Risk and Protective Factors Facing Refugees in Jordan

By

Hayley Pierce

A dissertation submitted in partial satisfaction of the requirements for the degree of

Doctor of Philosophy

in

Demography

in the

Graduate Division

of the

University of California, Berkeley

Committee in charge:

Professor Jennifer Johnson-Hanks
Professor Joshua Goldstein
Professor Dennis Feehan
Professor Ndola Prata

Spring 2018
Abstract

Risk and Protective Factors Facing Refugees in Jordan

By

Hayley Pierce

Doctor of Philosophy in Demography

University of California, Berkeley

Professor Jennifer Johnson-Hanks, Chair

The refugee and displacement problem is one of the most complicated humanitarian issues facing the Middle East, and perhaps the world. The UN Refugee Agency reports that there are 65.3 million people seeking protection and assistance as a consequence of forced displacement. Globally, over 40 million people are displaced within their own country, 21 million are refugees with 5.2 million of those listed as Palestinian refugees registered with the United Nations Relief and Works Agency (UNRWA), and the remaining 3.2 million are asylum seekers. A vast proportion of these individuals and families come from or find refuge in the Middle East.

This dissertation seeks to find out how the reproductive, maternal, and child health of refugees in Jordan compare to Jordanian nationals. Additionally, what possible risk factors or protective factors do refugees in these camps encounter? And then what void can donors fill? And what should be donors top priority among these factors? Refugees are separated from critical social institutions that provide health, education, security and economic opportunity. Support organizations ability to replace these social institutions depends on the complexity of the institution, resources available, and characteristics of the refugees. I will compare refugee characteristics to assess effectiveness of support communities. I will include characteristics of refugees so see how important these are. Results will help scholars, policy makers and governments understand which social institutions are or are not being replaced, and I will discuss possible reasons for this.

This research uses the 2012 Demographic and Health Survey (DHS) from Jordan and the 2012 DHS survey from Haiti. Findings across all three articles suggest that there is an ambivalence of refugee camp membership that is consistent- camp membership provides a health security and a social liability. In all instances involved in this research, the camps are able to provide provisional resources on par with or better than the host country while simultaneously making the refugees vulnerable to abuses and other social hardships. These findings suggest an agenda focused on social integration for aid organizations going further.
Dedication

It takes a village to navigate through a PhD program. My village consists of many people who have cheered me on through not only my PhD, but to infinity and beyond. First, my intellectual-giant of an advisor who always seemed to know what to say- thank you Jenna for being responsive, invested, and motivational. You always seemed to provide the feedback at the right time and in the right way. To my other committee members- Dennis, Ndola, and Josh- thank you for your support and well wishes. And Monique- thanks for answering my endless upon endless questions. Berkeley Demography has been good to my family and me; it will be a time of life I never forget.

Of course, my boys. Thank you to Jonathan who served as a listening ear from the very beginning- whether he knew what I was talking about or not. Without your constant support none of this would have been possible or worthwhile. This PhD program also saw the birth of my two littlest boys James and Miles. Thank you boys for being patient while I “study.”

Thank you to my parents and sister for loving my sons like their own and filling in when life got crazy.

So thank you to my Village, this work is dedicated to you.

XOXO
Table of Contents

REFUGEE CRISIS WORLDWIDE ........................................................................................................ IV
REFUGEE CRISIS IN JORDAN ........................................................................................................ IV
BACKGROUND OF POPULATION POLICY IN JORDAN ................................................................... VI
RELEVANT MEASURES IN THE DEMOGRAPHIC AND HEALTH SURVEY .................................... VII
UNITED NATIONS RELIEF AND WORKS AGENCY (UNRWA) ...................................................... VII
FURTHER HEALTH TRENDS AND POLICY IN THE LAST 20 YEARS ............................................. VIII
DEMOGRAPHIC AND HEALTH SURVEYS ...................................................................................... X
REFUGEE CAMPS ........................................................................................................................ XI
THIS RESEARCH ........................................................................................................................... XI
REFERENCES .................................................................................................................................. XII

ARTICLE 1 ...................................................................................................................................... 1

REPRODUCTIVE AND MATERNAL HEALTH CARE UTILIZATION IN JORDAN: PROVISIONAL
SUPPORT AND SENSE OF SPACE ................................................................................................ 1
THE SOCIODEMOGRAPHIC SITUATION .......................................................................................... 3
SEVERED TIES FOR REFUGEES ...................................................................................................... 4
GOVERNMENT AND NGO REPRODUCTIVE HEALTH SERVICES IN JORDAN ..................................... 5
THE DATA ....................................................................................................................................... 6
MEASURES ...................................................................................................................................... 7
THE COVERAGE OF REPRODUCTIVE CARE ................................................................................... 7
THE COVERAGE OF MATERNAL CARE ........................................................................................... 9
DIFFERENTIALS IN REPRODUCTIVE AND MATERNAL CARE ...................................................... 9
REFUGEE RISK FACTORS .............................................................................................................. 11
DISCUSSION .................................................................................................................................. 11
REFERENCES .................................................................................................................................. 14
TABLES .......................................................................................................................................... 16

ARTICLE 2 ...................................................................................................................................... 23

RISK AND PROTECTIVE FACTORS FOR GENERATIONAL REFUGEE CHILDREN IN JORDAN ...... 23
JORDANIAN CONTEXT .................................................................................................................. 24
RISK AND PROTECTIVE FACTORS ............................................................................................... 25
HEALTH .......................................................................................................................................... 26
EDUCATION ..................................................................................................................................... 27
PARENTING TECHNIQUES .............................................................................................................. 28
DATA .............................................................................................................................................. 29
MEASURES ...................................................................................................................................... 30
CHILDHOOD RISK AND PROTECTIVE FACTORS ....................................................................... 30
DISCUSSION .................................................................................................................................. 32
REFERENCES .................................................................................................................................. 36
TABLES .......................................................................................................................................... 39

ARTICLE 3 ...................................................................................................................................... 44

REFUGEE HEALTH AND SOCIAL OUTCOMES: A COMPARISON OF EXPERIENCES OF REFUGEES
IN JORDAN AND HAITI ..................................................................................................................... 44
JORDAN REFUGEE CONTEXT ......................................................................................................... 45
HAITI REFUGEE CONTEXT ............................................................................................................. 46
COMPARISON AND SELECTION .................................................................................................... 46
SIMILARITIES BETWEEN REFUGEES .............................................................................................. 47
Disruption of medical care
Disruption of social connections
Stress

DIFFERENCES BETWEEN REFUGEES
Site of relocation
Duration
Role of Aid Organizations

DATA
MEASURES
FINDINGS
Experience with Domestic Violence
The Coverage of Reproductive Care
The Coverage of Maternal Care
Differentials in Domestic Violence Experiences
Differentials in Reproductive and Maternal Health Care
Differentials by Social Characteristics

DISCUSSION
Research question 1: are displaced women more disadvantaged than residents in terms of reproductive health and domestic violence?
Research question 2: is the relative disadvantage influenced by context (Jordan vs. Haiti)?
Research question 3: is relative disadvantage influenced by social characteristics?

REFERENCES
TABLES
FIGURES

DISSEMINATION CONCLUSION
OVERVIEW
Article 1
Article 2
Article 3

THE EMERGENT STORY
SPECULATED SOLUTIONS
FUTURE PLANS
REFERENCES
Introduction
Refugee Crisis Worldwide

The refugee and displacement problem is one of the most complicated humanitarian issues facing the Middle East, and perhaps the world. The UN Refugee Agency reports that there are 65.3 million people seeking protection and assistance as a consequence of forced displacement. Globally, over 40 million people are displaced within their own country, 21 million are refugees with 5.2 million of those listed as Palestinian refugees registered with the United Nations Relief and Works Agency (UNRWA), and the remaining 3.2 million are asylum seekers. A vast proportion of these individuals and families come from or find refuge in the Middle East.

As of 2015, Lebanon hosted the largest number of refugees in relation to its population with 183 refugees per 1,000 native inhabitants. Jordan ranked second with 87. In terms of the numbers of refugees hosted within a country, Turkey hosted the most refugees worldwide, with 2.5 million people- and was followed by Pakistan, Lebanon, Iran, Ethiopia and Jordan (Refugees, 2016).

Ban Ki Moon, United Nations Secretary General said, “We are facing the biggest refugee and displacement crisis of our time. Above all, this is not just a crisis of numbers; it is also a crisis of solidarity” (Refugees, 2016 pg 5). Global forced displacement has steadily increased in recent years, producing record-high numbers. It is imperative to understand how people are faring under refugee status and what risk factors they face. The UN Refugee Agency noted that if these 65.3 million persons were a nation, they would be the 21st largest in the world. Considering the vast number of people affected, both in the sending and in the receiving countries- the needs of these individuals cannot be overlooked. Within the refugee community, literature suggests that they are a vulnerable population. Conflict and displacement are associated with loss of livelihood, poverty, disruption of services, reduced care for reproductive needs, and reduced provision of maternal care, among other things (Refugees, 2016). Additionally, maternal and neonatal mortality among refugees can be high due to limited reproductive health care available in most refugee settings, leaving many needs unmet (Bartlett et al., 2002). Women are also more vulnerable to rape during times of displacement and flight- making refugee women particularly vulnerable to gender-based violence during flight from conflict and in refugee camps (Hynes & Cardozo, 2000). Filippo Grandi, UN High Commissioner for Refugees stated, “More people are being displaced by war and persecution and that’s worrying in itself, but the factors that endanger refugees are multiplying too” (Refugees, 2016 pg. 21).

Refugee Crisis in Jordan

Jordan is an almost entirely landlocked country located in the Middle East with an area of 35,475 square miles and is comparable in size to Indiana. It is bordered on the north by Syria, on the east by Iraq, on the west by Israel, the Jordan River, and the Dead Sea, and on the south by Saudi Arabia. In regards to demographic features, in 1946, the population was around 400,000 people; in 1997, it reached 4.6 million; and it currently rests at a population of 6.5 million. The population is young, with a relatively high birth rate (3.31 births per woman) compared to the world average and surrounding countries- Syria (3.00), Israel (3.04) and Saudi Arabia (2.70). The influx of immigrants, the inflow of large numbers of foreign workers, the high rate of natural increase, the return of Jordanians from other states, and the migration of hundreds of thousands of Iraqis as a result of the 2003 Second Gulf War all contribute to the high and steady growth rate since the 1960’s.
Jordan has an extensive history with refugees. Following the 1967 war with Israel and Iraq’s 1990 invasion of Kuwait, there were vast influxes of Palestinian Arab refugees who now make up more than two-thirds of the population of Jordan. In 1996, 1,359,000 Palestinian refugees living in Jordan were registered with the United Nations (UN); 250,000 Palestinians continue to live in ten refugee camps. Jordan however, is the only Arab country where Palestinians can become citizens. A variety of geographic definitions of Palestine have been used throughout history. As of 2014, the State of Palestine consists of the West Bank, East Jerusalem and the Gaza Strip, which is surrounded by Israel, Syria, Jordan and Egypt.

Currently, the largest movements of refugees into Jordan are coming from Syria. As of 2015, the UN had registered over 622,000 Syrian refugees in Jordan. Approximately 80 percent of these refugees live in urban areas in the north of Jordan while the remaining refugees live in refugee camps. The northern border of Jordan that connects with Syria has been fluid in the past, with many individuals feeling as Syrian as they are Jordanian. When the conflict in Syria first began, many Syrians went to Jordan to stay with relatives and didn’t consider themselves “refugees”. However, as the war escalated, Syrians without relatives in Jordan began to cross the border. Regardless of the massive influx of Syrians, the Jordanian government didn’t officially recognize the growing refugee crisis until 2012 (Navarro, Moss, Fliba, Semo, & Harang, n.d.).

Although Syrians have dominated the current influx of refugees into Jordan, the Israeli-Palestinian peace process remains unresolved, causing an ongoing ebb and flow of Palestinian refugees into and out of Jordan. As recent as September 2000, a second Palestinian uprising against Israeli occupation of the West Bank and Gaza Strip broke out and is still ongoing. This second uprising, second to the original in 1987, is characterized by increasingly severe mobility restrictions imposed by Israeli occupying forces, which has generated a decline in overall access to health services in the region (Bosmans, Nasser, Khammash, Claeys, & Temmerman, 2008).

Palestinians, Iraqis and now Syrians have sought refuge in Jordan. They flee from conflict-ridden settings, but are often greeted with a lack of resources, protection, health care, jobs, etc. Additionally, Jordan is struggling with increasing unemployment rates especially among women and young people. Jordan is currently home to 1.4 million Syrians, which includes the 622,000 refugees who have arrived since the beginning of the Syrian conflict in
2011. Now the Syrians residing in Jordan and the Jordanian nationals are all competing for jobs. At a recent conference in London, $2.1 billion was pledged to support refugees in Jordan over the next three years, to ease the burden on the Jordanian government. This money came with conditions, including the provision of jobs for 200,000 Syrian refugees. Regardless of the reality of creating these jobs, this aid typically reaches the needs of refugees placed in camps, but misses those scattered in cities and towns throughout Jordan. This neglect strains resources from schools, hospitals, and other services only capable of serving the size of the native population.

The crises in Syria and Palestine are some of the largest humanitarian needs of the decade, and Jordan has received a vast portion of the weight of the problem due to its shared border. Understanding the needs of refugees and the Jordanian nationals can be eye opening for not only this humanitarian crisis, but those that are to come as well.

**Background of Population Policy in Jordan**

In 1973, Jordanian officials created the National Population Commission (NPC), with the goal to implement a national population policy and address all population-related topics. However, the NPC took no specific actions due to the controversial nature of population policy. The commission was revitalized in the late 1980s to reinforce several agencies working in the population field. From that time until the early 1990s, public and private sectors made efforts to provide family planning services. The first official population policy was proposed and accepted in 1993 when the NPC adopted the National Birth Spacing Program. The Birth Spacing Program was intended to increase maternal and child health and reduce fertility while considering the social, national, religious and free-choice dimensions of Jordanian society. The family planning efforts made by the NPC, as well as by the Ministry of Health through its Mother and Child Health Centers, and some voluntary nongovernmental organizations, were invaluable in this regard.

In 1996 the NPC created the National Population Strategy for Jordan that was later updated in 2000. The strategy was written in light of international and regional recommendations and focused on four domains- namely, reproductive health, gender equality and empowerment of women, population and sustainable development, and population and enhancing advocacy.

Simultaneous to this Jordanian population policy change, the refugee crisis was occurring throughout Jordan. By the early 1990s, over 1 million Palestinian refugees were registered with the Jordanian government. As a response to this constant crisis, the United Nations Reliefs and Works Agency (UNRWA) was created in 1950 in order to provide relief services, including health, to Palestinian refugees (Bosmans et al., 2008). In July of 1993, UNRWA became one of the leading providers of family planning services in Jordan when they adopted a more comprehensive maternal health strategy (Madi, 1998). UNRWA currently works through a network of 23 clinics both inside and outside refugee camps, providing free care to Palestinian refugees.

The Ministry of Health (MoH) is tasked with the provision of primary and preventive health services and secondary and tertiary health services. Additionally, they provide health insurance for Jordanian citizens, organize health services from the public and private sectors, and establish educational and health training to support graduates that have specialized in medical occupations. In light of recent challenges that face Jordan and the health sector, the MoH has created the National Health Strategy for the years 2008-2017. All programs, plans, and policies from these strategy documents focus on the following areas:

- Primary Healthcare: promote healthy lifestyles, enhance reproductive health services and child health, decrease chronic disease, improve mother and child
nutritional status, improve emergency care, maintain low HIV/AIDS infections, strengthen disease monitoring systems, and maintain high vaccination coverage

• Human Resource Management: provide on-the-job training and scholarships to maintain high-quality services
• Secondary and Tertiary Care: MoH hospitals should provide basic curative services such as: medication disbursement, blood transfusions, and rehabilitation
• Monitoring and Control: the MoH monitors public and private health professionals and institutions to regulate and evaluate laws, clinics, hospitals and laboratories
• Financial Management: provide health insurance coverage to all citizens in the coming years (they are currently at 85% covered)
• Knowledge Management: create a geographic information system (GIS) for all affiliated health facilities, computerize health center and hospital directories, and utilize scientific research for planning and decision-making purposes

Relevant Measures in the Demographic and Health Survey

The content of the 2012 Jordan survey was expanded from the 2007 and 2009 surveys to include additional questions on reproductive health, domestic violence, women’s status, and early childhood development and child discipline. The expansion of the survey allows for researchers to understand how the MoH and the public and private health care sectors are accomplishing the National Health Strategy outlined in 2008. I have selected my measures with these focus areas in mind. The MoH specifically mentioned reproductive health, maternal health, and child health as key focus areas for the years 2008-2017. This would suggest that significant improvements should have been made in the four years between the implementation of this strategy and the collection of the DHS data. My goal is to understand how reproductive, maternal, and child health is functioning within Jordan- and if there is an increase in health and the provision of services across Jordan as a whole- is that increase also reaching the vulnerable refugee population?

DHS data has altered how reproductive, maternal, and child health in developing countries is studied. Scholars and researchers often looked at DHS data to assess the status of the recent Millennium Development Goals (MDGs). This created a common understanding of the validity of DHS data as well as the necessity of its measures. Goal number two focused on universal access to primary education and was measured by children’s educational enrollment and attainment, both reported by mothers in the DHS. Goal number four focused on the reduction of child mortality. The DHS asked about child mortality, immunizations, disease, and child nutrition, which are all indicators of child health. Goal number five measured the improvement of maternal health and was often measured by maternal mortality, location of delivery, and use of skilled birth attendants, again, available in the DHS data. All of these measures, among others, were widely utilized to understand the MDGs in addition to other studies. This research will utilize these and other measures in accordance with the literature on reproductive, maternal, and child health in Jordan and risk factors for refugees.

United Nations Relief and Works Agency (UNRWA)

UNRWA provides services to ten camps in Jordan, nineteen in the West Bank, eight in the Gaza Strip, twelve in Lebanon and nine in Syria. Most camps are next to major towns or have become part of them. Though the size and the number of residents in camps may vary from a few thousand to almost 100,000, a high population density characterizes most refugee camps. It is also not unusual to find among camp dwellers non-registered refugees, be they Palestinians or
nationals of other countries who have similarly poor living standards. In principle, the camps have been considered “temporary.” Refugees do not own land in the camps, but they can use it under UNRWA supervision. Additionally, the boarders if the camps are porous- creating possible mobility between the inside of the camps and the communities outside of them (Bocco, 2009).

UNRWA supports Community Development Centers that offer a wide range of programs to women in the Palestinian camps including economic empowerment that enhance female economic opportunities through providing training on traditional and non-traditional skills, income generating programs, and cultural and educational programs, including legal literacy. In regards to violence against women, the United Nations report that UNWRA provides legal counseling, psychological counseling, referrals, health care, investigation, court representation, advocacy, help hotlines, campaigns and networks to support women. This is the most expansive violence care that UN organizations provide.

**Further Health Trends and Policy in the last 20 Years**

The Jordan Population DHS survey has been administered six times from 1990-2012. These surveys provide reliable estimates of maternal and child health indicators over this twenty year period. They not only indicate upward or downward trends in key indicators, but statistical significance of these trends can be calculated as well. Assaf and Bradley (2014) took time to analyze key maternal and child indicators across these six surveys. They report that the total fertility rate (TFR), or the average number of births a woman would have at the end of her reproductive years if she experienced the current age-specific fertility rates, has significantly decreased from 5.6 births in 1990 to 3.5 births in 2012. The decrease in TFR was quicker in the first ten years and has drastically slowed in the latter half. Jordan’s current TFR is 3.31, which is still quite high compared to national and regional averages. Having a high fertility rate not only can impact the health of the child and mother, but also has implications for the sustainable development of a country. Similarly, the completed fertility rate, or the mean number of children ever born to women age 40-49, has also significantly decreased from 8.1 in 1990 to 4.6 in 2012, which is still relatively high.

Knowledge of contraceptive methods is very high in Jordan, almost 100 percent for all six surveys, so a focus on usage is best. Current contraceptive use has significantly increased from 40 percent in 1990 to 61 percent in 2012 and the percentage of women using modern methods is higher than those using traditional methods in all six surveys. Additionally, the percentage of women using modern methods had significantly increased from 13 percent in 1990 to 42 percent in 2002, where it has remained stable ever since. The IUD was the most common contraceptive method from 1990 to 2012 but the most drastic changes in contraceptive use can be attributed to condom use as a modern method and withdrawal as a traditional method. Condom use increased from 8 percent in 1990 to 11 percent in 2012, and withdrawal increased from 4 percent to 14 percent during this same period. In regards to unmet need, which refers to women who are not using contraception but who still wish to postpone the next birth (spacing) or to stop having children completely (limiting), the total unmet need for currently married women decreased from 26.5 percent in 1990 to 12 percent in 2012- though it was not always significant.

