in this sample seem to be discussing family planning with anyone, and a fear of birth control seems to be fairly common. Finding culturally sensitive ways to broach this topic, and engage more women in this discussion, is paramount to providing better reproductive health services.

Recommendations

1. Increase the separation of men and women at points of service. This was listed as a top obstacle in accessing services, suggesting the need for better and more appropriate separation of the sexes, and more female staff. This may include the need to separate women from male family members, as obstacles listed in Section 4 indicate that family members may be preventing women and girls from accessing required services.

2. Improve awareness and access to psychosocial services (for all demographics), as psychological violence is perceived as high but access to psychological support is perceived as low. Women and girls especially require ways to access this care confidentially, sometimes even without knowledge of their families, as stigmatization and being prevented by the family are key concerns. Action on this may be challenging and may require more research to determine the best course, as the home was ranked as one of the top locations for both physical and psychosocial violence.

3. Improve/increase outreach, awareness and child protection programs in schools, as school was consistently perceived as a top location for psychosocial, physical, and sexual violence. Teachers need to be engaged in this discussion and assist with reporting and documenting violence, as do school administrators, and parents. However, action in this area must be taken with each situation carefully considered—for example, who are the perpetrators of violence? The survey did not ask this, and if the teachers or administrators are complicit, then involving them in reporting could simply exacerbate the situation.

4. Improve health mobile teams, both in terms of quantity or quality. These services were not ranked as very important, very accessible, or as meeting needs. Clearly awareness, access, and quality of health mobile teams are all in need of improvement so that vulnerable people can see their utility.

5. Improve women and girls' access to non-health services, such as social workers, cash assistance and training/awareness. These services were frequently ranked as "very important" for women and girls, but not perceived as very accessible. Some awareness is there—women and girls already know they need these things, though awareness could still improve—but they need more help in obtaining them easily.

APPENDIX A

Methodological Details

As mentioned above, this survey was not intended to be statistically representative of the entire refugee population. The sample was estimated to provide a reasonably accurate snapshot of the knowledge, awareness and practices in the Irbid, Mafraq and Ramtha areas only.

The calculation of sample size was estimated to provide results with CV% less than 7% at area level. Below is the formula that used to calculate the sample size for each area:

$$SS = \frac{Z^2 * (p) * (1 - p)}{C^2}$$

Where:

Z = Z value (e.g. 1.96 for 95% confidence level)
p = percentage picking a choice, expressed as decimal
(.5 used for sample size needed)
c = confidence interval, expressed as decimal (e.g., .07 = ±7)

Correction for finite population:

$$New \quad SS = \frac{ss}{1 + \frac{ss - 1}{pop}}$$

Where: pop = population

The study sample was drawn in three stages, using the cluster sampling method:

- First Stage: ZENID targeted "clusters" of four households located on one side of the main street located in each governorate. After four houses on one side of the street had been successfully surveyed, the researcher sought four household respondents from the other side of the street. This process alternated until the target number of respondents had been fulfilled for each governorate (50 respondents in Mafraq, 25 respondents in Irbid). ZENID employed a "ketch table" tool to ensure random selection of respondents within households. No more than one member of each household was administered the questionnaire, and the ketch table was used as a method of randomly choosing the respondent if more than one household member met the target criteria assigned to that household. For example, if a household contained three members who were female and above the age of 18, the ketch table was used to randomly determine which member would

be surveyed. A detailed description of how the tool was used is listed in the following stages.

- Second Stage: The "cluster" method was employed to identify target households, totaling 48 households located on the main street of the Irbid governorate and 23 houses located on the main street of the Mafraq governorate. In the event that the household members did not answer the door or refused the survey, the researcher skipped this home and continued on the same side of street, obtaining four completed surveys before alternating to the other side of the street.
- Third stage: Each household was designated a target respondent age group and gender. In the event that more than one household member fulfilled the designated respondent criteria, the researchers used the ketch table. The process of using the ketch table to ensure random selection is described below:
    1. Each house was randomly assigned a serial number.
    2. If one member of the household belonged to the targeted age and gender demographic, then the respondent administered to the survey to this individual without the use of the ketch table. However, if multiple household members fell in the same targeted demographic respondent criteria assigned to this household, their names were listed on the ketch table.
    3. The last participant's number was matched with the corresponding household serial number on the graph. For example, if the household members of the targeted demographic group numbered 5 and the household serial number was 14, then Respondent #2 would be chosen for survey data collection.

Further methodological details, including risk reduction strategies, are available upon request.