Women who had a live birth in the five years preceding the survey were asked about the antenatal, delivery, and postnatal care they received. The World Health Organization recommends that women have four or more antenatal visits for each pregnancy. The percentage of women who received less than for antenatal visits decreased from almost 40 percent in 1990 to 5.5 percent in 2012. The decrease was significant was significant before 2007. Caesarean
section (C-section) delivery is often used as an indicator to measure access to obstetric care. The World Health Organization declared that C-sections should constitute between 5 to 15 percent of all deliveries in a population. This data shows that the percentage of births delivered by C-section significantly increased from about 6 percent in 1990 to about 30 percent in 2012. This suggests that many C-sections are not medically indicated and could be exposing women to unnecessary risks associated with surgery.

In regards to child health, the neonatal mortality rate, or the deaths in the first month of life appear to be decreasing until 2007 and then increasing again. However, the total change from 21.4 deaths per 1,000 live births in 1990 to 13.7 deaths in 2012 is significant. Postnatal mortality rates, or deaths in the first year of life but after the first month did not significantly change until a drop from 7.7 deaths per 1,000 live births in 2009 to 3.5 deaths in 2012. Child mortality, or death between the first and fifth year of life dropped from 5 deaths per 1,000 live births in 1990 to 4 deaths in 2012, though it was not significant. Total immunizations (including tuberculosis, measles, whooping cough, tetanus, polio and diphtheria) increased significantly between 1990 and 2012, reaching a high of 94 percent in 2012. Rates of anemia in children have remained relatively stable over this time period, and nutritional measures such as wasting, underweight and stunting have generally decreased.

The Higher Population Council of Jordan compiled a “Policy Document” titled, The Demographic Opportunity in Jordan, which was presented in October of 2009. This document established goals to be met by 2030 and was approved by the Prime Minister of Jordan. The executive summary begins with the following statement:

The importance of this document stems from the expectation that Jordan-like other countries that have witnessed a recent decline in their high fertility rates- is on the verge of a historic demographic change that holds a “Demographic Opportunity” or “Demographic Window of Opportunity”. This opportunity is usually accompanied by various social and economic changes, which can take the form of challenges in case they are not employed appropriately. Therefore, prior preparation, planning and monitoring of these changes can create useful opportunities, which can occur in conjunction with the continued decline in fertility rates. Unlike developed countries, which closed the demographic window since many decades, the demographic window of many developing countries, including Jordan, is yet to occur.

This document goes on to outline the benefits that will be accrued by Jordan from the anticipated demographic opportunity as well as possible policies to maximize those benefits. This document, presenting the importance of investing in the demographic opportunity, suggests the importance of complementing and supporting the National agenda as well as national strategies such as the National Population Strategy, the National Reproductive Health/Family Planning Action Plan, as well as education training. Reproductive, maternal and childhood health rates are important indicators that can be used to assess a country’s socioeconomic situation and quality of life. They are also useful to measure quality of health programs and guide future policy decisions. In addition, this document takes into account the principles of Islamic “Shareea’a”, making decisions focused on tolerant terms, human rights, the right to education, health care and reproductive health, justice, labor, and welfare. The following are policies to accelerate the demographic shift and reach the demographic opportunity period that are relevant for this research:

• Achieve targeted fertility rate of 2.1 births per woman in 2030
• Increase the effectiveness and efficiency of reproductive health/ family planning programs
• Raise awareness and advocate population issues and their relationship with Reproductive Health/ Family Planning at the level of policy makers, decision makers and civil society
• Ensure coordination between the relevant parties concerned with awareness raising issues of Reproductive Health/ Family Planning, taking into account adherence to the teachings of Islamic law and the impact of customs and traditions.
• Increase awareness in the educational institution in reproductive health and family planning issues and the importance of investing in the demographic opportunity and expanding the integration of population related concepts in educational curricula and training programs
• Improve child health due to improved level of education, nutrition, living conditions, housing and increased investment and spending on health to lead to a rise in life expectancy

The specific policies addressed by the National Agenda document for years (2006-2015) through its various executive programs in the health field are:
• Reduce the population growth rate
• Ensure equity in accessing health service, including reproductive health services
• Strengthen partnership between the health sectors
• Provide health insurance coverage for Jordanians

This document points out that utilizing the demographic opportunity requires monitoring the progress towards it as well as following it up on the national level. This dissertation hopes to do just that- monitor the successes and failures experienced from 2009, the initiation of this document, to 2012 when the data was collected.

The National Action Plan for Reproductive Health/Family Planning was created in 2003 and established the first plan through 2007. This plan emphasized the development of information systems, financial sustainability, advocacy, and modifying attitudes and behavior change, policy development and access to services. Phase 2 was implemented from 2008-2012, based on the successes and lessons learned in the first phase, in addition to including some emerging issues. The purpose for phase 2 of the plan was to improve reproductive health/family planning in Jordan to contribute to improving the health of woman and the child and expediting reaching the population opportunity. Many Jordanian national policies focus on reproductive, maternal, and child health suggesting that Jordan should have high levels of care and good outcomes for their nationals as well as their more vulnerable populations.

Demographic and Health Surveys

Since 1984, The Demographic and Health Surveys (DHS) Program has administered over 300 surveys in 90 countries, enhancing comprehensive awareness of health and population trends in developing countries. The DHS covers topics such as fertility, family planning, and maternal and child health. The U.S. Agency for International Development (USAID) funds the DHS program with additional support from outside donors and funds from participating countries. The DHS program has created a set of standard procedures, methodologies, and measures that ensure that the data are comparable across countries. Pairing this with the wide utilization of DHS data, research on health and population in developing countries has never been more accessible and influential.
This research utilizes the 2012 DHS survey from Jordan. In addition to funding from USAID, this survey was funded by the government of Jordan, the United Nations Population Fund (UNFPA) and the United Nation’s Children’s Fund (UNICEF). These organizations conducted the survey from September to December 2012, producing the sixth DHS survey in Jordan. The sample is nationally representative and has been designed to provide estimates of major survey variables at the national level for urban and rural areas and refugee camp areas. Over 15,000 households and more than 11,000 ever-married women age 15-49 were interviewed.

The 2012 sample was selected from the 2004 Jordan Population and Housing Census sampling frame. The frame excludes individuals living in collective housing unites such as hotels, prisons and work camps in addition to the nomad population living in remote areas. Regardless, this sample was produced to provide reliable estimates for the country as a whole. Stratification was achieved by separating each governorate into urban and rural areas and then, within each urban and rural area, by Badia areas, refugee camps, and other. The designation between urban and rural areas is widely used throughout DHS data- the separation of refugee populations, however, is not otherwise used in accessible DHS data. The opportunity to use reliable data on refugees is limited at this time- making this research very important. It is crucial to understand how individuals are faring under refugee status.

**Refugee Camps**

The 2012 Jordan sample for the refugee camp areas was identified by the Department of Statistics based on the United Nation’s Relief and Works Agency (UNRWA) records. The camps are defined at the block level. A cluster is defined as camp if refugees represent 80 percent of the total population or more of the cluster. With this cutoff, only 33 clusters with refugee population were not counted in this domain. For reference, there are 13,025 clusters in Jordan. The average size of a cluster is 74 households in the urban areas and 62 in the rural areas. The overall average size is 72 households, which is adequate for a sample of 20 households per cluster. The refugee camps exist only in urban areas.

The DHS program provides no more information about the refugee camps. We do not know how individuals select into these camp populations and if that produces a systematic difference between refugees who live in densely populated refugee areas versus other areas throughout Jordan. We do not know how many people are in each camp area or where these camps are specifically located throughout Jordan.

**This research**

How does the reproductive, maternal, and child health of refugees in Jordan compare to Jordanian nationals? What possible risk factors or protective factors do refugees in these camps encounter? And then what void can donors fill? And what should be donors top priority among these factors? Refugees are separated from critical social institutions that provide health, education, security and economic opportunity. Support organizations ability to replace these social institutions depends on the complexity of the institution, resources available, and characteristics of the refugees. I will compare refugee characteristics to assess effectiveness of support communities. I will include characteristics of refugees so see how important these are. Results will help scholars, policy makers and governments understand which social institutions are or are not being replaced, and I will discuss possible reasons for this.
References


Article 1

Reproductive and Maternal Health Care Utilization in Jordan: Provisional Support and Sense of Space

Abstract

The refugee and displacement problem is one of the most complicated humanitarian issues facing the Middle East, and perhaps the world. Globally 21 million people are seeking protection and assistance as refugees, with 5.2 million of those listed as Palestinian refugees registered with the United Nations Relief and Works Agency (UNRWA). Conflict and displacement are associated with poverty, disruption of services, loss of identity, reduced care for reproductive needs, and reduced provision of maternal care, among other things. This paper uses the 2012 Jordan Demographic and Health Survey and a framework outlined by Obermeyer and Potter (1991) to test how refugee and native status influence utilization of reproductive and maternal health services in a context of high refugee inhabitants and strong refugee-focused NGO presence. This article addresses the following: (1) coverage, source, and method of contraceptives; (2) variation in reproductive health experience by source of contraception; (3) coverage of prenatal care and delivery site (4) variation in maternal health care by source of care; and finally, (4) factors determining variation in the utilization of reproductive and maternal health services. Findings suggest that refugee women serviced by UNRWA have greater access to health-related resources (family planning, contraception, and birth centers), but they have weaker positions in the family as evidenced by domestic violence experiences. I speculate that provisional resources are the easiest for an aid organization to provide while the complications of identity loss and the loss of a sense of space pose a challenge for refugees and aid organizations.
Reproductive and Maternal Health Care Utilization in Jordan: Provisional Support and Sense of Space

The refugee and displacement problem is one of the most complicated humanitarian issues facing the Middle East, and perhaps the world. The UN Refugee Agency reports that there are 65.3 million people seeking protection and assistance as a consequence of forced displacement. Globally 21 million are refugees, with 5.2 million of those listed as Palestinian refugees registered with the United Nations Relief and Works Agency (UNRWA). A vast proportion of these individuals and families come from or find refuge in the Middle East. As of 2015, Jordan hosted the second largest number of refugees in relation to its population, with 87 refugees per 1,000 native inhabitants. Jordan has an extensive history with refugees. The establishment of the Israeli State in 1948 resulted in the displacement of more than 700,000 Palestinian civilians followed by the 1967 war with Israel and then Iraq’s 1990 invasion of Kuwait, there have been vast flows of Palestinian Arab refugees who now make up more than two-thirds of the population of Jordan.

Conflict and displacement are associated with loss of livelihood, poverty, disruption of services, loss of identity, reduced care for reproductive needs, and reduced provision of maternal care, among other things (Refugees 2016; Jackson 2017). Additionally, maternal and neonatal mortality among refugees can be high due to limited reproductive health care available in most refugee settings, leaving many needs unmet (Bartlett et al. 2002). Women are also more vulnerable to rape during times of displacement and flight- making refugee women particularly vulnerable to gender-based violence during flight from conflict and in refugee camps (Hynes and Cardozo 2000). Filippo Grandi, UN High Commissioner for Refugees stated, “More people are being displaced by war and persecution and that’s worrying in itself, but the factors that endanger refugees are multiplying too” (Refugees 2016, pg. 5).

As a response to this constant Palestinian refugee crisis, the UNRWA was created in 1950 in order to provide relief services, including health, to Palestinian refugees (Bosmans et al. 2008). Over the years, governments and Nonprofit Organizations (NGOs) have heeded the opportunity and obligation to step in to provide the services often lost in displacement. Following the Geneva conference of June 2004, UNRWA implemented several reforms. While underlying its role in advocating and providing for the development and humanitarian needs of the Palestinian refugees, the agency has a renewed commitment to meeting the human development aspirations of refugees through basic education, primary health care, social safety-nets, infrastructure improvement, and microfinance (Bocco 2009). This raises an important question: when displacement severs ties to health care, schools, and economic means to provide health care, can governments and NGOs make up the difference? Or, at least in the case of Palestinian refugees, do fifty years of exile and three generations of refugees engender different experiences of “refugee-ness” causing different attitudes of adaptation to changing political contexts and economic opportunities and investment in government and NGO support? While I cannot prove the causal relationship here, I can only demonstrate convincingly that the political and social forces behind Palestinian displacement are too comprehensive and long lasting to not be random.

Obermeyer and Potter (1991) looked into the patterns and determinants of maternal health care utilization in Jordan, using data from 1983. I use their model as a framework to test how refugee and native status influence utilization of reproductive and maternal health service in a context of high refugee inhabitants and strong refugee-focused NGO presence. This article...
addresses the following: (1) the regional coverage, source, and method of contraceptives; (2) variation in reproductive health experience by source of contraception; (3) the regional coverage of prenatal care and delivery site (4) the variation in maternal health care by source of care; and finally, (5) factors determining variation in the utilization of reproductive and maternal health services respectively.

**The Sociodemographic Situation**

Jordan is an almost entirely landlocked country located in the Middle East with a population of 6.5 million. Obermeyer and Potter (1991) noted that Jordan was going through rapid social and demographic changes in the 1980s. At that time, Jordan had a total fertility rate (TFR) of 7 lifetime births per woman, some of the shortest average birth intervals ever recorded, 26 percent contraceptive use among married women of reproductive age, a life expectancy of 66 years, and an infant mortality rate of 44 per thousand. They also noted that while these changes were rapid, they were far from complete and proceeded at different paces among different groups in the country. Looking three decades later, the population is still young, with a relatively high birth rate (3.31 births per woman) compared to the world average and surrounding countries—Syria (3.00), Israel (3.04) and Saudi Arabia (2.70) but drastically reduced from a TFR of 7 in 1983. Even quicker gains have been made for reproductive health in Jordan. Knowledge of contraceptive methods is very high in Jordan, almost 100 percent starting in 1990. Current contraceptive use has significantly increased from 40 percent in 1990 to 61 percent in 2012 and the percentage of women using modern methods is higher than those using traditional methods throughout those years. In regards to child health, the neonatal mortality rate appears to have been decreasing from 1990 until 2007 and then increasing again. However, the total change from 44 deaths per 1,000 live births in 1987 to 13.7 deaths in 2012 is significant. Total immunizations (including tuberculosis, measles, whooping cough, tetanus, polio and diphtheria) increased significantly between 1990 and 2012, reaching a high of 94 percent in 2012. Rates of anemia in children have remained relatively stable over this time period, and nutritional measures such as wasting, underweight and stunting have generally decreased (Assaf & Bradley 2014). In 2012 the life expectancy was about 74 years, drastically up from 66 years in 1987.

In regards to maternal health, The World Health Organization recommends that women have four or more antenatal visits for each pregnancy. The percentage of women who received less than four antenatal visits decreased from almost 40 percent in 1990 to 5.5 percent in 2012. The decrease was significant before 2007 (Assaf & Bradley 2014). Since the report from Obermeyer and Potter, Jordan has continued to experience drastic changes where some indicators have neared completion and others still have significant room for improvement; but overall, maternal and reproductive health indicators are improving throughout Jordan.

Policy efforts by the Jordanian government may play a role in this progress. The first official population policy was proposed and accepted in 1993 when the National Population Commission (NPC) of Jordan adopted the National Birth Spacing Program. The Birth Spacing Program was intended to increase maternal and child health and reduce fertility while considering the social, national, religious and free-choice dimensions of Jordanian society. The family planning efforts made by the NPC, as well as by the Ministry of Health through its Mother and Child Health Centers, and some voluntary nongovernmental organizations, were invaluable in this regard. In 1996 the NPC created the National Population Strategy for Jordan that was later updated in 2000. The strategy was written in light of international and regional recommendations and focused on four domains—namely, reproductive health, gender equality
and empowerment of women, population and sustainable development, and population and enhancing advocacy.

The current policy climate is focused on renewed attention on the basics. The Ministry of Health (MoH) has created the National Health Strategy for the years 2008-2017. All programs, plans, and policies from these strategy documents focus on the following areas: primary healthcare, human resource management, secondary and tertiary care, monitoring and program control, financial management, and knowledge management. Additionally, The Higher Population Council of Jordan compiled a “Policy Document” titled, The Demographic Opportunity in Jordan, which was presented in October of 2009. This document established goals to be met by 2030 and was approved by the Prime Minister of Jordan and is to be enacted in accordance with other national level policy. The goal of this document is to present a window of opportunity for Jordan. Like many countries before, a decline in fertility rates, paired with social and economic improvements, opens a window to a period of great potential (Lee and Reher 2011).

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

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

**Severed Ties for Refugees**

Displacement has been shown to sever ties to health care, education, and safety. Several studies have looked into the implications of displacement on a variety of indicators. One key research area involves reproductive health as it is often seen as a first line of defense in protecting against maternal ill health in conflict or flight settings where resources are often inadequate or unavailable. Research suggests that refugees experience reduced access to reproductive health care services, causing limited contraceptive use around the world (Okanlawon, Reeves, and Agbaje 2010). This limitation can stem from unfamiliarity with family planning or other health programs, ineligibility for health benefits, time barriers, financial limitations, or transportation difficulties. At the same time, they may have less access due to supply limitations or a lack of facilities or staff (Madi 1998). Additionally, the potential for unintended births and other reproductive health risks increase as women begin sexual relationships at earlier ages, take more sexual risks, and face exploitation on the absence of traditional sociocultural constraints, all of which are associated with displacement (Women’s Refugee Commission 2006). Moreover, women in displacement, left in situations accompanied by powerlessness, poverty, and lack of security, may resort to prostitution or trading sex for protection or food in order to survive (McGinn et al 2004).

Safe motherhood is another important issue impacting women both in and out of refugee camps. Many of the dangers women face in pregnancy are the same in conflict settings and out
of them, though war makes it more challenging for women to get proper treatment for these dangers (Madi 1998). Refugee status has been associated with a higher burden of maternal mortality among refugees of reproductive age (Bartlett et al. 2002). Additionally, Aroian (2001) conducted a systematic literature review about immigrant woman’s health, including refugees. She found that for all types of health services, immigrant women are more disadvantaged and face greater barriers to utilizing health services than nonimmigrant women, including nonimmigrant minorities. Regardless of barriers to utilization, a few studies noted that infant birth weight, prematurity and mortality are often superior among immigrant mothers, though these finding may not be tied to the refugee population. Scholars attribute these superior outcomes to lifestyle choices regarding smoking, drugs and alcohol use (Alexander et al. 1996; Balcazar, Peterson, and Krull 1997), or an increase in family support during pregnancy (Sherraden & Barrera 1996) which seem to be more present among the traditional immigrant population. Nevertheless, there are many pregnancy related problems for immigrant women. TB infection, parasites, and depression are particularly high among refugee women (Kahler et al. 1996).

Domestic violence against women is seen as a violation of human rights and a significant public health issue. One in three women has been coerced into sex, beaten, or otherwise abused in her lifetime (Division of Reproductive Health 2000). Women of all reproductive ages are at risk for intimate partner violence and marital status and pregnancy does not protect women from this physical or mental abuse (Hammoury et al. 2009). Refugee women are especially vulnerable to gender-based violence during conflict, flight from conflict, and in refugee camps when disintegration of social structures or flight from war-torn countries is occurring (Hynes and Cardozo 2000). Domestic violence against women has been linked with nonuse of contraception, unwanted pregnancy and obstetric complications (Jasinski 2004; Nasir and Hyder 2003; Pallitto, Campbell, and O’Campo 2005). Despite its increasing global importance, there has been little research on domestic violence against women in the Arab region. The studies that are available suggest that the majority of Palestinian refugee women are subjected to physical or emotional abuse at some point in their lives (Diop-Sidibé, Campbell, and Becker 2006; Hammoury et al. 2009; M Khawaja 2004). An additional finding is that men and women have a similar disposition about wife beating (acceptance around 60% in Jordanian refugee camps), which has only become more acceptable (M Khawaja 2004). And 44.7% of women in Jordanian refugee camps will experience domestic violence in their lifetime (Marwan Khawaja 2003).

The available data on reproductive, maternal and pregnancy outcomes suggests that poor outcomes are common in many populations affected by conflict. Considering the disruption in services and increase in certain risk factors, the literature suggests that this research will discover lower use of contraceptives, restricted access to family planning services, worse maternal health care such as fewer prenatal visits and later initiation, and increased experiences with domestic violence. However, these outcomes may be no more common than in extremely poor host or home countries with a lack of infrastructure and services. Women in refugee camps may in fact receive better care than was available in their home country, or is available to the local population if the infrastructure is in place to serve their needs upon displacement. Most research on the effects of displacement on women’s health has been almost exclusively problem or risk-oriented. A more balanced view of refugee women is warranted due to the conflicting research findings (Aroian 2001).

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

As a response to the refugee crisis affecting Jordan since 1948, the UNRWA was created in 1950 in order to provide relief services, including health, to Palestinian refugees (Bosmans et al. 2008). By July of 1993, UNRWA became one of the leading providers of family planning services in Jordan when they adopted a more comprehensive maternal health strategy. UNRWA currently works through a network of 23 clinics both inside and outside refugee camps, providing free care to Palestinian refugees. All Palestine refugees registered with UNRWA in Jordan- whether they reside in camps or outside camps- are eligible for UNRWA services. However, those living in or near the camps have easier access to services.

As of 2002, the commercial sector serves about 38 percent of modern method users, NGOs have family planning clinics that serve about 28 percent and hospitals and health centers serve the remaining 34 percent. The government or public sector supplies all methods and is almost completely subsidized by donors and the government. These services are distributed through ministry of health (MoH) facilities including 347 primary health centers, 20 post partum clinics, and 28 hospitals. In addition, the Royal Medical Services has 81 ambulatory care centers, 10 hospitals and 5 clinics as well as one Jordan University Hospital that provide family planning services. The NGO sector supplies all methods except sterilization and is funded by donors and fees charged to clients. Some NGOs are donor-owned and operated, the largest being UNRWA which serves about 7.5 percent of family planning users (who are Palestinian refugees) (Sharma 2004).

The UNRWA supports Community Development Centers that offer a wide range of programs to women in the Palestinian camps. These services include economic empowerment that enhance female economic opportunities through providing training on traditional and non-traditional skills, income generating programs, and cultural and educational programs, including legal literacy. In regards to violence against women, the United Nations report that UNWRA provides legal counseling, psychological counseling, referrals, health care, investigation, court representation, advocacy, help hotlines, campaigns and networks to support women. This is the most expansive violence care that any UN organization provides.

The Data

The data used in this analysis comes from The Demographic and Health Survey (DHS), which have been administered in over 90 countries, advancing global understanding of health and population trends in developing countries. The DHS are nationally representative household surveys of women of childbearing age (15-49). They include information regarding health, nutrition, family planning and maternal well-being. This analysis utilizes the Individual Recode data, which has one record for every respondent. This specific dataset is the Jordan Population and Family Health Survey (JPFHS) and was gathered September to December 2012. The JPFHS 2012 is a collaborative effort between the Jordanian Government, the U.S. Agency for International Development (USAID), and other outside donors. I selected this location and year because there is access to information about refugees and domestic violence, which are not always available in other DHS country datasets. The sampling methodology of the JPFHS yielded a self-weighting sample of 11,352 women ages 15 to 49.
The JPFHS sample for the refugee camp areas was identified by the Department of Statistics based on UNRWA records. The camps are defined at the block level. A cluster is defined as a camp if refugees represent 80 percent of the total population or more of the cluster. With this cutoff, only 33 clusters with refugee population were not counted in this domain. For reference, there are 13,025 clusters in Jordan. The average size of a cluster is 74 households in the urban areas and 62 in the rural areas. The overall average size is 72 households, which is adequate for a sample of 20 households per cluster. The refugee camps exist only in urban areas.

**Measures**

The outcome variables for reproductive health care include modern contraceptive use, being taught family planning at a health facility, being given contraceptive advice from medical personnel, source of contraception and experience with domestic violence. Modern use and intent is a dichotomous variable comparing those who currently use modern contraception or intend to use contraception later and those who use traditional methods or do not intend to use contraception later (coded 1=modern or intent, 0= traditional or no intent). Taught FP at health facility is a dichotomous variable that compares women who reported being taught about family planning at her health facility in the last 12 months and those who reported no mention of family planning at the facility (coded 1= taught family planning at health facility, 0= no family planning at health facility). Similarly, FP advice from medical personnel compares women who reported being advised on contraceptive methods from medical personnel and women who reported having no outside advice or advice given from a family or friend (coded 1= FP advice from medical personnel, 0= FP advice from family, friends, or no one). Source of contraception is a dichotomous variable coded (1= UNRWA, 0=Private or Public). Experience with domestic violence is a dichotomous variable coded (0= no experience with domestic violence, 1= at least some experience with domestic violence) with domestic violence including women who have ever been: pushed, shook, slapped, punched, arm twisted or hair pulled, kicked, dragged, strangled, burnt, or threatened with a weapon. And finally, experience with emotional violence is a dichotomous variable coded (0= no experience with emotional violence, 1= experience with emotional violence). Emotional violence experiences include being humiliated by your husband, being threatened with harm by your husband, or made to feel bad by your husband.

The outcome variables for maternal health care include birth location, birth interval, cost of delivery, and prenatal care. The location of delivery is first split into home births and hospital or clinic births (coded 1=home birth, 0=hospital or clinic birth). Then, among the women who delivered in a hospital or clinic, those were divided into public or private locations coded (1=public, 0= private). A healthy birth interval is a dichotomous variable coded (0= not healthy interval, 1= healthy interval) with a healthy interval being between 24 and 48 months following the proceeding birth or pregnancy termination. And finally, adequate prenatal care is a dichotomous variable that compares mothers who report adequate care by WHO standards (initiating care in the first trimester and attending care 5 or more times) and mothers who report no care or less than adequate care (coded 1= adequate care, 0= no or less than adequate care).

**The Coverage of Reproductive Care**

The analysis of the use of reproductive and maternal health services is based on the entire sample of ever-married women. However, all analysis completed with domestic violence measures is based on data from a subsample of women who were selected for the domestic violence module. There were 7,027 such women out of the 11,352 women in the total sample. The sociodemographic characteristics of the subsample were similar to those of the sample as a whole.
Table 1 presents the overall distribution of the maternal, household, and socioeconomic variables in this subsample. The population is predominantly age 25-39, with just over 30 percent being 40-49 and 13 percent being 15-24. Overall educational levels are relatively high, with a mean completion of 11 years of schooling. About 18 percent of women work in the private sector or are self-employed and 95 percent of houses have all amenities—electricity, flush toilets, television and refrigerator. Almost 50 percent of women have 5-7 people in their household, with 1-4 people and 8 or more people equally sharing the remaining 50 percent. Additionally, over half of these households (55.80%) have 1-2 children age five and under in the household, and only 9 percent have three or more children in the house. In terms of experience with domestic violence, 21 percent of women say that have ever experienced mild domestic violence (including ever been: pushed, shook, slapped, punched, arm twisted or hair pulled), almost 6 percent say they have experienced severe domestic violence (including ever been: kicked, dragged, strangled, burnt, or threatened with a weapon), and 24 percent of women say they have experienced emotional violence (including ever been: humiliated, threatened, or insulted by husband). All of this considered, over 24 percent of women say that domestic violence is ever justified in cases of a wife going out without telling her husband, neglecting the kids, arguing with husband, or less often, if the wife burns the food.

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

Table 3 presents information on the type of reproductive health choices and care women have or receive according to the provider of modern contraception, and attempts to give, however crudely, some sense of their reproductive health experience. Reproductive health experience is based on their visitation from a family planning worker in the last year, their introduction to family planning at a health facility, the person advising their choice of contraception, the modern contraception method, and their experience with domestic violence. For the women who receive their modern contraception from the public sector and pharmacy or private health sector, they were about half as likely to be visited by a family planning worker in the last year compared to women who received their contraception from UNRWA (20.15, 18.07, and 35.98, respectively). Similarly, they were less likely to talk about family planning in a health facility. Medical personnel advise the greatest proportion of contraceptive methods in all three cases, followed by no outside advise, and then advise from a family member or friend, but women receiving contraception from UNRWA had slightly more advice given from medical personnel. The women who receive their contraception from UNRWA are more likely to have experienced mild, severe, and emotional domestic violence and more likely to say that beating is
ever justified in certain scenarios. 31 percent of women using modern contraception from UNRWA have experienced mild domestic violence and 9 percent have experienced severe domestic violence. In comparison, 15 percent and 3 percent of women who use contraception from a pharmacy or private source have experienced mild or severe domestic violence respectively.

(Table 3 about here)

**The Coverage of Maternal Care**

The distribution of respondents according to their utilization of maternal services is presented in Table 4. Over 99 percent of women received at least some prenatal care in the refugee camps, urban and rural settings. The main source of prenatal care was UNRWA clinics in the refugee camps (59.5 percent), and private settings in both the urban and rural regions (69.3 percent and 66.5 percent, respectively). The prevalence of home births was below 1 percent in all three regions. The most common site for delivery in all three regions was a public hospital or clinic.

(Table 4 about here)

Table 5 presents information on the type of prenatal care women receive according to the provider of that care, and similar to reproductive health experience, attempts to give, however crudely, some sense of the quality of their maternal health care. This is based on the number of visits and when the care was initiated, which is used to calculate the quality of prenatal care. For the women who receive prenatal care from the UNRWA, almost 96 percent of women have five or more prenatal visits, and 87 percent initiate care in the first trimester. Of these women, 85 percent both initiate care in the first trimester and have five or more visits, which was the criteria used to determine “adequate” care. The number of prenatal care visits was slightly lower for women who receive care from the private and public sectors; 90 percent of women who receive care from the private sector and 90.5 percent of women who receive prenatal care from the public sector had 5 or more visits. Although women who receive care from private or public providers initiate care earlier than do those who receive care from UNRWA. Overall, the proportion of women with adequate prenatal care is highest for those served by the private sector (86.6 percent), followed by UNRWA (85.3 percent), and then by the public sector (82.6 percent).

(Table 5 about here)

**Differentials in Reproductive and Maternal Care**

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

The results of these analyses are presented in Table 6 and 7. Table 6 looks at reproductive health while Table 7 looks at maternal health. The first analysis looks at the use of and intent to use modern contraception compared to women who currently use a traditional contraceptive method or do not plan to use contraception in the future. The model indicates that educational attainment, age, employment, number of living children, and wealth have a significant effect on use of modern contraception. Increased education, a larger number of living children, and higher wealth are associated with increased use of modern contraception, while older age, and
employment are associated with less use of modern contraception. Residence proved not to be a significant predictor of utilization of modern contraception, though living in a refugee camp increased the likelihood of using modern contraception.

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

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

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

(Table 6 about here)

Table 7 is comprised of indicators of maternal health care utilization, focusing on prenatal care, location of delivery, and healthy birth interval. The first analysis looks at respondents who receive adequate prenatal care in regards to the amount of visits and proper initiation of care compared to women who did not receive proper care. The model indicates that educational attainment, number of living children, and wealth have a significant effect on prenatal care. Increased education and wealth are associated with adequate prenatal care, and having more living children is associated with inadequate prenatal care. Residence proved not to be a significant predictor of utilization of adequate prenatal care, though living in a refugee camp increased the likelihood of receiving sufficient care.

The second model predicts home delivery versus hospital or clinic delivery. Residence in a camp or rural area, educational attainment, age, and wealth are significantly associated with reduced odds of delivering at home while number of living children increases those odds. However, the third model predicts whether a respondent would give birth in a public versus private facility, given that she delivered in a hospital or clinic rather than at home. In that case, residence and wealth come to the fore. Both living in a refugee camp and wealth are strong predictors of the decreased utilization of a public facility over a private facility while employment status increases the odds of a public delivery. Finally, residing in a camp, educational attainment, age, and wealth are significantly associated with a health birth interval.
between the last two births. Living in a refugee camp, increased education, and being aged 25-39 are associated with a healthy birth interval, and the ages 40-49 and wealth are associated with decreased odds of a health birth interval.

(Table 7 about here)

**Refugee Risk Factors**

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

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

**Discussion**

At first glance, the ambivalence of camp membership may be overwhelming. Being a female refugee hurts in some instances and seems to benefit in others. This seemingly chaotic and unspecified conclusion begins to take clearer form upon further investigation. Though that answer remains, being a refugee appears to be both beneficial and harmful, I begin to see how a single cause can have contradictory effects. As scholars, our models are based on success or failure— that is, we expect something to have a singular positive effect or a singular negative effect. But when you look at a variety of outcomes, you begin to see that that is not the case (Holzer 2013). In the case of female refugees in Jordan, camps improve outcomes tied to provision, while we simultaneously see breakdowns in outcomes tied to social life. These two concepts, social breakdown and provisional success begin to put structure to the ambivalence. Women appear to have greater access to health related resources (family planning, contraception, birth centers etc.), but they have weaker positions in the family as evidenced by a wide range of physical and emotional domestic violence experiences.
I imagine this outcome does not just apply to refugee circumstances. All organizations providing aid or relief to any group of the population may get satisfied when it comes to success with provisions. Provisional success may be the easiest to administer and measure; making it a logical first step for an organization- but it cannot be the final goal. The implications for these social inadequacies are large with drastic problems that arise with domestic violence. This suggests that UNRWA and other organizations alike must figure out how to address social concerns as well as fulfilling the physical needs of their constituents.

We know that displacement severs ties to resources in the home country- including reproductive and maternal health care. The available data on reproductive, maternal and pregnancy outcomes suggests that poor outcomes are common in many populations affected by conflict. Considering the disruption in services and increase in certain risk factors, the literature suggests that this research would discover lower use of contraceptives, restricted access to family planning services, worse maternal health care such as fewer prenatal visits and later initiation, and increased experiences with domestic violence among the refugee population. However, this research alternatively found that an organization with proper infrastructure could overcome many of the severed ties introduced with displacement.

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

Regardless of the successes achieved by UNRWA, domestic violence, both physical and emotional, is an issue that must be further explored. This survey only asks about experience with domestic violence. But research shows that in conflict situations strangers are more likely to perpetrate sexual violence against women i.e. soldiers, guards, police, fellow refugees, local residents, and aid workers (Hynes and Cardozo 2000). This suggests that violence is even more of an issue than this survey can show. UNRWA has many resources for refugees who experience domestic violence, regardless; over 31 percent of women who receive contraceptives from this source say that wife beating is ever justified. This suggests that there is significant room for improvement in domestic violence education and treatment within the UNRWA organization.

Refugee women appear to have access to health related resources, but weaker positions in the family. This makes me wonder what it really means to be displaced, and both the short and long-term consequences. I can speculate about the possible causes and consequences of this social breakdown. Displacement research brings up the complications of identity loss in addition to the loss of a sense of space (Garrido 2013; Jackson 2017). Although Palestinian refugees have had a vast presence in Jordan for the last 70 years, there are still divisions in society both physically, by placing many refugees in refugee camps, and socially, through customs and practice. A commitment to the relative status positioning of the refugee and national population is clearly visible through their separation in space. When thinking about the clear social and physical boundaries that exist between much of the national and refugee population, it becomes clear how an outside organization such as UNRWA can fulfill provisional needs, but not overcome the impaired identity creation and sense of ownership one has over their physical space. It is important to note that many refugees in Jordan are not segregated into refugee camps, and refugee camps may have some national citizens as well. Regardless, this study shows that
there are emotional and physical abuses occurring in the refugee camps that cannot be overlooked.

The literature on spatial cognition tends to focus on the symbolic power of place to represent people (e.g., the ghetto demeaning black people by association) (Garrido 2013). This creates a paradigm worth considering—this study suggests that refugee camps have the power to help women receive on par or better reproductive and maternal care than the native population—but are these camps simultaneously creating a symbolic but pervasive sense of “other” between the refugee and native population. A sense of “other” that leaves refugee women vulnerable to abuse. I draw this speculation based on fieldwork in Metro Manila by Garrido (2012). He claims that certain types of places (in my case—refugee camps) or the people associated with those places elicit certain introspective states (mental states, including affect and motivation), which, in turn, predispose certain practices (in my case—physical and emotional abuse). Continuing with his line of thought, the idea of spatial decision making (whether to go and where to go) reminds us that Palestinian refugees are able to move into and out of these refugee camps—suggesting that certain refugees might be choosing to stay in these camps. This idea further complicates the issue—are abusive refugees abusive because they live in the refugee camp, or do they choose to live in the camp because they are abusive. Regardless, research suggests that people adjust their actions in accordance to the symbolic boundaries separating spaces (Anderson 1999). This suggests that there is something about these refugee camps that perpetuates domestic violence.

This complicated relationship between a sense of identity and ownership of one’s space, refugee displacement, and support organizations is one worth focusing on, in fact, it is an issue of international urgency (Jackson 2017). Displacement is affecting over 65 million people throughout the world. This research proposes that displacement does not have to produce entirely negative outcomes. Governments and NGOs can step in to provide resources and care to reduce poor outcomes that are associated with populations in conflict. I also suggest that the solution is not that simple. While camp settings provide a mechanism to provide services, is it simultaneously hurting one’s ownership of their identity and their space? Is there a way that UNRWA and other organizations can address this issue? This research also suggests that the work is not quick or easy, but it can be done—which should provide motivation but caution when intervening in the refugee camps.
References


### Tables

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

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Category (if continuous)</th>
<th>Percent (mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Woman’s age</td>
<td>15-24</td>
<td>12.57</td>
</tr>
<tr>
<td></td>
<td>25-39</td>
<td>56.54</td>
</tr>
<tr>
<td></td>
<td>40-49</td>
<td>30.90</td>
</tr>
<tr>
<td>Number of children living</td>
<td>(1 thru15)</td>
<td>(3.976)</td>
</tr>
<tr>
<td>Woman’s education</td>
<td>(0 thru19)</td>
<td>(10.937)</td>
</tr>
<tr>
<td>Employed</td>
<td></td>
<td>17.92</td>
</tr>
<tr>
<td>Standard of living (electricity, flushing toilet, TV and refrigerator)</td>
<td></td>
<td>94.88</td>
</tr>
<tr>
<td>Number of people in household</td>
<td>1-4</td>
<td>29.29</td>
</tr>
<tr>
<td></td>
<td>5-7</td>
<td>48.27</td>
</tr>
<tr>
<td></td>
<td>8+</td>
<td>22.43</td>
</tr>
<tr>
<td>Children in household aged 5 and under</td>
<td>0</td>
<td>35.62</td>
</tr>
<tr>
<td></td>
<td>1-2</td>
<td>55.80</td>
</tr>
<tr>
<td></td>
<td>3+</td>
<td>8.58</td>
</tr>
<tr>
<td>Husband’s education</td>
<td>None</td>
<td>1.21</td>
</tr>
<tr>
<td></td>
<td>Incomplete primary</td>
<td>5.89</td>
</tr>
<tr>
<td></td>
<td>Complete primary</td>
<td>4.64</td>
</tr>
<tr>
<td></td>
<td>Incomplete secondary</td>
<td>46.10</td>
</tr>
<tr>
<td></td>
<td>Complete secondary</td>
<td>13.14</td>
</tr>
<tr>
<td></td>
<td>Higher</td>
<td>29.02</td>
</tr>
<tr>
<td>Experienced mild domestic violence</td>
<td></td>
<td>21.04</td>
</tr>
<tr>
<td>Experienced severe domestic violence</td>
<td></td>
<td>5.69</td>
</tr>
<tr>
<td>Experienced emotional violence</td>
<td></td>
<td>24.71</td>
</tr>
<tr>
<td>Domestic violence is ever justified</td>
<td></td>
<td>24.32</td>
</tr>
</tbody>
</table>
Table 2 Percent distribution according to the use, source, and method of contraception, by region: JPFSH 2012

<table>
<thead>
<tr>
<th>Variable</th>
<th>Refugee Percent</th>
<th>Urban Percent</th>
<th>Rural Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contraceptive use and intention</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using modern</td>
<td>42.70</td>
<td>39.83</td>
<td>39.00</td>
</tr>
<tr>
<td>Using traditional</td>
<td>14.38</td>
<td>18.36</td>
<td>21.41</td>
</tr>
<tr>
<td>Intends to use later</td>
<td>18.47</td>
<td>21.04</td>
<td>19.75</td>
</tr>
<tr>
<td>Does not intend to use</td>
<td>24.45</td>
<td>20.76</td>
<td>19.83</td>
</tr>
<tr>
<td><strong>Contraceptive Source</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td>14.81</td>
<td>49.67</td>
<td>57.63</td>
</tr>
<tr>
<td>UNRWA</td>
<td>54.81</td>
<td>4.93</td>
<td>2.56</td>
</tr>
<tr>
<td>Private/Pharmacy</td>
<td>29.31</td>
<td>43.18</td>
<td>37.78</td>
</tr>
<tr>
<td>Other</td>
<td>2.08</td>
<td>2.23</td>
<td>2.03</td>
</tr>
<tr>
<td><strong>Modern Contraceptive method</strong>&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pill</td>
<td>19.96</td>
<td>13.45</td>
<td>16.86</td>
</tr>
<tr>
<td>IUD</td>
<td>34.88</td>
<td>34.31</td>
<td>28.42</td>
</tr>
<tr>
<td>Condom</td>
<td>13.37</td>
<td>11.53</td>
<td>9.98</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>18.60</td>
<td>24.58</td>
<td>27.25</td>
</tr>
<tr>
<td>Other&lt;sup&gt;b&lt;/sup&gt;</td>
<td>13.18</td>
<td>16.13</td>
<td>17.48</td>
</tr>
</tbody>
</table>

<sup>a</sup>Only for women currently using modern contraception, so n=5,924

<sup>b</sup>Other includes: injections, female sterilization, periodic abstinence, lactational amenorrhea, and diaphragm
Table 3 Percent distribution of women using modern contraception according to reproductive health variables, by source: JPFSH 2012

<table>
<thead>
<tr>
<th>Reproductive health variables</th>
<th>Source of contraception*</th>
<th>Public</th>
<th>Private or Pharmacy</th>
<th>UNRWA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visited by family planning worker in last 12 months</td>
<td></td>
<td>20.15</td>
<td>18.07</td>
<td>35.98</td>
</tr>
<tr>
<td>Told about family planning at health facility</td>
<td></td>
<td>35.74</td>
<td>28.58</td>
<td>48.36</td>
</tr>
<tr>
<td>Person who advised family planning method</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No one</td>
<td></td>
<td>35.24</td>
<td>33.90</td>
<td>29.63</td>
</tr>
<tr>
<td>Medical personnel</td>
<td></td>
<td>51.78</td>
<td>49.29</td>
<td>55.56</td>
</tr>
<tr>
<td>Family or friend</td>
<td></td>
<td>12.98</td>
<td>16.82</td>
<td>14.81</td>
</tr>
<tr>
<td>Modern Contraceptive method</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pill</td>
<td></td>
<td>26.56</td>
<td>15.86</td>
<td>34.66</td>
</tr>
<tr>
<td>IUD</td>
<td></td>
<td>35.64</td>
<td>63.12</td>
<td>35.71</td>
</tr>
<tr>
<td>Condom</td>
<td></td>
<td>19.04</td>
<td>11.33</td>
<td>24.87</td>
</tr>
<tr>
<td>Other(^a)</td>
<td></td>
<td>18.76</td>
<td>9.69</td>
<td>4.76</td>
</tr>
<tr>
<td>Experienced Domestic violence</td>
<td></td>
<td>19.13</td>
<td>15.21</td>
<td>30.60</td>
</tr>
<tr>
<td>Mild</td>
<td></td>
<td>5.21</td>
<td>3.13</td>
<td>8.62</td>
</tr>
<tr>
<td>Severe</td>
<td></td>
<td>22.21</td>
<td>18.75</td>
<td>31.47</td>
</tr>
<tr>
<td>Beating is ever justified</td>
<td></td>
<td>25.17</td>
<td>22.13</td>
<td>31.22</td>
</tr>
</tbody>
</table>

*Source of contraception is only listed for women receiving modern contraception, so n=2,845
\(^a\)Other includes: injections, female sterilization, periodic abstinence, lactational amenorrhea, and diaphragm
Table 4 Percent distribution of women who had a child in the five years preceding the survey, according to the use of prenatal care, the source of care, and the site of the birth, by region: JPFSH 2012

<table>
<thead>
<tr>
<th>Variable</th>
<th>Refugee Percent</th>
<th>Urban Percent</th>
<th>Rural Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No prenatal care</td>
<td>0.36</td>
<td>0.66</td>
<td>0.82</td>
</tr>
<tr>
<td>Prenatal care</td>
<td>99.64</td>
<td>99.34</td>
<td>99.18</td>
</tr>
<tr>
<td>Source of care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private</td>
<td>32.73</td>
<td>69.34</td>
<td>66.46</td>
</tr>
<tr>
<td>Public</td>
<td>7.78</td>
<td>25.06</td>
<td>30.66</td>
</tr>
<tr>
<td>UNRWA</td>
<td>59.49</td>
<td>5.60</td>
<td>2.88</td>
</tr>
<tr>
<td>Site of birth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td>0.35</td>
<td>0.86</td>
<td>0.40</td>
</tr>
<tr>
<td>Public hospital/clinic</td>
<td>70.35</td>
<td>68.73</td>
<td>82.28</td>
</tr>
<tr>
<td>Private hospital/clinic</td>
<td>29.29</td>
<td>30.41</td>
<td>17.32</td>
</tr>
<tr>
<td>Variable</td>
<td>Private</td>
<td>Public</td>
<td>UNRWA</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------</td>
<td>--------</td>
<td>-------</td>
</tr>
<tr>
<td>Number of visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;4</td>
<td>10.02</td>
<td>9.48</td>
<td>4.31</td>
</tr>
<tr>
<td>&gt;5</td>
<td>89.98</td>
<td>90.52</td>
<td>95.69</td>
</tr>
<tr>
<td>Initiation of care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt; trimester</td>
<td>93.53</td>
<td>87.95</td>
<td>86.90</td>
</tr>
<tr>
<td>Later</td>
<td>6.47</td>
<td>12.05</td>
<td>13.10</td>
</tr>
<tr>
<td>Scale of care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some</td>
<td>13.43</td>
<td>17.43</td>
<td>14.70</td>
</tr>
<tr>
<td>Adequate</td>
<td>86.57</td>
<td>82.57</td>
<td>85.30</td>
</tr>
<tr>
<td>Variable*</td>
<td>Modern use and intent</td>
<td>Taught FP at health facility</td>
<td>Given FP advice from medical personnel</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------</td>
<td>------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>Residence (Urban)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Camp</td>
<td>1.109</td>
<td>1.751**</td>
<td>1.154</td>
</tr>
<tr>
<td>Rural</td>
<td>0.906</td>
<td>0.762**</td>
<td>0.953</td>
</tr>
<tr>
<td>Woman’s education</td>
<td>1.053**</td>
<td>1.021*</td>
<td>0.997</td>
</tr>
<tr>
<td>Woman’s age (15-24)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-39</td>
<td>0.559**</td>
<td>0.704**</td>
<td>1.173</td>
</tr>
<tr>
<td>40-49</td>
<td>0.181**</td>
<td>0.339**</td>
<td>1.321*</td>
</tr>
<tr>
<td>Employed</td>
<td>0.750**</td>
<td>1.030</td>
<td>0.777**</td>
</tr>
<tr>
<td>Living children</td>
<td>1.277**</td>
<td>1.092**</td>
<td>1.054**</td>
</tr>
<tr>
<td>Wealth index</td>
<td>1.068**</td>
<td>0.914**</td>
<td>1.074**</td>
</tr>
</tbody>
</table>

*Significant at p ≤ 0.05  
**Significant at p ≤ 0.01  
*The reference category is in parentheses. All variables are dichotomous except woman’s education, number of living children, and wealth index.
Table 7 Logistic regression of maternal health care showing odds ratios for background variables: JPFSH 2012

<table>
<thead>
<tr>
<th>Variable</th>
<th>Adequate prenatal care</th>
<th>Home birth vs. hospital or clinic</th>
<th>Public vs. private delivery</th>
<th>Healthy birth interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residence (Urban)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Camp</td>
<td>1.075</td>
<td>0.239*</td>
<td>0.689**</td>
<td>1.264*</td>
</tr>
<tr>
<td>Rural</td>
<td>0.974</td>
<td>0.462*</td>
<td>1.905**</td>
<td>1.070</td>
</tr>
<tr>
<td>Woman’s education</td>
<td>1.075*</td>
<td>0.872**</td>
<td>1.018</td>
<td>1.027**</td>
</tr>
<tr>
<td>Woman’s age (15-24)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-39</td>
<td>1.082</td>
<td>0.437*</td>
<td>1.071</td>
<td>1.218*</td>
</tr>
<tr>
<td>40-49</td>
<td>1.347</td>
<td>0.122**</td>
<td>1.035</td>
<td>0.589**</td>
</tr>
<tr>
<td>Employed</td>
<td>1.092</td>
<td>0.807</td>
<td>1.172*</td>
<td>1.083</td>
</tr>
<tr>
<td>Living children</td>
<td>0.624**</td>
<td>1.256**</td>
<td>1.061</td>
<td>1.015</td>
</tr>
<tr>
<td>Wealth index</td>
<td>1.285**</td>
<td>0.593**</td>
<td>0.547**</td>
<td>0.949*</td>
</tr>
</tbody>
</table>

*Significant at p ≤ 0.05
**Significant at p ≤ 0.01

*a* The reference category is in parentheses. All variables are dichotomous except woman’s education, number of living children, and wealth index.
Risk and Protective Factors for Generational Refugee Children in Jordan

Abstract

The United Nations Refugee Agency reports that of the 21 million refugees in the world, over half of them are children (UNHCR, 2015). Refugees are separated from critical social institutions that provide health, education, security and economic opportunity. Support organizations ability to replace these social institutions depends on the complexity of the institution, resources available, and characteristics of the refugees. This paper uses the 2012 Jordan Demographic and Health Survey to compare individuals residing in a refugee camp to the population outside the camp to assess risk and protective factors for refugee children and the effectiveness of support communities. Findings suggests that outside organizations can ease some of the provisional burdens that refugee children encounter, but it is not able to protect them from the difficulties of social integration. Refugee children may be protected, thanks to immunizations, but they are at risk for delayed education, increased illness, increased violence, and increased physical punishment from parents.

Key words: international child health, forced migration
Risk and Protective Factors for Generational Refugee Children in Jordan

The UN Refugee Agency reports that of the 21 million refugees in the world, over half of them are children (UNHCR, 2015). These children often endure great physical and mental challenges, both during and after displacement as the adverse events that necessitated their or their parent’s flight begin a long period of uncertainty. The process of adaptation can be quite gradual, and refugees integrate to different extents with fellow refugees and the host country. Displacement immerses children with disrupted or minimal school education into a new educational system. Discrimination and bullying are rampant in areas where disadvantages are widespread, yet policies are focused on trying to accommodate refugees (Berry, Kim, Minde, & Mok, 1987). Refugee children relocating to low or middle-income countries can lack basic material necessities that place their healthy development at risk. Alternatively, displaced refugee children or those who are born into a refugee camp may have access to increased resources due to connections with government or non-governmental organizations (NGOs). Regardless, the success of refugee camps as a form of refugee protection is a crucial form of international human rights activism (Holzer, 2013; Zolberg, 2006). This paper deploys an underused survey to examine the specific risk and protective factors that affect the physical wellbeing of refugee children in Jordan.

Although there are a reasonable number of reports about children exposed to conflict and their mental and physical health, many of these papers focus on relocation to high-income countries or single indicators. This paper, rather, focuses on children who are born into an extensive refugee history. This implies that most of these children were very young upon displacement or were born to refugee parents living in a camp setting. On one hand, evidence suggests that the next refugee generation is affected with more physical and psychotic disorders compared with the native population, while on the other, duration of residence in a host country may trend towards a reduction of negative symptoms associated with displacement (Montgomery, 2010).

Refugees are separated from critical social institutions that provide health, education, security and economic opportunity. Support organizations ability to replace these social institutions depends on the complexity of the institution, resources available, and characteristics of the refugees. I will compare refugee characteristics to assess effectiveness of support communities. These results will help us to understand which social institutions are and are not being replaced, and also suggest why. It is important to know how a child who grows up in a refugee camp with extensive NGO involvement and a strong refugee presence fares under these conditions. Such complexities of the intergenerational aspects of coping with adverse experiences and social disadvantage are poorly understood in the context of refugee families (Fazel, Reed, Panter-Brick, & Stein, 2012). Similarly, the impact of protective and risk factors varies with ethnic origin and a specific migratory context (Cecile Rousseau, Drapeau, & Corin, 1998). This research aims to understand the specific risk and protective factors that affect children in an established refugee camp setting in the Middle East.

Jordanian Context

Jordan has an extensive history with refugees. Following the 1948 Arab-Israeli conflict, the 1967 war with Israel, and Iraq’s 1990 invasion of Kuwait, there were vast influxes of Palestinian Arab refugees who now make up more than two-thirds of the population of Jordan. In 1996, 1,359,000 Palestinian refugees living in Jordan were registered with the United Nations (UN); almost 400,000 Palestinians continue to live in ten refugee camps. A variety of geographic definitions of Palestine have been used throughout history. It is important to note that the
definition of Palestinian refugees in international law is different from the definition applied to other refugees. Palestinian refugees are people “whose normal place of residence was Mandatory Palestine between June 1946 and May 1948, who lost both their homes and means of livelihood as a result of the 1948 Arab-Israeli conflict.” Additionally, their descendants are also considered refugees regardless of citizenship (UNRWA 2015; Devictor & Do, 2017). This is important to note because many forced migrants throughout history were absorbed into the receiving nationality, but political tension in the Middle East made that difficult for the Palestinian Arabs. As a result, they became a population of permanent refugees, uniquely reproducing as a refugee population over several generations to date (Zolberg, 2006).

Currently, the largest movements of refugees into Jordan are coming from Syria. As of 2015, the UN had registered over 622,000 Syrian refugees in Jordan. Approximately 80 percent of these refugees live in urban areas in the north of Jordan while the remaining refugees live in refugee camps. Although Syrians have dominated the current influx of refugees into Jordan, the Israeli-Palestinian peace process remains unresolved- causing an ongoing ebb and flow of Palestinian refugees into and out of Jordan. The refugees included in this study have a heritage of refugee flight into Jordan. For the last 70 years their people have sought refuge in Jordan, suggesting the implications of refugee status have impacted three generations of Palestinians.

Selection is an issue for all refugee research. In the case of Jordan, the current refugee camp population consists of long-duration Palestinian refugees and recent Syrian refugees fleeing a deadly conflict, though this is not as much the case in 2012 when the data was collected. Additionally there are many Palestinian refugees living in Jordan who do not reside in official refugee camps – and they would show up as members of the general non-refugee urban and rural populations, which could present a confounding element for the comparison utilized in this paper. I suggest that because there are refugees who are not in camps, my estimates are lower bounds, or the likely differences are larger. High-quality quantitative data about refugees are rare. Nationally representative population samples often exclude refugees, or perhaps include them but fail to identify them. The DHS has produced a high-quality survey from Jordan that sampled both refugees and non-refugees, making it possible to conduct valid and reliable comparisons, and to address the problems of sample selection and bias better than in almost all previous studies. Of course, no cross-sectional study can entirely control for selection, and this paper is no exception. Regardless, the implications of refugee camp living should not be overlooked.

Risk and Protective Factors

There is a complex interplay between significant stressors experienced pre or post-migration and mediating factors such as child-specific context, parental and family responses and social and community context. Refugee children, even if they are in a relatively safer environment, have also to deal with the losses associated with exile and acculturative stress (Cecile Rousseau et al., 1998). Additionally, cultural, political, and historical traditions of the sending and receiving countries narrow treatment and prevention programs to a targeted population, suggesting that refugee research and policy must address all needs specifically. This is a highly complex task, given the vast number of refugee groups and locations of resettlement. Yet it is worth considering to what extent it is possible to extrapolate from specific knowledge about a particular group to all refugee children. The challenge is to determine what configurations of factors play a role in protecting or harming refugee children in certain conditions, acknowledging that it may be difficult to extrapolate from specific knowledge about a particular group to all refugee children.
Refugee children experience many stressors and risks otherwise avoided by children who do not experience displacement. Conversely, governments and NGOs may provide possible protective factors for refugee children by connecting them to resources otherwise difficult to obtain in many low- or middle-income countries. For example, The United Nations Relief and Works Agency (UNRWA) provide services for Palestinian refugees who relocate to Jordan or other countries in the Middle East. The United Nations General Assembly established UNRWA in 1950 following a surge in Palestinian refugees throughout the Middle East and currently provides assistance and protection for 5 million registered Palestinian refugees. UNRWA provides preventative and curative health services to promote health among the Palestinian refugees from conception to advanced age. Basic life course services include family planning, prenatal care and post-natal follow up, infant care (growth monitoring, medical check-ups, and immunizations), school health, oral health, outpatient consultations, diagnostic and laboratory services and the treatment of non-communicable diseases. UNRWA is unique in terms of its long-standing commitment to one group of refugees. It has contributed to the welfare and human development of four generations of Palestinian refugees and their descendants. It is important to understand how a focused, invested, and integrated institution can influence the wellbeing of refugee children, at the same time remembering that in other refugee contexts, the support institutions may be less sophisticated.

Refugee children are subject to a variety of risk and protective factors due to the complex nature of their displacement and resources that they may or may not receive from outside sources. Outlined below are common risk and protective factors found throughout the refugee literature, and resources provided by UNRWA. Again, the conflicting findings are a testament to the complex nature of refugee children- where they came from, when, and where they end up, all connected to family and community support.

Health

Caring for health needs of refugee children can be a challenge due to the range of possible health conditions and the resources available upon displacement. These children are at high risk of growth and nutritional problems. Slow growth is more common in children from developing countries, and can be magnified among the refugee population (Davidson et al., 2004). However, evidence suggests that growth potential of refugee children should approach that of the children of the resettlement country over time (Yip, Scanlon, & Trowbridge, 1992).

In regards to mental health, there are a variety of risk factors children may experience both in-flight and in a refugee camp. In terms of children who experience the conflict at home, then the flight to the refugee camp, Fazel and colleagues (2012) conducted a systematic literature review about risk and protective factors for refugee children relocated to high-income countries. They found that direct experience of adverse events is associated with an increased likelihood of psychological disturbance in refugee children. Children who witnessed violence while they were detained in a refugee camp on route to the USA showed more withdrawn behavior than did children without exposure to violence in the camp (Rothe et al., 2002). Similarly, another study found a correlation between the number of pre-migration traumas experienced by the families and the children’s post-traumatic stress disorder (PTSD) scores as well as a correlation between the families’ number of post-migration stresses and children’s depression scores (Heptinstall, Sethna, & Taylor, 2004). Two studies suggested that the number of lifetime traumatic events could be more consequential than pre-displacement events, suggesting the importance of considering the refugee’s whole experience rather than just pre-migration occurrences (Berthold, 1999; Montgomery, 2010).
Additionally, refugees may carry a significant infectious disease burden as a result of disease prevalence in their country of origin or exposures during migration, such as poor nutrition and disruption of immunization and healthcare programs (Barnett, 2004). Migration to many high-income countries is associated with health screenings pre and post migration. These include tests for HIV, syphilis, malaria, tuberculosis and vaccine status, among others. Refugees with no records or incomplete immunizations should receive vaccines at the first health assessment in these countries, immediately connecting them to crucial health resources. This is not true for most low- or middle-income countries where health screenings are not mandatory or closely monitored.

Considering the research that suggests that refugee status is associated with increased health risks, living in a refugee camp also connects individuals to resources otherwise difficult to obtain in low-income or conflict-inflicted settings. UNRWA reports that nearly all registered refugee children — 99.6 percent of those aged 12 months and 18 months — receive all required immunizations. Vaccine coverage for registered refugee children has been close to 100 percent for almost a decade. They provide immunizations against the following diseases: tuberculosis, pertussis, diphtheria, tetanus, polio, haemophilus, influenza type B, hepatitis, measles, mumps and rubella. Additionally, UNRWA reports that they conduct regular screenings and medical checkups for children, including a record of children under the age of five who have physical or mental impairments, in order to facilitate medical follow-ups and procedures. After age 5, school age children experience regular oral health, nutrition, and medical examinations as needed.

Education

The United Nations High Commission for Refugees (UNHCR) protects and supports refugees since its creation in 1950. They recently compiled a report about the world’s six million refugee children and adolescents under UNHCR’s mandate who are of primary or secondary school-going age between 5 and 17. Data refers to the 2015-16 school year, utilizing data from UNHCR’s population database. They found that refugee children are five times more likely to be out of school: 91 percent of children around the world attend primary school, while only 50 percent of refugee children attend primary school. This gap becomes wider at secondary schooling, with only 22 percent of refugee adolescents attending secondary school compared to a global average of 84 percent. Additionally, less than one percent of refugees attend university, compared to 34 percent at the global level. Education is particularly important for refugee children because it should be a safe haven used to identify refugee children at risk of abuse, sexual and gender-based violence, and adverse health conditions. After identification it should then help connect refugee children with appropriate services. While their lives may no longer be at risk upon displacement, their basic rights and essential economic and social needs appear to remain unfulfilled (Refugees, 2015).

Aid organizations often serve an important role in providing education. The UNRWA reportedly operates one of the largest school systems in the Middle East providing basic and preparatory education to Palestinian refugees. The Agency provides basic education free of charge to all Palestinian refugee children in the area of operations. They operate 677 elementary and preparatory schools in its five areas of operation. There are also vocational and training courses provided in eight training centers, two of which are in Jordan. The UNRWA has established an Institute of Education training center, headquartered in Amman, to provide training to the UNRWA teaching staff to ensure quality education for all students.
In Jordan, not all refugee children attend UNRWA schools. Most of the refugees have access to government schools; therefore, a number of refugees send their children to nearby government schools. UNRWA reports that during the 2011-2012 school year, enrolled students numbered 490,000 in their schools. In Jordan specifically, UNRWA provides basic education to over 118,500 students in 174 schools. Students in fourth, eighth, and tenth grades take national tests in Arabic, English, science and math.

Social Support

Perceptions of acceptance or discrimination are relevant issues for refugee children. High perceived peer support was associated with improved psychological functioning (Berthold, 1999; Kovacev & Shute, 2004). Additional studies find that a perceived sense of safety and belonging at school protect against depression and anxiety in refugee children (Kia-Keating & Ellis, 2007; Cécile Rousseau, Drapeau, & Platt, 2004a; Sujoldzić, Peternel, Kulenović, & Terzić, 2006). Strong school connectedness was also linked to increased self-esteem, while low social support at school and within the neighborhood was correlated with increased depression (Sujoldzić et al., 2006). Regardless of these findings, extensive research on subjective childhood experiences such as peer relationships are lacking within the refugee context (Fazel et al., 2012).

Refugee children, whether brought into a new culture by displacement or by birth, must experience a process of acculturation, or adaptation to new and often-conflicting cultural values and traditions. Acculturation is typically a slow, continuous process, often measured by linguistic competency and time since migration, though those are only a few of its mechanisms. One study found that some degree of acculturation in adolescent refugees (maintaining the individual’s original culture while participating in the host society and fostering positive attitudes towards acculturation) was linked to improved psychosocial adjustment. Separation-by maintaining one’s own culture or complete assimilation to the values of the host society were not predictors of psychosocial adjustment, whereas the feeling of marginalization had negative effects (Kovacev & Shute, 2004). Adolescent refugees perceived themselves to be more acculturated than their parents, which can create familial discord (Ho & Birman, 2010; Nguyen & Williams, 1989). If acculturation translated into feelings of connectedness with the neighborhood and friends, then connectedness was associated with lower rates of depression and improved psychosocial adjustment (48, 30). Other studies found that acculturation mattered differently for boys and for girls, which further complicates the issue (Reed, Fazel, Jones, Panter-Brick, & Stein, 2012; Cécile Rousseau, Drapeau, & Platt, 2004b).

UNRWA claims that one aim is to promote the development and self-reliance of less-advantaged members of the Palestine refugee community- especially children- by ensuring access to proper social services. Some services include food support, personal record management (such as birth certificates and registration documents), and community based organizations that promote development and self-reliance. These community-based organizations create networks for women and children that cultivate a socially acceptable venue in which they can socialize and participate in educational, cultural and recreational activities.

Parenting Techniques

Familial experiences of adverse events affect children’s psychological functioning (Fazel et al., 2012). Some types of parental exposures are more strongly associated with children’s mental health problems than are children’s own exposures (Montgomery & Foldspang, 2006; Cecile Rousseau et al., 1998; Spencer & Le, 2006). However, little is understood about the nature and effects of parenting styles in refugee families and whether interventions could promote resilience and modify outcomes for parents and children (Williams, 2010). Child abuse
and neglect occur in all societies, but lower economic status and poverty is a specific risk factor for physical abuse of children (Helfer, Kempe, & Krugman, 1997). Refugee children, who are often subject to these stresses, are therefore at increased risk of abuse, although few published data exist to confirm this (Davidson et al., 2004).

UNRWA notes that refugee women and children are particularly vulnerable to violence and abuse. As a result, they have significantly strengthened their capacity to provide protection through various initiatives, including protection training for staff, focused protection activities on the most vulnerable population, and the addition of protection staff in all field offices. UNRWA is equipped to address violence, abuse, neglect and exploitation of vulnerable groups, including children. They have a particularly involved staff of nurses, doctors, teachers, principals, social workers and others who interact with Palestinian refugee children on a daily basis. The Child and Family Protection Program in the Jordan Field Office is committed to support frontline staff to carry out their safeguarding responsibilities to protect these children. The program aims to grant children access to basic social services and a safe environment, while knowing that child abuse and neglect can occur in the home, community or school.

Many different factors influence the health and lifestyle of refugee children. Exposure to violence—whether experienced, witnessed, or feared—has implications for both behavioral and emotional health outcomes. The World Health Organization (WHO) framework says that researchers cannot simply add up risks, rather, the inter-related pathways that lead to the outcomes need assessing. Thus, pre-migration factors contribute to childhood adversities— but repeated exposure to violence, perceived lack of social support, familial hardships, and lack of safety soon after displacement are of pivotal importance (Fazel et al., 2012). The ecological model emphasizes that children develop in a social environment in which society, community, and family contribute to quality of life. This model provides a helpful conceptual framework to shape humanitarian responses to children in crisis. Thus prioritization of certain practices such as family bonding, reinstitution of school education and community building activities are key (Betancourt & Williams, 2008; Fazel et al., 2012). These interventions in combination with structural interventions such as proper housing, skill training, and adjustment techniques should be able to ease integration for refugee children and their families (Betancourt & Williams, 2008).

Data

This paper utilizes data from the Demographic and Health Surveys (DHS), specifically the Jordan Population and Family Health Survey (JPFHS) conducted in 2012. The DHS is a widely used data set, but it has not been widely used to study refugees. The DHS interviews women between the ages of 15 and 49 about household characteristics, family planning, fertility, child health and mortality, and child nutrition among other topics. The DHS asks mothers specific questions about child nutrition, child illness and treatment for children born up to five years prior to the survey. I utilize the child file that provides this detailed information for children 59 months of age and younger.

For information regarding age adjusted education level for the children and use of physical disciplinary techniques, I utilize the household file, which has one record for each individual within the household. I was able to sort out the line number of the mother to pair with each of her children in instances where two or more mothers were residing in the household. The household file is useful to get information about children from birth to 18 years old, in contrast to just the children born five years before the survey.

The Department of Statistics identified the sample for the refugee camp areas based upon the United Nation’s Relief and Works Agency (UNRWA) records. A cluster is defined as camp
if refugees represent 80 percent of the total population or more of the cluster. With this cutoff, only 33 clusters with refugee population were not counted in this domain. For reference, there are 13,025 clusters in Jordan. The average size of a cluster is 74 households in the urban areas and 62 in the rural areas. The overall average size is 72 households, which is adequate for a sample of 20 households per cluster. The refugee camps exist only in urban areas.

**Measures**

This research utilizes a variety of outcome measures to assess potential risk and protective factors found throughout the literature and targeted in UNRWA programs. Proper immunizations is a dichotomous variable comparing children twelve months or older who have complete vaccines and those who have one or more vaccines missing as reported by the mother or seen on a vaccine card. The eight vaccines include Bacille Calmette Guerin (BCG), diphtheria rounds 1, 2, and 3, polio rounds 1, 2, and 3, and measles. Bite or kick is a dichotomous variable looking at kids who reportedly bite or kick other children or adults and those who do not (1= bite or kick, 0= no biting or kicking). Child education is age adjusted, meaning that I compare the expected education for that child’s age and the average education of children according to the background variables. Initiated non-breast milk compares mothers who gave their children milk other than breast milk in the first 3 days of the child’s life and mothers who only initiated breast milk (1=initiated non-breast milk, 0= only breast milk).

This paper examines three key measures of child nutrition: height-for-age (HAZ), weight-for-age (WAZ), and weight-for-height (WHZ). In 2006, the World Health Organization (WHO) released global child growth standards for infants and children up to the age of 5 years. I use this standard and the Z-score system to compare nutritional values as several standard deviations above or below the reference given by the WHO in 2006.

The next outcomes look at child sickness and treatment within the last two weeks. Diarrhea, fever and cough are dichotomous variables comparing children who were sick in the last two weeks and those who were not. These are coded (0 = not sick, 1= sick). For the children reported as sick, the mothers then reported if their child received treatment. Diarrhea treatment and fever/cough treatment is similarly a dichotomous variable coded (0 = no treatment, 1= treatment). The final section of outcomes includes a variety of parental disciplinary techniques. Spank, hit with belt, hit child in the head, and beat child are all dichotomous variables comparing parents who reportedly have used physical punishment and those who have not. This is coded (0 = no physical punishment, 1=physical punishment). The survey also asks the mothers if they think that physical punishment is needed to raise a child. This variable is coded (0= no, 1= yes).

I assessed differentials in these outcomes according to background characteristics of the mother. These include residence in an urban or rural area or in an urban refugee camp, her education level which is a continuous variable of education completed in single years, her age group (15-24, 25-39, 40-49), her employment (0= no employment, 1= employed by self or other), the continuous number of living children, and her wealth index.

**Childhood Risk and Protective Factors**

Table 1 presents the minimum, maximum and mean values for specific health, support, and physical punishment indicators for all children in the sample, both camp living refugees and non-camp living children. The mean values indicate that over 95 percent of the children have complete immunization records and diarrhea, fever or cough are present in about 17 to 23 percent of children. For the children who have diarrhea, fever or a cough, 60 to 70 percent of them receive treatment. Children, on average, have completed just over 5 years of schooling and non-breast milk initiation in the first three days of a child’s life occurred in only 4 percent of the
population. Over half of children reportedly bit or hit another child or adult and physical punishment from parents in the form of spanking, hitting or beating occurred in a range of 4 percent to 31 percent of households. And finally, just over 20 percent of mothers reportedly believe in the necessity of physical punishment for disciplining children.

(Table 1 about here)

Table 2 presents the differentials in complete immunization status, early initiation of non-breast milk, the child’s propensity to bite or kick other adults or children, and the child’s age adjusted educational level. The first analysis looks at completed immunizations after 12 months of age compared to children who have incomplete immunizations. The model indicates that residence in a camp, mother’s educational attainment, mother’s employment, and wealth index have a significant effect on child immunization status. Increased education, increased wealth, and residing in a camp are associated with complete immunization status, and mother’s employment is associated with incomplete child immunizations. This model suggests that children in a refugee camp are 2.4 times more likely to have completed immunizations compared to urban living children, though it is important to note that immunization coverage of children 12 months old or older is very high in Jordan. Mother’s age, rural living, and the number of living children proved not to be a significant predictor of immunization status.

The second analysis looks at mothers that initiated non-breast milk in the first three days after their most recent child’s birth and those who only fed their child breast milk. The model indicates that women living in a refugee camp are three times more likely to initiate non-breast milk than their urban living counterparts. Increased wealth is also significantly associated with increased likelihood of non-breast milk initiation. Mother’s education, age, employment, rural living and the number of living children were not significantly associated with non-breast milk initiation. The third model looks at children with a tendency to bite or kick other adults or children compared to children with no reported tendency. Children who live in a refugee camp are statistically more likely to bite or kick other children or adults while children with mothers aged 40-49 are statistically less likely. No other significant predictors were found among the background characteristics. The fourth analysis is completed with linear regression to look at age adjusted education levels. This model suggests that camp children are 0.14 years behind other children in education age adjusted.

(Table 2 about here)

Table 3 uses logistic regression to look at nutritional outcomes for children according to background characteristics. Overall trends among the three nutritional indicators height for age (HAZ), weight for age (WAZ) and weight for height (WHZ) suggest that residence, maternal education, and wealth have the most pervasive impact on child nutrition. For reference, the WHO states that low WHZ indicates cases of recent and severe weight loss, which is often associated with starvation or disease. Low HAZ indicates stunted growth, which presents itself over longer time. High levels of stunting are associated with poor economic conditions and increased risk of early exposure to adverse conditions. Low WAZ indicates the relationship between chronological age relative to body mass. A child’s HAZ score is significantly decreased by 0.109 z-score if they live in a rural residence. Inversely it is significantly increased by the same amount for each unit increase in wealth, and increased by 0.034 for each additional year of completed education of the mother. Though different than the model for HAZ, WAZ and WHZ tell a similar story to each other. A child’s nutrition is decreased by 0.136 and 0.156 standard deviations if they live in a refugee camp, respectively. Alternatively, nutritional status is slightly increased with each unit increase in maternal education and wealth. This suggests that refugee
camps have evidence of producing short-term nutritional deficits for children that might not be present in the long term.  

(Table 3 about here)

Table 4 presents information about child illness and treatment in the last two weeks. The first analysis looks at children who reportedly had diarrhea in the last two weeks compared to those who did not. The model shows that living in a camp, mother’s education, mothers age, the number of living children, and wealth all have a significant effect on children having diarrhea. Children living in a camp were 1.2 times more likely to have been reported to have diarrhea in the last two weeks while higher education, older mothers, more living children, and increased wealth reduced the likelihood of having diarrhea. For children with reported diarrhea, their mothers were asked if they received any medical treatment. Living in a rural area significantly increased a child’s chance of treatment, while living in a camp reduced a child’s chance of treatment, though not significant.

The second and third models look at children with reported fever and cough in the last two weeks. The models similarly suggest that children who live in a refugee camp have a significantly increased likelihood of having a fever or a cough while larger numbers of living children slightly reduces the odds of illness. The model for treatment for a fever or cough is similar to that of diarrhea. Living in a rural area significantly increases a child’s chance of receiving treatment while living in a camp reduces that chance, but not statistically significant.  

(Table 4 about here)

The final table looks at a variety of disciplinary techniques used by parents according to residence, education and wealth. The story for spanking, hitting one’s child with a belt, hitting one’s child in the head, and beating is similar across all indicators. Living in a refugee camp significantly increases the likelihood of a parent using physical force on their child. This ranges from a 1.3 to 2.1 increase in the odds of physical punishment. Inversely, women’s education and wealth significantly reduces the use of physical punishment. The mother’s were also asked if they believe that physical punishment is needed to raise a child. The model indicates that living in a refugee camp and increased wealth significantly increases the likelihood of believing in the need for physical punishment while living in a rural residence deceases that likelihood. Women who live in a refugee camp are over 1.7 times more likely to believe in the need for physical punishment.

(Table 5 about here)

Discussion

Refugees are separated from critical social institutions that provide health, education, security and economic opportunity. Support organizations ability to replace these social institutions depends on the complexity of the institution, resources available, and characteristics of the refugees. These results will help scholars, policy makers, and governments to understand which social institutions are not being replaced and which are. As scholars we have a tendency to paint situations as helpful or harmful, often neglecting the intricacies of the human experience. The body of literature as a whole, rather, suggests that refugee status has potential to both improve and harm the life circumstances of children (Holzer, 2013). This paper looks at a variety of outcomes in order to parse out both the positive and negative effects of being a refugee and the potential influence of support organizations.

What seems like a chaotic list of positive and negative outcomes, i.e. camp living increasing access to immunizations while also increasing a child’s exposure to physical punishment sorts out into a less chaotic story. Being a refugee can be helpful in regards to direct
health provision but harmful in regards to the broader social sphere. UNRWA has programs and procedures in place to immunize children and prevent long term nutritional stunting, as evidenced by the support for cases of recent weight loss in children (WHZ) but no evidence of sustained nutritional deficits (HAZ). Similarly, mothers in the camp are more likely to initiate non-breast milk in the first three days of a child’s life. While some literature does not support this practice, it is still evidence of provisional support in the form of baby formula, milk, or medical advice. Whether it is access to immunizations, nutrition, or baby formula, physical support can be provided by an organization that may increase refugee wellbeing. This suggests that in terms of provisional support, refugee children may be better off than country nationals if there is an established and integrated organization that can provide these resources and support.

I speculate that provisional supports are the easiest for all outside organizations to provide- not just UNRWA. All organizations that need to measure impact and numerically determine their influence for donor and research purposes rely on relief efforts that are easily quantifiable. The number of immunizations, the number of formula ounces, the weight of a child, as examples, are all quantifiable indicators of achievement. It then makes sense that an organization would find success with these indicators and become complacent with the indicators that are more difficult to quantify.

The story is not as positive when it comes to the social sphere. Refugee children appear to be more physically violent to other adults or children, more sick, more behind in school, and more likely to experience physical punishment from their parents. This suggests that while an outside organization can provide for many physical and directly medical needs of refugee children, the social integration is a different problem that is not being properly addressed. Refugee children are falling behind in school and they are sick more frequently, which intimates a divide between refugee children and the educational and medical system. These areas could fall under provisional support seeing as UNRWA provides educational and medical opportunities for refugees. Improving these two groups of indicators could be an immediate goal of UNRWA, which could make quick progress due to the established schools and medical clinics. They need to sort out how they can effectively immunize children but then fall behind on short term illnesses. Similarly, how can they catch refugee children up to their age adjusted education level by utilizing their extensive school networks that are available?

The next group of indicators may present more of a problem inherent in the refugee experience. Physical violence by both the children and the parents expresses a need for change at the family level. There is evidence that parenting practices can serve as potential mediators between children’s adjustment, traumatic events, and adverse environmental contexts (Gewirtz, Forgatch, & Wieling, 2008; Qouta, Punamäki, & El Sarraj, 2008). Similarly, negative parenting practices can seemingly halt a child’s social integration. It is hard to separate if cultural practices of physical violence are being used in parenting compared to violence being a response to stresses experienced as a refugee. Regardless, some combination of the physical punishments of spanking and hitting and the refugee experience are manifesting themselves in increased hitting or kicking among refugee children.

One scholar looked at the relationship between three parenting styles (authoritarian, permissive, and authoritative) and the mental health of Palestinian-Arab Adolescents in Israel. Drawing upon the work by Diana Baumrind, these three basic styles of childrearing differ in particular to the amount of nurturing a child receives and the extent to which their activities are controlled (Baumrind 1991). The authoritarian style emphasizes parent’s control of the child and his/her obedience. This includes enforced discipline, where parents require immediate and
unquestioned adherence to their commands. Parents are the sole regulating authority in the child’s life and they use punishment as a means of control. Nurturing, comfort, praise and affection tends to be low in these relationships. The permissive parenting style is comprised of strong nurturing but weak child control. These parents encourage children’s autonomy through decision-making and planned activities. The authoritative style is a combination of the authoritarian and permissive styles. Parents who utilize this style tend to have good nurturing skills and exercise moderate parental control to allow the child to become progressively more autonomous. These parents enforce limits but also allow a degree of latitude in the child’s behavior.

Looking at the influence of these three parenting styles on Palestinian-Arab adolescents, Dwairy (2004) suggests that there is a lack of relationship between authoritarian style parenting and the psychological adjustment measures among these adolescents because Arab adolescents accept their parents’ authoritarian style as culturally appropriate. Additionally, a significant positive relationship between authoritative parenting style and the mental health of children was found. While, the permissive parenting style was associated with negative attitudes, lower self-esteem and increased anxiety, phobia, depression and conduct disorders among boys. Taking that one step further, one could speculate that a combination of authoritarian parenting style and refugee stressors could increase parenting violence that in turn manifests itself in child violence. Evidence for this speculation can be found in a study that looked at child psychological maltreatment in Palestinian families. Parents who perceived that the family did not have enough money to meet the child’s needs, practiced gender inequality, practiced harsh discipline, perceived poor family ambiance, and gave a lack of parental support were the most likely to execute child psychological maltreatment. Psychological maltreatment also occurred with other forms of maltreatment such as physical abuse (Khamis, 2000). One could imagine that in addition to harsh discipline (which this research finds is highly prevalent in refugee homes), refugee parents experience financial, gender, and parenting stressors that increases both the physical and psychological maltreatment of their children.

Research seems to suggest that Palestinian children are accustomed to authoritarian, harsh parenting styles (Dwairy, 2004). But this research, along with others, suggests that when this type of parenting style turns excessively violent then negative outcomes begin to arise, whether that is psychological maladjustment or physical violence from the children.

The question arises, what can an organization do in order to alter cultural practices while simultaneously removing the effects of stressors that manifest themselves in the form of violence. Evidence proposes that loving, wisely guiding parenting, children’s flexible and high cognitive capacity, flexible and multiple coping strategies as well as social support and good peer relations can protect child development and mental health following war, violence, or relocation (Qouta et al., 2008). This would require tremendous attention from an outside organization. Efforts could include, culturally specific parenting classes, psychological stress outlets for both parents and children, peer integration techniques, stress coping classes for parents and children, among others. Other features of resilient children in conditions of military violence in a Palestinian community were: good parent mental health, supportive parenting practices, good school performance, superior cognitive functioning, good physical health, and high body weight (Punamäki, Qouta, Miller, & El-Sarraj, 2011). The argument for a well-rounded approach to child outcomes is made clear—provisional support is important, but it is also important to target parent wellbeing and parenting techniques, child education, child cognitive development, and peer and other social integration.
Refugee children experience a complex set of challenges throughout their lives that do not disappear upon relocation. This research intimates that outside organizations can ease some of the provisional burdens that refugee children encounter, but it is not able to protect them from the difficulties of social integration. Refugee children may be protected, thanks to immunizations, but they are at risk for delayed education, increased illness, increased violence, and increased physical punishment from parents. These risk factors should present new goals for UNRWA and other organizations alike. Providing resources is not enough, refugees need an extensive social network that wraps them into the school system, the educational system, and a social support system that deals with possible anger management techniques for parents and children.
References


### Tables

Table 1 Descriptive statistics for all children: JPFSH 2012

<table>
<thead>
<tr>
<th>Variable</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Indicators</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete Immunizations</td>
<td>0</td>
<td>1</td>
<td>0.955</td>
</tr>
<tr>
<td>Height for age</td>
<td>-5.97</td>
<td>5.97</td>
<td>-0.464</td>
</tr>
<tr>
<td>Weight for age</td>
<td>-5.91</td>
<td>4.98</td>
<td>-0.858</td>
</tr>
<tr>
<td>Weight for height</td>
<td>-5</td>
<td>4.99</td>
<td>0.249</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>0</td>
<td>1</td>
<td>0.173</td>
</tr>
<tr>
<td>Fever</td>
<td>0</td>
<td>1</td>
<td>0.188</td>
</tr>
<tr>
<td>Cough</td>
<td>0</td>
<td>1</td>
<td>0.230</td>
</tr>
<tr>
<td><strong>Support Indicators</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea treatment*</td>
<td>0</td>
<td>1</td>
<td>0.603</td>
</tr>
<tr>
<td>Fever treatment*</td>
<td>0</td>
<td>1</td>
<td>0.693</td>
</tr>
<tr>
<td>Child education</td>
<td>0</td>
<td>14</td>
<td>5.387</td>
</tr>
<tr>
<td>Non-breast milk initiation</td>
<td>0</td>
<td>1</td>
<td>0.036</td>
</tr>
<tr>
<td><strong>Physical Action Indicators</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child bite or kick</td>
<td>0</td>
<td>1</td>
<td>0.564</td>
</tr>
<tr>
<td>Spank</td>
<td>0</td>
<td>1</td>
<td>0.309</td>
</tr>
<tr>
<td>Hit with belt</td>
<td>0</td>
<td>1</td>
<td>0.112</td>
</tr>
<tr>
<td>Hit in head</td>
<td>0</td>
<td>1</td>
<td>0.163</td>
</tr>
<tr>
<td>Beat</td>
<td>0</td>
<td>1</td>
<td>0.044</td>
</tr>
<tr>
<td>Believe in physical punishment</td>
<td>0</td>
<td>1</td>
<td>0.205</td>
</tr>
</tbody>
</table>

*Only for children with diarrhea, cough or fever in the last two weeks
<table>
<thead>
<tr>
<th>Variable</th>
<th>Proper immunizations&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Initiated non-breast milk</th>
<th>Bite or kick</th>
<th>Child education&lt;sup&gt;c&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residence (Urban)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Camp</td>
<td>2.400**</td>
<td>3.031**</td>
<td>1.359**</td>
<td>-0.140**</td>
</tr>
<tr>
<td>Rural</td>
<td>0.875</td>
<td>0.747</td>
<td>0.911</td>
<td>0.042</td>
</tr>
<tr>
<td>Woman’s education</td>
<td>1.097**</td>
<td>1.029</td>
<td>1.001</td>
<td>0.036**</td>
</tr>
<tr>
<td>Woman’s age (15-24)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-39</td>
<td>1.158</td>
<td>1.220</td>
<td>0.944</td>
<td></td>
</tr>
<tr>
<td>40-49</td>
<td>1.431</td>
<td>1.013</td>
<td>0.686**</td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>0.627*</td>
<td>1.267</td>
<td>0.941</td>
<td></td>
</tr>
<tr>
<td>Living children</td>
<td>0.893**</td>
<td>1.028</td>
<td>1.011</td>
<td></td>
</tr>
<tr>
<td>Wealth index</td>
<td>1.109</td>
<td>1.144*</td>
<td>0.961</td>
<td>0.039**</td>
</tr>
</tbody>
</table>

*Significant at \( p \leq 0.05 \)

**Significant at \( p \leq 0.01 \)

<sup>a</sup>The reference category is in parentheses. All variables are dichotomous except woman’s education, number of living children, and wealth index

<sup>b</sup>Only for children over 12 months

<sup>c</sup>Uses regression
<table>
<thead>
<tr>
<th>Variable</th>
<th>Height for age</th>
<th>Weight for age</th>
<th>Weight for height</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residence (Urban)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Camp</td>
<td>-0.060</td>
<td>-0.136**</td>
<td>-0.156**</td>
</tr>
<tr>
<td>Rural</td>
<td>-0.109**</td>
<td>0.036</td>
<td>0.115**</td>
</tr>
<tr>
<td>Woman’s education</td>
<td>0.034**</td>
<td>0.023**</td>
<td>0.006</td>
</tr>
<tr>
<td>Woman’s age (15-24)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-39</td>
<td>-0.103*</td>
<td>-0.050</td>
<td>0.005</td>
</tr>
<tr>
<td>40-49</td>
<td>-0.008</td>
<td>-0.015</td>
<td>0.019</td>
</tr>
<tr>
<td>Employed</td>
<td>0.011</td>
<td>0.044</td>
<td>0.100*</td>
</tr>
<tr>
<td>Living children</td>
<td>-0.014</td>
<td>-0.018*</td>
<td>-0.013</td>
</tr>
<tr>
<td>Wealth index</td>
<td>0.109**</td>
<td>0.088**</td>
<td>0.026*</td>
</tr>
</tbody>
</table>

*Significant at $p \leq 0.05$

**Significant at $p \leq 0.01$

*aThe reference category is in parentheses. All variables are dichotomous except woman’s education, number of living children, and wealth index.

This table uses z scores compared to the WHO 2006 nutritional standards.
Table 4 Logistic regression of child sickness in the last two weeks and treatment showing odds ratios for background variables: JPFSH 2012

<table>
<thead>
<tr>
<th>Variable</th>
<th>Diarrhea</th>
<th>Diarrhea Treatment</th>
<th>Fever</th>
<th>Cough</th>
<th>Fever/Cough Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residence (Urban)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Camp</td>
<td>1.204*</td>
<td>0.909</td>
<td>1.445**</td>
<td>1.236*</td>
<td>0.948</td>
</tr>
<tr>
<td>Rural</td>
<td>0.898</td>
<td>1.396*</td>
<td>0.872*</td>
<td>0.894</td>
<td>1.303*</td>
</tr>
<tr>
<td>Woman’s education</td>
<td>0.971**</td>
<td>1.013</td>
<td>0.988</td>
<td>1.001</td>
<td>1.010</td>
</tr>
<tr>
<td>Woman’s age (15-24)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-39</td>
<td>0.799**</td>
<td>0.958</td>
<td>1.071</td>
<td>1.090</td>
<td>0.925</td>
</tr>
<tr>
<td>40-49</td>
<td>0.584**</td>
<td>0.872</td>
<td>1.047</td>
<td>1.017</td>
<td>1.082</td>
</tr>
<tr>
<td>Employed</td>
<td>1.076</td>
<td>0.984</td>
<td>0.906</td>
<td>1.000</td>
<td>0.921</td>
</tr>
<tr>
<td>Living children</td>
<td>0.894**</td>
<td>1.011</td>
<td>0.946**</td>
<td>0.915**</td>
<td>0.987</td>
</tr>
<tr>
<td>Wealth index</td>
<td>0.931**</td>
<td>0.955</td>
<td>0.985</td>
<td>0.994</td>
<td>0.956</td>
</tr>
</tbody>
</table>

*Significant at p ≤ 0.05
**Significant at p ≤ 0.01

The reference category is in parentheses. All variables are dichotomous except woman’s education, number of living children, and wealth index.

Only for children with reported illness.
Table 5 Logistic regression of disciplinary techniques showing odds ratios for background variables: JPFSH 2012

<table>
<thead>
<tr>
<th>Variable</th>
<th>Spank</th>
<th>Hit with belt</th>
<th>Hit child in head</th>
<th>Beat</th>
<th>Believe physical punishment is needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residence (Urban)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Camp</td>
<td>1.321**</td>
<td>2.098**</td>
<td>1.386**</td>
<td>1.749**</td>
<td>1.736**</td>
</tr>
<tr>
<td>Rural</td>
<td>0.924</td>
<td>0.972</td>
<td>0.837**</td>
<td>0.744**</td>
<td>0.798**</td>
</tr>
<tr>
<td>Woman’s education</td>
<td>0.983**</td>
<td>0.970**</td>
<td>0.958**</td>
<td>0.972*</td>
<td>1.000</td>
</tr>
<tr>
<td>Wealth index</td>
<td>0.914**</td>
<td>0.935**</td>
<td>0.932**</td>
<td>0.956</td>
<td>1.093**</td>
</tr>
</tbody>
</table>

*Significant at p ≤ 0.05  
**Significant at p ≤ 0.01
Refugee Health and Social Outcomes: A Comparison of Experiences of Refugees in Jordan and Haiti

Abstract

The wellbeing of displaced people is an important humanitarian issue, considering that 65.6 million people are currently forced from their home. As a result, there is a need for a conceptual model to understand consequences of displacement and effective programs to address these consequences. People become refugees for a variety of reasons and research rarely compares across refugee contexts. There are many potential differences and similarities between refugee groups and a lack of proper research comparisons are denying these patterns. This paper will initiate discussion of issues that need to be considered in building a framework to understand the effects of displacement by comparing two very different types of displacement and two different consequences. Using data from the 2012 Haitian and Jordanian Demographic and Health Surveys, I examine three related questions regarding the impact of refugee status on health and social outcomes. First, are displaced women more disadvantaged than residents in terms of reproductive health and domestic violence? Second, is the relative disadvantage influenced by country context? And third, is relative disadvantage influenced by social characteristics? The logistic regression and predicted probability analysis shows that there is not a reproductive health disadvantage, but there is a domestic disadvantage. Second, although context matters for overall wellbeing, it does not have a big effect on the relative disadvantage. I suggest that if social disadvantage is evident in these two disparate settings, there may be a general pattern. And third, relative disadvantage is evident in all social characteristic sub-groups, implying that displacement exposes women to the risk of violence regardless of setting or social characteristic. This pattern has important implications for types of services that are needed.
People become refugees for a variety of reasons and research rarely compares across refugee contexts. Individuals fleeing persecution and conflict inside and outside their home country make up a majority of the 65.6 million people around the world forced from their home. A smaller proportion of people are displaced due to natural disaster such as floods, earthquakes, mudslides, and hurricanes. Most of the displacement caused by these events is internal, so international and regional refugee law does not specifically address the plight of such people. Regardless, all of these circumstances—conflict or natural disaster—pose an enormous challenge for the international humanitarian community. Refugee status, no matter the cause, comes with similar challenges. All refugees are faced with a loss of place to live, disruption of services such as education and medical care, and loss of community sanctions and security.

There are also immense differences between refugee groups including source of disruption, place of relocation (whether internal or external to the source country), and selection of people displaced. This paper aims to compare two diverse contexts to see if there are similarities and differences in how camp-living refugees compare to the host society. Although refugee situations appear distinctive, the study and analysis of recurring themes offer explanations of the events actually observed and enable one to predict the course which future events may take (Kunz, 1981). In fact, one scholar suggests that an unjustified dichotomy exists in the social science literature dealing with displaced populations that separates the study of different types of refugees. The dichotomy must be overcome by exploring similarities and differences between different categories of displaced populations (Cernea, 1990).

This paper will initiate discussion of issues that need to be considered in building a framework to understand effects of displacement by comparing two very different types of displacement and two different consequences. My goal is to understand these two distinct contexts in order to draw out similarities and dissimilarities to understand the implications of each circumstance. I am not necessarily comparing refugees in Jordan to refugees in Haiti; rather I am comparing the overall experience of camp living refugees in Jordan and Haiti to their non-camp-living counterparts. This paper addresses three related questions regarding the impact of refugee status on woman’s health and social outcomes. First, are displaced women more disadvantaged than residents in terms of reproductive health and domestic violence? Second, is the relative disadvantage influenced by context (Jordan vs. Haiti)? And third, is relative disadvantage influenced by social characteristics? Answers to these questions will inform a conceptual framework for understanding displacement by expressing the need to look at the “three C’s” of displacement consequences: comparisons, context, and characteristics.

Jordan Refugee Context

Jordan is an almost entirely landlocked country located in the Middle East with an area of 35,475 square miles and is comparable in size to Indiana. The population is currently around 6.5 million and is predominately young, with a relatively high birth rate (3.31 births per woman) compared to the world average and surrounding countries—Syria (3.00), Israel (3.04) and Saudi Arabia (2.70). The current life expectancy is over 74 years and the GDP per capita is roughly 4,000 USD. Refuge from persecution and conflict describes the relationship between Jordan and its refugees over the last fifty years. The 1967 war with Israel served as the catalyst for the vast influx of Palestinian Arab refugees who sought safety in Jordan. Since then, about 1,359,000 Palestinian refugees live in Jordan and are registered with the United Nations (UN); 250,000
Palestinians continue to live in ten refugee camps. In fact, Palestinian Arab refugees now make up more than two-thirds of the population of Jordan. Currently, the largest movements of refugees into Jordan are coming from Syria. As of 2015, the UN had registered over 622,000 Syrian refugees in Jordan. Approximately 80 percent of these refugees live in urban areas in the north of Jordan while the remaining refugees live in refugee camps.

Although Syrians have dominated the current influx of refugees into Jordan, the Israeli-Palestinian peace process remains unresolved- causing an ongoing ebb and flow of Palestinian refugees into and out of Jordan. As recently as September 2000, a second Palestinian uprising against Israeli occupation of the West Bank and Gaza Strip broke out and is still ongoing. This second uprising, second to the original in 1987, is characterized by increasingly severe mobility restrictions imposed by Israeli occupying forces, which has generated a decline in overall access to health services in the region (Bosmans, Nasser, Khammash, Claeys, & Temmerman, 2008).

**Haiti Refugee Context**

The location, makeup, and wealth of Haiti are vastly different than Jordan’s. Haiti is a Caribbean country with a population of almost 11 million; about double the population of Jordan though the birth rate is slightly lower at 2.97 births per woman. The size of Haiti is 10,714 square miles, about one-third the size of Jordan. The average life expectancy is 63 years, over 10 years less than Jordan’s. The GDP per capita is 739.6 USD, which is drastically lower than Jordan’s 4,000 USD.

Additionally, in contrast to Jordan’s Palestinian refugee population, which is externally displaced due to conflict over the last 50 years, the Haitian refugees studied in this paper are internally displaced due to a recent natural disaster. On January 12, 2010 a large-scale earthquake hit Haiti. The initial shock registered a magnitude of 7.0 followed by two aftershocks of magnitudes 5.9 and 5.5 with more aftershocks occurring in the following days. The Haitian government suggested a death toll of more than 300,000 with an additional hundreds of thousands of survivors being displaced. More conservative estimates range from deaths around 100,000 to 160,000. A lack of building codes and poor infrastructure caused the collapse of vital infrastructure necessary to respond to the disaster. This included hospitals, transport facilities and communication systems. Additionally, the Prime Minister estimated that 250,000 residences were severely damaged. The death toll and property damage left a large part of the population in accommodation camps. The Metropolitan Area was the hardest hit. A significant population movement was observed as a result of the homeless people that took refuge in the other departments, causing areas with very high population density, food shortages and high cost of living. Camps were mainly in the Metropolitan Area and also in other areas to accommodate homeless people who had remained there.

**Comparison and Selection**

High-quality and nationally representative data about refugees is hard to come by. The Demographic and Health Survey (DHS) is administered in over 90 countries, many of which house refugees, and yet refugee data is rarely available. One obvious justification for the comparison between Jordan and Haiti is that there is data available for the same year and same data source. The DHS surveys for these countries are rare and important and cannot be overlooked. Another justification is the need to reduce the unjustified dichotomy that exists in refugee research where comparison of context and cause of refugee status is overlooked (Cernea, 1990). Jordan and Haiti are extremely different in terms of geographic location, climate, gross domestic product, living standards, and population size. This allows for a stark comparison of context’s role in refugee health. A third justification for this comparison is the cause of refugee
displacement. Haitian refugees are recently and internally displaced due to a natural disaster. Meanwhile, the Palestinian refugees in Jordan have existed for years, and are externally displaced due to conflict. This comparison encompasses differences in timing, location, and cause of refugee status. By utilizing data from these two different countries, I suggest that if I find similar patterns in such diverse contexts, this suggests some underlying consequences of displacement that may be generalizable to displacement overall.

Selection is a part of the story for any occurrence of refugee displacement. Selection happens when the crisis occurs and who is affected and who is not. Conflict or disaster can inequitably influence a certain religious group, ethnic group, or geographic group, in addition to specifications by region or at random. Disruptions are spatial events that impact some places and some groups within those places more heavily than others (Chang & Miles, 2004). Further selection occurs on who is placed in refugee camps and where. All of these factors can confound possible differences between the refugees and the native population.

In Jordan there are Palestinian refugees living in refugee camps and Palestinian refugees living out of refugee camps that would show up as the general Jordanian native population in the data. This could present a confounding component for the comparisons looked at in this paper. Similarly for Haiti, the natural disaster could have affected people who did not relocate to a refugee camp; this could drive down national levels of health, thus reducing the native base line in the comparison. Regardless of selection issues, the DHS has produced a high-quality survey from Jordan and Haiti that sampled both refugees and non-refugees, making it possible to conduct valid and reliable comparisons. Of course, no cross-sectional study can entirely control for selection, and this paper is no exception. Regardless, the implications of refugee camp living should not be overlooked.

**Similarities between Refugees**

No matter why an individual becomes a refugee, refugee status is associated with immense loss. While the specific losses, their severity, and their duration can differ between circumstances, there are a variety of losses that seem to permeate across contexts.

*Disruption of medical care*

Displacement means leaving one’s regular life to one of uncertainty and disruption. This leaves a group of people vulnerable to certain problems with limited means to fix them. One example of this is an increase in the infectious disease burden among refugees. This increase results from potentially high disease prevalence in their country of origin or exposures during migration, such as poor nutrition and disruption of immunization and healthcare programs (Barnett, 2004).

Women of reproductive age are particularly vulnerable to the disruption of services that occur during displacement. Reduced reproductive health care services naturally leads to limited contraceptive use due to lack of availability, options, and awareness (Okanlawon, Reeves, & Agbaje, 2010). This limitation stems from financial struggles, limited transportation, lack of medical supplies and supervision, time barriers, ineligibility for health benefits, or complete lack of medical infrastructure (Madi, 1998). A lack of contraceptive use increases the potential for unintended births and other reproductive health risks. When traditional social constraints are weakened upon displacement, women are more likely to take more sexual risks, face sexual exploitation, and begin sexual relationships at early ages. Poverty, powerlessness, and decreased security that are also associated with displacement increase a woman’s propensity to resort to prostitution or trading sex for security in order to survive (McGinn et al 2004).

*Disruption of social connections*
Leaving one’s community and neighborhood and possibly one’s family is inherent in the displacement scenario. As a result, many interrelated challenges face the displaced population such as social isolation, social insecurities, language difficulties, diminishing social networks and family conflicts. This lack of personal resources and social networks are an impediment to coping with integration and resettlement challenges. Refugee’s efforts to seek help are often frustrated by systemic complications that are hard to navigate without social connections and cultural understanding. It is suggested that policies that affect the lives of refugees are inadequate to replace or bridge deficiencies in social support. These support gaps then hinder the successful settlement and integration of the displaced population (Stewart et al., 2008).

A lack of social connectedness often manifests in an increase in domestic violence. This increase in violence stems from a reduction in external and social controls that occur upon displacement (Enrique Gracia & Juan Herrero, 2007). Refugee women are especially vulnerable to gender-based violence during conflict, flight from conflict, and in refugee camps when disintegration of social structures or flight from war-torn countries is occurring (Clark et al., 2010; Hynes & Cardozo, 2000). Domestic violence against women has been linked with nonuse of contraception, unwanted pregnancy and obstetric complications (Jasinski, 2004; Nasir & Hyder, 2003; Pallitto, Campbell, & O’Campo, 2005). Despite its increasing global importance, there has been little research on domestic violence against women in the Arab region, and social stigma makes it particularly hard to quantify (Hynes & Cardozo, 2000). The studies that are available suggest that the majority of Palestinian refugee women are subjected to physical or emotional abuse at some point in their lives (Diop-Sidibé, Campbell, & Becker, 2006; Hammoury, Khawaja, Mahfoud, Afifi, & Madi, 2009; M Khawaja, 2004). An additional finding is that men and women have a similar disposition about wife beating (acceptance around 60% in Jordanian refugee camps), which has only become more acceptable (M Khawaja, 2004). And 44.7% of women in Jordanian refugee camps will experience domestic violence in their lifetime (Marwan Khawaja, 2003).

In regards to domestic violence in Haiti, husband’s jealousy, controlling behavior and women’s validation of traditional norms concerning a husband’s right to beat his wife were shown to increase a woman’s exposure to domestic violence, though these effects were mediated by relationship quality (Gage & Hutchinson, 2006). As with research in the Arab region, there is not extensive research that looks into the mechanisms of domestic violence in Haiti, though it is clear that violence is prevalent in both regions.

**Stress**

Displacement increases stress levels through its psychosocial impact on social and functional abilities (Vandemark, 2007). One’s sense of space, place, belonging, and identity are associated with increased or decreased stress levels in coordination with how connected or disconnected one feels. Displacement makes individuals particularly vulnerable to diminished abilities that are necessary for reentry into homes and society. And paradoxically, entry into society is key to decreasing stress levels through increasing connectedness.

Living in a refugee camp can also increase stress. One study revealed a high prevalence and severity of mental distress in Afghan mothers caring for young children in refugee camps. 36 percent of women in the sample screened positive for a mental disorder. Among those with the disorder, 91 percent had suicidal thoughts in the previous month and 8 percent rated suicidal feelings as their topmost concern. This mental disorder may have a serious long-term psychological effect on the mother in addition to her children (Rahman & Hafeez, 2003).
Stress upon displacement can also arise from breakdowns in basic provisions and means of survival for families and communities (Mooney, 2005). Stress results from a loss of tangible (home and income) and less tangible (heritage, sense of belonging, support, sense of safety) entities because of the changing expectations of basic day to day living and the effect on individuals and their communities (Castles et al., 2005; Hawkins & Maurer, 2011).

Research on psychological distress and natural disasters gives us an idea how displacement, a breakdown of social fabric, a loss of a sense of community, and a loss of a sense of safety and trust in their land have an important effect on an individual and their community stress levels. For example, research was conducted 3-4 years following an earthquake evacuation. Findings suggest that increased stress was reported by permanently relocated individuals, while those who were evacuated but returned to their homes reported distress levels comparable to their non-evacuated counterparts (Bland et al., 1997). Similarly, a study that looked at a community following Hurricane Katrina found feelings of disconnectedness, reduced safety and mistrust that have influential psychological effects on stress (Hawkins & Maurer, 2011).

**Differences between Refugees**

*Site of relocation*

There are many possible reasons why an individual may voluntarily or involuntarily claim the title of refugee including: violence, conflict, disease, environmental erosion, natural disaster etc. Further confounding the matter is the seemingly catch-all phrase of “refugees”, which tends to be applied to all uprooted peoples without regard to whether they have left the country or for what issue.

One broad classification of refugees is internally displaced compared to those who flee across boarders. Internal displacement is not a new phenomenon, though it was not in the international agenda until the early 1990s. It is important to note that the terms “internal displacement” and “internally displaced persons” did not have a singular meaning and has undergone many transformations. For some, “internally displaced persons” refers only to people uprooted by conflict or violence, that is, someone who would be considered a refugee if they crossed a boarder. Others, however, use a more liberal term and consider internal displacement to be caused by natural disasters and other development projects in addition to conflict and violence. The term, as it is understood now, tends to take on the more expansive definition. Internal displacement covers persecution, conflict, natural disasters and development projects.

It is also important to note that the definition of internally displaced person is descriptive, rather than legal. The term does not confer a special legal status in the same way that recognition as a “refugee” who has fled to a new country does. This has an essential implication: not all situations of internal displacement will necessarily be of concern to the international community (Cohen & Deng, 1998). Some cases may be sufficiently covered by the specific government, while other cases may be overlooked altogether. Regardless, internal displacement forces people from their homes, cuts them off from basic provisions, strips people of their means of survival, and breaks up families and communities (Mooney, 2005). One study found that internal displacement leads to loss of commodities such as a home and income, in addition to the loss of less tangible goods such as friendship, cultural heritage, and sense of belonging to a particular place. All of these less tangible losses stem from social isolation, exclusion from health and education systems, the breakdown of social support, and the undermining of authority structures and social roles (Castles et al., 2005).
Women and children typically make up the majority of internally displaced populations. These populations tend to experience heightened levels of sexual violence, in addition to higher levels of domestic violence (Spindler, 2005). Trafficking is another serious risk that increases as families are displaced and possibly separated. Their opportunities to escape these risks are weakened, in both the short and long-term, by the interference to formal education that displacement typically entails (Mooney, 2001).

Regardless of the extent of consequences from displacement, food and shelter are the most immediate needs for internally displaced people (Mooney, 2005). Another common problem is the lack of documentation that is often lost, stolen, or destroyed upon displacement. In Sri Lanka, it is estimated that more than 70 percent of survivors of the tsunami of 2004 lost their documentation (Kalin, 2005). A lack of documentation can lead to denial of health care, education, and other government services as well as the problems of resolving lost property compensation. When these initial needs are met and safe and voluntary return becomes possible, internally displaced people, like refugees, require assistance to return home. Yet, despite facing similar problems, internally displaced peoples rarely receive the same type of reintegration help provided to external refugees (Mooney, 2005). Humanitarian worker, Dennis McNamara has worked with internally displaced peoples for over 30 years and stated, “no doubt that the internally displaced have been among the most vulnerable. Not only that, but they also get the least help” (McNamara, 2005 pg. 24). There are clear needs among internally displaced people, but it is also clear that humanitarian aid is not tailored to address the particular needs and priorities of these individuals, families, and communities (Borton, Buchanan-Smith & Otto, 2005).

In addition to many of the problems encountered by internally displaced peoples, refugees who seek refuge outside of their country of origin have many different problems to face. Upon arrival, refugees will begin to explore surroundings, assess the attitudes of the hosts, and begin to find a niche for themselves that is consistent with their background and with their changing lifestyle. In doing all this, whether conscious or not, the nature of the country of resettlement and its population are of vital importance (Kunz, 1981). It has been said that no other host factor has more influence on the satisfactory resettlement of the refugee than cultural compatibility between background and the society that is confronted. This can be similarity across language, money, religion, values, traditions, politics, food etc. Initial cultural incompatibility can be overcome by the highly educated and the young with greater ease, but in the long run the highly educated may remain more resistant to assimilationist pressures than less educated counterparts (Kunz, 1981).

**Duration**

The vulnerabilities produced by displacement do not necessarily diminish over time. One study found no indication that households who have been displaced for a long time have the ability to generate the income needed to obtain sufficient food (IRCR, 2005). The World Bank looked into displaced peoples in South-eastern Europe and Central Asia, and found that after more than a decade of being forced from their homes, the displaced ‘constitute a significant source of vulnerability in affected societies and that the numbers of those who fall into this category are high enough to justify a significant concern.’ In particular, internally displaced people continued to rely on government subsidies and free housing. They concluded that internally displaced peoples are a group deserving continued and significant attention from government and donors (Holtzman & Nezam, 2004).
On one hand, evidence suggests that the negative effects of displacement last over generations which leaves them affected with more physical and psychotic disorders compared with the native population, while on the other, duration of residence in a host country may trend towards a reduction of negative symptoms associated with displacement (Montgomery, 2010).

**Role of Aid Organizations**

The roles of aid organizations are different depending on the circumstances of displacement. In the case of natural disaster, aid organizations serve as initial recovery mechanisms in the days after disaster, but they also focus on long term replacement months and years following the destruction (Chang & Miles, 2004). Immediate reconstruction following disaster is a condition particular to natural disaster, while destruction as a result of conflict may take longer to address until the conflict is resolved or removed.

The role of an aid organization is particularly prevalent and particular to the refugee situation in Jordan. Following the onset of the Palestinian refugee flow into Jordan and other countries in the Middle East, the United Nations Relief and Works Agency (UNRWA) was created to address the needs of these individuals. UNRWA was set up as a temporary program but it has turned into a seventy-year institution that has been solidified into the Palestinian refugee story.

The UNRWA provides education, health counseling, health services, and support for Community Development Centers. These centers offer a wide range of programs to women in the Palestinian camps including: economic empowerment classes, training on traditional and non-traditional skills, income generating programs, and cultural and educational programs, including legal literacy. In regards to violence against women, the United Nations report that the UNRWA provides legal counseling, psychological counseling, referrals, health care, investigation, court representation, advocacy, help hotlines, campaigns, and networks to support women. This is the most expansive violence care that UN organizations provide.

There is not specific information about the aid organizations that serviced Haiti following their natural disaster. This lack of specification seems typical of natural disaster relief. A study on allocation of natural disaster relief funds in Honduras following Hurricane Mitch specified that it is feasible to target individuals receiving relief after a natural disaster, but it is hard to differentiate the amount of relief provided and by whom. This is because most of the relief consists of food, medicine and clothing, all goods for which a household’s ability to recognize the value, assimilate it, and apply it is limited (Morris & Wodon, 2003).

Taking these refugee similarities and differences into consideration, this paper compares maternal health and domestic violence experiences of refugees in Haiti and Jordan to the native populations. My research questions include: first, if displaced women are more disadvantaged than residents in terms of reproductive health and domestic violence? Second, is the relative disadvantage influenced by country context? And third, is relative disadvantage influenced by social characteristics?

**Data**

This analysis uses data from The Demographic and Health Survey (DHS), which has collected and disseminated representative data on population health, nutrition, maternal and child well being, and family planning in over 90 countries. The DHS are household surveys of women of childbearing age (15-49). High-quality quantitative data about refugees are rare. Nationally representative population samples often exclude refugees, or perhaps include them but fail to identify them. The DHS surveys used in this research serve as high-quality samples of both
refugees and non-refugees, making it possible to conduct valid and reliable comparisons, and to address the problems of sample selection and bias better than in almost all previous studies.

There are two specific datasets used in this research. The first is the Jordan Population and Family Health Survey (JPFHS) that was gathered September to December 2012. The JPFHS 2012 is a collaborative effort between the Jordanian Government, the U.S. Agency for International Development (USAID), and other outside donors. I selected this location and year because there is access to information about refugees and domestic violence, which are not always available in other DHS country datasets.

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

The second data set is the Haiti Mortality, Morbidity and Service Utilization Survey (EMMUS-V), gathered from January to June 2012. The Haitian Childhood Institute carried out this research with funding from the United States Agency for International Development, the United Nations Children’s Fund, and the Canadian International Development Agency, among others. Similar to the reasoning for Jordan, I selected this survey location and year because of the influence of natural disaster on refugee displacement and the availability of data on those refugees.

At the time of selection of the sample in Haiti, The International Organization for Migration (IOM) estimated the number of Camps to 1,001 and its population to more than 600,000 inhabitants. As in Jordan, data is drawn at the cluster level. Overall, 400 clusters, of which 144 were in urban areas and 256 in rural areas were selected by making a systematic draw with probability proportional to the size of the population and area. In total, 45 clusters were selected in the accommodation camps.

It should be recalled once again that EMMUS-V was carried out only two years after the Earthquake in January 2010 which resulted in countless casualties and the displacement of hundreds of thousands of inhabitants. The data collected during EMMUS-V thus reflect this "exceptional" and in principle, temporary situation. As a result, caution should be exercised in interpreting the data presented in this report, particularly with regard to comparisons with previous data.

**Measures**

The first table outlines descriptive information about the women in the refugee camps in both Jordan and Haiti. This includes their age, number of living children; education in completed years, employment status (either self employed or by an outside source), standard of living (having electricity, flushing toilets, TV and refrigerator in the residence), total number of people in the household, the number of people in the household younger than 5, and the husband’s education level.

The outcome variables for the social sphere include a women’s experience with mild, severe, sexual and emotional violence as well as her belief that domestic violence is ever justified. Each experience with domestic violence is a dichotomous variable coded (0=no experience with domestic violence, 1=at least some experience with domestic violence). Mild
domestic violence includes women who have been pushed, shook, slapped, punched, arm twisted or hair pulled; severe domestic violence includes women who have been: kicked, dragged, strangled, burnt, or threatened with a weapon; and emotional domestic violence includes women who have been: humiliated by your husband, being threatened with harm by your husband, or made to feel bad by your husband. Justify beating is a dichotomous variable comparing those who suggest domestic violence is ever justified (coded 1) and those who say it is never justified (coded 0) in cases of a wife going out without telling her husband, neglecting the kids, arguing with husband, or less often, if the wife burns the food.

The outcome variables for the medical care indicators include modern contraceptive use, prenatal care, location of delivery and being taught family planning at a health facility. Modern use and intent is a dichotomous variable comparing those who currently use modern contraception or intend to use contraception later and those who use traditional methods or do not intend to use contraception later (coded 1=modern or intent, 0= traditional or no intent). No prenatal care is a dichotomous variable that compares mothers who report having no prenatal care either at home or in a clinic and those who received some care (coded 1= no care, 0= some care). The location of delivery looks at women who delivered at home compared to those who delivered in a private or public hospital (coded 1=home birth, 0=hospital or clinic birth). And finally, taught FP at health facility is a dichotomous variable that compares women who reported being taught about family planning at her health facility in the last 12 months and those who reported no mention of family planning at the facility (coded 1= taught family planning at health facility, 0= no family planning at health facility). The logistic models were then used to graph camp and non-camp women according to their predicted probability of each form of domestic violence and adequate prenatal care according to the sub-groups- education and age. For brevity, I only include the graphs for severe and mild domestic violence and prenatal care, but I checked the other variables and categorical sub-groups in the model and the stories are the same.

Findings

Table 1 presents the distribution of the maternal, household, and socioeconomic variables in the refugee population within the Jordan and Haiti subsample, it tells which women are selecting into refugee camps. Overall, refugee women are younger, have fewer living children and are less educated in Haiti than they are in Jordan. About 14 percent of Jordanian refugees are aged 15-24 compared to over 42 percent of Haitian refugees, which could be a cause of the reduced number of children and years of education completed. Jordanian refugees have a mean of 4.3 living children and 10 years of education compared to 2.5 children and 6 years of education in Haiti. Refugees in Haiti are much more likely to have a job, 42 percent compared to almost 10 percent in Jordan. The standard of living is drastically different as well. Almost 93 percent of refugees in Jordan have electricity, flushing toilet, TV and refrigerator compared to only 2.8 percent in Haiti. As a breakdown, 40 percent of Haitian refugees have electricity, 24 percent have TV, 6 percent have a flushing toilet and 3 percent have a refrigerator. These numbers make more sense when considering the more recent and temporary displacement of the Haitian accommodations. The number of people in a household is smaller in Haiti, the children are younger, and like the wives, husbands have less education.

(Table 1 about here)

Experience with Domestic Violence

In terms of experience with domestic violence in the social sphere, table two compares women living in the refugee camps in both Jordan and Haiti to their non-camp living rural and urban counterparts. Table two suggests that almost 30 percent of Jordanian refugees say that they
have ever experienced mild domestic violence (including ever been: pushed, shook, slapped, punched, arm twisted or hair pulled) compared to only 18 percent of non-camp living women, almost 11 percent say they have experienced severe domestic violence (including ever been: kicked, dragged, strangled, burnt, or threatened with a weapon) compared to 4 percent out of the camps, and 31 percent of women say they have experienced emotional violence (including ever been: humiliated, threatened, or insulted by husband) compared to 21 percent of non-camp women. All of this considered, 32 percent of women say that domestic violence is ever justified in cases of a wife going out without telling her husband, neglecting the kids, arguing with husband, or less often, if the wife burns the food compared to just under 24 percent of non-camp women. The numbers are similar, though slightly reduced for Haiti: 21 percent of camp refugees report experiencing mild domestic violence compared to 14 percent of non-camp women, 9 percent experienced severe violence compared to under 7 percent of non-camp women, 26 percent experienced emotional domestic violence in the camp compared to 22 percent out of the camp, and Haiti asks a few more questions about sexual violence, and almost 14 percent of camp women have experienced sexual violence compared to 11 percent of women who live in non-camp urban and rural areas. Overall, for all types of domestic violence, both in Jordan and Haiti, the refugee camp population has a higher percent distribution of women experiencing these events. One distinction is that refugees and non-camp women in Haiti report similar justification, 17 percent think violence is ever justified in both residences.

(Table 2 about here)

The Coverage of Reproductive Care

The distribution of refugee respondents according to their utilization of contraceptive services is presented in Table 3. Around 43 percent of Jordanian refugees currently use modern contraception in comparison to 23 percent in Haiti. Both of these percentages are comparable to their non-camp counterparts (40 and 21 percent respectively). Among such camp women, the most prevalent method in Jordan is the intrauterine device (IUD) and injections in Haiti. In Jordan, 35 percent of women use the IUD, 20 percent use the pill, 13 percent use the condom, 19 percent use withdrawal method, and 13 percent use another method (comprised of female sterilization, periodic abstinence, lactational amenorrhea, and diaphragm) and only 1 percent use injections. The method mix is drastically different among Haitian refugees, 52 percent use injections, 24 percent uses the condom, 12 percent use an “other” method, 10 percent use the pill, 2 percent use withdrawal and 0.3 percent uses the IUD. Considering the drastic difference in method mix between Jordan and Haiti refugees, the breakdown in each country is similar for both the camp and non-camp women. The largest distinction between the camp and non-camp women in each country is the source of contraception. The main source of contraception for the Jordanian refugee women is the UNRWA (55 percent) while the main source for non-camp women is the government (52 percent) followed by a private clinic or pharmacy (42 percent), with only 4 percent getting contraception from UNRWA outside of the camps. The main source of contraception for Haitian refugees is a private source or pharmacy (38 percent) with only 14.6 percent receiving contraception from an NGO, in contrast, 41 percent of non-camp women receive their contraception from the government.

In regards to learning about family planning, it appears that refugees in Jordan are more likely to be visited by a family planning worker in the last 12 months (34 percent compared to only 16 percent of non-camp women) and more likely to be told about family planning in their health facility (41 percent compared to 26 percent). The family planning experiences in Haiti are more similar for refugees in the camps and women living in urban and rural areas. Around 43
percent were told about family planning in the health facility in both residences, and 14 percent of camp women were visited by a family planning worker compared to almost 7 outside of the camp.

An important difference between Jordan and Haiti to note is that over 74 percent of Haitian refugees (with a similar breakdown outside of the camp) report that they were not using contraception at the time of the survey, with only 44 percent of those intending to use it later. This is in contrast to 42 percent of Jordanian women who were not using contraception at the time of the survey. For Haitian refugees, I looked into the reasons they were not currently using contraception. They reported the following mix of reasons: not married (20.4%), not having sex (21.8%), infrequent sex (16.67%), or fear of side effects/health concern (28.6%).

*(Table 3 about here)*

**The Coverage of Maternal Care**

The distribution of respondents according to their utilization of maternal health services is presented in Table 4. Over 99 percent of women received at least some prenatal care in the refugee camps and outside of them in Jordan compared to almost 90 percent in Haiti. In Jordan, the refugee’s main source of prenatal care was the UNRWA clinics in the refugee camps (59.5 percent) and then outside of the refugee camps was the private sectors (69 percent). In Haiti, the main source of care for refugees was the private sector (56 percent), same for the non-camp population though slightly elevated (68 percent). The prevalence of home births was below 1 percent for all women in Jordan in stark contrast to 56 percent in Haitian refugee camps and 71 percent in the non-camp population. The most common site for delivery in Jordan was a public hospital or clinic (around 70 percent for both populations).

The next section looks at the prenatal care women receive according to the number of visits and the timing of initiation of care and attempts to give, however crudely, some sense of the quality of their maternal health care. In Jordan, almost 94 percent of refugee women attended five or more prenatal visits compared to almost 91 percent in the non-camp population. In comparison, 62 percent of camp refugees and 56 percent of non-camp women attended five or more prenatal visits. Of the refugee women who attended at least one prenatal visit, 87 percent were initiated in the first trimester in Jordan camps and 92 percent outside the camps compared to almost 66 percent in Haitian camps and 63 percent outside. Of these women, about 85 percent in Jordan camps and non-camps and 73 percent in Haitian camps and 67 percent in non-camps both initiated care in the first trimester and had five or more visits, which was the criteria used to determine “adequate” care.

*(Table 4 about here)*

**Differentials in Domestic Violence Experiences**

Differentials exist in the various measures of domestic violence and medical care experiences according to country and refugee status. However, it remains to be seen to what extent the observed relationships are independent of each other. To address this question, I carried out a logistic regression analysis of the variation in select domestic violence and reproductive and maternal health care measures. The predictor variables are the respondent’s residence in a camp compared to the urban and rural population, education level, age, employment status, number of living children and wealth index. The results of these analyses are presented in Table 5 and 6. Table 5 looks at domestic violence while Table 6 looks at health care.

The first analysis in table 1 looks as experience with mild domestic violence. In Jordan, residence, years of completed education, and wealth have a significant effect on mild domestic
violence. Women who live in a refugee camp are about 1.5 times more likely to have experienced domestic violence while women who have more education and increased wealth are less likely to have experienced this form of violence. This story is true for both severe and emotional violence as well. Women in a refugee camp in Jordan are almost 2 times more likely to experience severe domestic violence and 1.5 times more likely to experience emotional domestic violence with significant reductions for women with increased education and wealth.

In Haiti, refugee women are 1.6 times more likely to have experienced mild domestic violence than their non-accommodation camp counterparts. Increased education and increased age reduced the likelihood while increased number of living children and increased wealth increased that likelihood. This is an important and interesting thing to point out. Higher education seems to increase a woman’s chance of experiencing domestic violence. This finding has been checked for accuracy with a squared wealth term and the finding still stands. Again, the story is similar for both severe and emotional domestic violence. Women in the camps are 1.4 and 1.3 times more likely to experience severe and emotional domestic violence, respectively, with reduced odds with increasing education and age and increased odds with more living children and more wealth.

In regards to justification of beating, women in Jordanian refugee camps are 1.2 times more likely to justify beating, while residence is not significant for Haiti.

(Table 5 about here)

Differentials in Reproductive and Maternal Health Care

Table 6 is comprised of indicators of medical care utilization, focusing on modern contraception use, prenatal care, location of delivery, and being taught about family planning at a health facility. The first analysis looks at women who currently use modern contraception or plan to use contraception in the future compared to women who currently use a traditional contraceptive method or do not plan to use contraception in the future. The model for Jordan indicates that camp living, educational attainment, age, employment, number of living children, and wealth have a significant effect on use of modern contraception. Living in a camp, increased education, a larger number of living children, and higher wealth are associated with increased use of modern contraception, while older age, and employment are associated with less use of modern contraception. The model is similar for Haiti, though residence proved not to be a significant predictor of utilization of modern contraception, living in a refugee camp slightly decreased the likelihood of using modern contraception, but not significant. Alternatively, increased education and more living children increased the likelihood of using modern contraception while increased age and wealth decreased the likelihood.

The second model looks at women who received no prenatal care. In Jordan, increased education and increased wealth decreases a woman’s odds of receiving no care, while the number of living children increases those odds. But in Haiti, women living in a camp are over 1.5 times more likely to receive no prenatal care and the number of living children also increases a woman’s odds of receiving no prenatal care while increased education, age, employment and wealth decreases those odds.

The third analysis predicts home delivery versus hospital or clinic delivery. The models for Jordan and Haiti are similar, residence in a camp, educational attainment, age, and wealth are significantly associated with reduced odds of delivering at home while number of living children (and employment in Haiti) increases those odds.

The final analyses look at a respondent’s interaction with family planning and contraception in health facilities, this specifically looks at women who have discussed family
planning at their health facility. Similar to modern contraception, women who live in a refugee camp in Jordan were significantly more likely to have talked about family planning in their health facility while there is no significant effect in Haiti. The model in Jordan further indicates that increased education and having more living children significantly increases the likelihood of talking about family planning at your health facility while older age and increased wealth significantly decreases that likelihood. The model for Haiti suggests that living in a camp, education level and being aged 25-39 was not associated with any change, while employment and more living children increased the likelihood of hearing about family planning in a health facility and being aged 40-49 and higher wealth decreased that likelihood.

(Differential by Social Characteristics)

Figures 1 and 2 show the predicted probabilities of a camp and non-camp woman experiencing severe domestic violence in Jordan by education and age respectively. In both cases the camp and non-camp lines are parallel across all age groups and educational achievement groups, with the camp women showing a higher probability for severe domestic violence in all cases. Figures 3 and 4 tell the same story for mild domestic violence. Camp residing women in all age and educational groups experience proportional, but elevated probabilities of violence compared to the Jordanian natives. Though not pictured here, the same story holds for emotional violence and for the employed sub-group. Figures 5 and 6 show the predicted probabilities for mild domestic violence for camp and non-camp women in Haiti by education and age. The story is the same for refugees in Haiti. In all age groups and educational attainment groups, camp women experience proportional but elevated probabilities of violence. There is a slight convergence at higher ages and higher educational attainment in Haiti, though there are still elevated probabilities among the camp women.

In comparison, figures 7 and 8 show the predicted probabilities of camp and non-camp women experiencing adequate prenatal care by educational attainment groups in Jordan and Haiti respectively. The story is similar here. In this case, camp women have a marginally elevated probability of experiencing adequate prenatal care compared to the native, non-camp living population, but the probabilities remain proportional across the sub-groups.

Discussion

Overall, it appears that women are experiencing different maternal and reproductive care not only due to the differences between the nations of Jordan and Haiti, but also due to their experiences as refugees compared to the native urban and rural populations.

Research question 1: are displaced women more disadvantaged than residents in terms of reproductive health and domestic violence?

The simple answer is that there does not appear to be a health disadvantage for refugees in both Jordan and Haiti, but there is a domestic violence disadvantage in both countries. The more complicated answer is that in regards to within country comparisons between refugees in the camps and non-camp native women, refugees in Jordan appear to have better or on par reproductive and maternal health care than non-camp nationals (as indicated by their increased use of modern contraception, 99 percent utilization of prenatal care, decreased home births and increased interaction with family planning at a health facility) and Haitian refugees have no different or slightly worse care (as indicated by the lack of difference in contraception use interaction with family planning at the health facility and their increased susceptibility to no prenatal care).
With all of these health care indicators considered, and the fact that refugee women are doing the same if not better than their native counterparts in both countries, the experiences in the social sphere appear to be a more pressing concern. Domestic violence is a problem for refugee women in both Jordan and Haiti. This suggests the importance of and opportunity for NGO involvement in these areas, with particular emphasis on domestic violence.

Research question 2: is the relative disadvantage influenced by context (Jordan vs. Haiti)?

In regards to the largest overall differences at the national level, women in Jordan have a higher standard of living than women in Haiti, which seems to carry through to improved health care across most indicators. Women in Jordan have a higher percent distribution of modern contraception, they have more prenatal visits and more women are initiating those visits in the first trimester, and fewer are delivering at home compared to the women in Haiti. Although context matters for overall wellbeing, it does not have a big effect on the relative disadvantage of refugees compared to the native populations. I suggest that this finding is important. If social disadvantage (domestic violence) is evident in these two disparate settings, there may be a general pattern across refugee contexts.

Research question 3: is relative disadvantage influenced by social characteristics?

The predicted probabilities suggest that the relative disadvantage for domestic violence is evident in all sub-groups, suggesting that displacement exposes women to the risk of violence regardless of setting or social characteristics. The social characteristics of age and education seem to have the same effect in society and in the camps, i.e. the graphs stay level but do not change shape. There is something in the camp setting that is increasing risk among all groups, with no groups being particularly susceptible. Contrary to most findings about education, there does not appear to be a way for more educated women to get better help in the camps. Similarly, the benefits of living in a camp are evident in all subgroups as well. This has important implications for types of services that are needed. All women are subject to increased chance of domestic violence in the camp setting. This is an area of concern that must not be overlooked.

Overall, this research suggests that country level context is important for general refugee wellbeing, but there may be similarities that exist across different contexts. Domestic violence appears to affect refugee women no matter their location or their social characteristics. This information should be used to inform aid organizations of the severity and importance of violence in the home. In regards to a general framework for research on refugees, this paper shows how important comparisons across comparisons (with residents), context, and (social) characteristics are. It is easy to say that domestic violence is important in one context, but when you see its pervasiveness in two disparate settings and across many social characteristics it allows us to see possible patterns that would otherwise be missed.

This leaves room to speculate about why it is easier to substitute the services required for maternal health than to rebuild the social connections that reduce domestic violence. I speculate that provisional security required to improve maternal health is the easiest and quickest for an aid organization to provide. Provisional success may be the easiest to administer and measure: making it a logical first step for an organization. These provisions require limited knowledge of the sending country, they are quick, they are tangible, and they are measurable— you can count how many women used contraception for example. In this case, the UNRWA and disaster relief in Haiti were equally able to benefit women through providing proper prenatal care, contraception, contraceptive knowledge, birth centers etc. This is interesting considering the UNRWA has been established and integrated for centuries, while relief in Haiti was only two years old. Regardless of length of existence, both entities were able to provisionally support their
refugees. Alternatively, both the long-standing UNRWA and short-term Haitian relief were unable to provide domestic security. This shows an important area of need for refugees that is being missed in both the long term and the short term.

What is going on socially to produce vulnerable refugee women? This is important to consider because the implication is that any framework for addressing the consequences of displacement must consider how to replace social conditions that protect personal safety. I can only speculate that displaced couples are in situations full of stress and fear combined with a loss of social control and sanctions, which seems to create a breeding ground for violence no matter the country context or social characteristics. Future research must replace this speculation with certainty about what is occurring among the refugee population to produce and perpetuate domestic violence and about what can be done to increase security for future refugee women.
References


## Tables

Table 1 Selection Descriptives: Individual and household characteristics of the Jordan and Haiti Refugee Women. JPFHS, 2012

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Category (if continuous)</th>
<th>Jordan (mean)</th>
<th>Haiti (mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Woman’s age</td>
<td>15-24</td>
<td>13.61</td>
<td>42.06</td>
</tr>
<tr>
<td></td>
<td>25-39</td>
<td>54.87</td>
<td>42.64</td>
</tr>
<tr>
<td></td>
<td>40-49</td>
<td>31.53</td>
<td>15.30</td>
</tr>
<tr>
<td>Number of children living(^a)</td>
<td>(1 thru 13)</td>
<td>(4.277)</td>
<td>(2.510)</td>
</tr>
<tr>
<td>Woman’s education</td>
<td>(1 thru 17)</td>
<td>(10.095)</td>
<td>(6.052)</td>
</tr>
<tr>
<td>Employed</td>
<td></td>
<td>9.73</td>
<td>42.06</td>
</tr>
<tr>
<td>Standard of living (electricity, flushing</td>
<td></td>
<td>92.92</td>
<td>2.76</td>
</tr>
<tr>
<td>toilet, TV and refrigerator)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of people in household</td>
<td>1-4</td>
<td>22.12</td>
<td>63.92</td>
</tr>
<tr>
<td></td>
<td>5-7</td>
<td>50.66</td>
<td>30.17</td>
</tr>
<tr>
<td></td>
<td>8+</td>
<td>27.21</td>
<td>5.90</td>
</tr>
<tr>
<td>Children in household aged 5 and under</td>
<td>0</td>
<td>31.97</td>
<td>48.63</td>
</tr>
<tr>
<td></td>
<td>1-2</td>
<td>57.52</td>
<td>49.04</td>
</tr>
<tr>
<td></td>
<td>3+</td>
<td>10.51</td>
<td>2.33</td>
</tr>
<tr>
<td>Husband’s education</td>
<td>None</td>
<td>3.10</td>
<td>10.29</td>
</tr>
<tr>
<td></td>
<td>Incomplete primary</td>
<td>8.64</td>
<td>22.31</td>
</tr>
<tr>
<td></td>
<td>Complete primary</td>
<td>8.31</td>
<td>7.98</td>
</tr>
<tr>
<td></td>
<td>Incomplete secondary</td>
<td>52.93</td>
<td>47.17</td>
</tr>
<tr>
<td></td>
<td>Complete secondary</td>
<td>10.63</td>
<td>6.94</td>
</tr>
<tr>
<td></td>
<td>Higher</td>
<td>16.39</td>
<td>5.32</td>
</tr>
</tbody>
</table>

\(^a\)Only for respondents with at least 1 child living

<p>| N=                                         | 904                       | 1,203         |</p>
<table>
<thead>
<tr>
<th>Variable</th>
<th>Jordan Camp</th>
<th>Jordan Non-Camp</th>
<th>Haiti Camp</th>
<th>Haiti Non-Camp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced mild domestic violence</td>
<td>29.95</td>
<td>18.35</td>
<td>21.32</td>
<td>14.37</td>
</tr>
<tr>
<td>Experienced severe domestic violence</td>
<td>10.89</td>
<td>4.46</td>
<td>9.27</td>
<td>6.69</td>
</tr>
<tr>
<td>Experienced sexual domestic violence</td>
<td>NA</td>
<td>NA</td>
<td>13.64</td>
<td>10.96</td>
</tr>
<tr>
<td>Experienced emotional domestic violence</td>
<td>31.22</td>
<td>21.28</td>
<td>26.49</td>
<td>22.52</td>
</tr>
<tr>
<td>Domestic violence is ever justified</td>
<td>31.86</td>
<td>23.58</td>
<td>17.29</td>
<td>17.14</td>
</tr>
</tbody>
</table>
Table 3 Medical: Percent distribution according to the use, source, and method of contraception for Jordan and Haiti camp and non-camp women: JPFSH 2012

<table>
<thead>
<tr>
<th>Variable</th>
<th>Jordan Camp</th>
<th>Jordan Non-camp</th>
<th>Haiti Camp</th>
<th>Haiti Non-Camp</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contraceptive use and intention</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using modern</td>
<td>42.70</td>
<td>39.62</td>
<td>22.78</td>
<td>21.30</td>
</tr>
<tr>
<td>Using traditional</td>
<td>14.38</td>
<td>19.16</td>
<td>1.83</td>
<td>1.91</td>
</tr>
<tr>
<td>Intends to use later</td>
<td>18.47</td>
<td>20.70</td>
<td>43.56</td>
<td>45.07</td>
</tr>
<tr>
<td>Does not intend to use</td>
<td>24.45</td>
<td>20.52</td>
<td>31.84</td>
<td>31.72</td>
</tr>
<tr>
<td><strong>Contraceptive Source</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td>14.81</td>
<td>51.72</td>
<td>29.59</td>
<td>41.19</td>
</tr>
<tr>
<td>NGO (UNRWA for Jordan)</td>
<td>54.81</td>
<td>4.32</td>
<td>14.61</td>
<td>15.39</td>
</tr>
<tr>
<td>Private/Pharmacy</td>
<td>29.31</td>
<td>41.78</td>
<td>37.83</td>
<td>26.16</td>
</tr>
<tr>
<td>Other b</td>
<td>2.08</td>
<td>2.17</td>
<td>17.98</td>
<td>17.25</td>
</tr>
<tr>
<td><strong>Modern Contraceptive method</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pill</td>
<td>19.96</td>
<td>14.37</td>
<td>9.89</td>
<td>6.19</td>
</tr>
<tr>
<td>IUD</td>
<td>34.88</td>
<td>32.73</td>
<td>0.34</td>
<td>0.42</td>
</tr>
<tr>
<td>Injections</td>
<td>1.16</td>
<td>2.13</td>
<td>52.03</td>
<td>52.19</td>
</tr>
<tr>
<td>Condom</td>
<td>13.37</td>
<td>11.11</td>
<td>23.65</td>
<td>22.09</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>18.60</td>
<td>25.30</td>
<td>2.03</td>
<td>3.42</td>
</tr>
<tr>
<td>Other c</td>
<td>12.02</td>
<td>14.36</td>
<td>12.16</td>
<td>15.68</td>
</tr>
<tr>
<td>Visited by family planning worker in last 12 months</td>
<td>34.07</td>
<td>16.20</td>
<td>14.13</td>
<td>6.70</td>
</tr>
<tr>
<td><strong>Told about family planning at health facility</strong></td>
<td>41.46</td>
<td>26.35</td>
<td>44.19</td>
<td>42.45</td>
</tr>
</tbody>
</table>

*For modern method users only, so n=269*

b*Other comprised of shop, slot-machine, school, friends/relatives and “other”*

c*Other comprised of female sterilization, periodic abstinence, implants, lactational amenorrhea, female condom and “other”*
Table 4 Medical: Percent distribution of women who had a child in the five years preceding the survey, according to the use of prenatal care, the source of care, and the site of the birth for Jordan and Haiti refugee women: JPFSH 2012

<table>
<thead>
<tr>
<th>Variable</th>
<th>Jordan</th>
<th>Haiti</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Camp</td>
<td>Non-Camp</td>
</tr>
<tr>
<td>No prenatal care</td>
<td>0.36</td>
<td>0.70</td>
</tr>
<tr>
<td>Prenatal care</td>
<td>99.64</td>
<td>99.30</td>
</tr>
<tr>
<td>Source of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private</td>
<td>32.73</td>
<td>68.56</td>
</tr>
<tr>
<td>Public</td>
<td>7.78</td>
<td>26.58</td>
</tr>
<tr>
<td>NGO (UNRWA for Jordan)</td>
<td>59.49</td>
<td>4.86</td>
</tr>
<tr>
<td>Site of birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td>0.35</td>
<td>0.73</td>
</tr>
<tr>
<td>Public hospital/clinic</td>
<td>70.35</td>
<td>72.44</td>
</tr>
<tr>
<td>Private hospital/clinic</td>
<td>29.29</td>
<td>26.82</td>
</tr>
<tr>
<td>Number of visits</td>
<td>&lt;4</td>
<td>&gt;5</td>
</tr>
<tr>
<td>&lt;4</td>
<td>6.33</td>
<td>9.23</td>
</tr>
<tr>
<td>&gt;5</td>
<td>93.67</td>
<td>90.77</td>
</tr>
<tr>
<td>Initiation of care</td>
<td>1st trimester</td>
<td>Later</td>
</tr>
<tr>
<td>1st trimester</td>
<td>87.16</td>
<td>91.69</td>
</tr>
<tr>
<td>Later</td>
<td>12.84</td>
<td>8.31</td>
</tr>
<tr>
<td>Scale of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some</td>
<td>15.91</td>
<td>13.59</td>
</tr>
<tr>
<td>Adequate</td>
<td>84.09</td>
<td>86.41</td>
</tr>
</tbody>
</table>
Table 5 Logistic regression of reproductive health care for Jordan and Haiti refugees compared to Jordanian and Haitian nationals, showing odds ratios for background variables: JPFSH 2012

<table>
<thead>
<tr>
<th>Variable*</th>
<th>Experienced Mild DV</th>
<th>Experienced Severe DV</th>
<th>Experienced Emotional DV</th>
<th>Justify Beating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jordan</td>
<td>Haiti</td>
<td>Jordan</td>
<td>Haiti</td>
</tr>
<tr>
<td>Camp</td>
<td>1.509**</td>
<td>1.634**</td>
<td>1.999**</td>
<td>1.385*</td>
</tr>
<tr>
<td>Woman’s education</td>
<td>0.920**</td>
<td>0.962**</td>
<td>0.927**</td>
<td>0.957**</td>
</tr>
<tr>
<td>Woman’s age (15-24)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-39</td>
<td>0.988</td>
<td>0.560**</td>
<td>1.306</td>
<td>0.555**</td>
</tr>
<tr>
<td>40-49</td>
<td>0.842</td>
<td>0.328**</td>
<td>1.176</td>
<td>0.340**</td>
</tr>
<tr>
<td>Employed</td>
<td>0.997</td>
<td>1.026</td>
<td>1.401*</td>
<td>0.935</td>
</tr>
<tr>
<td>Living children</td>
<td>1.002</td>
<td>1.113**</td>
<td>0.984</td>
<td>1.129**</td>
</tr>
<tr>
<td>Wealth index</td>
<td>0.969**</td>
<td>1.185**</td>
<td>0.744**</td>
<td>1.198**</td>
</tr>
</tbody>
</table>

*Significant at p ≤ 0.05
**Significant at p ≤ 0.01

*The reference category is in parentheses. All variables are dichotomous except woman’s education, number of living children, and wealth index.
Table 6 Logistic regression of medical care for Jordan and Haiti refugees compared to Jordanian and Haitian nationals, showing odds ratios for background variables: JPFSH 2012

<table>
<thead>
<tr>
<th>Variable*</th>
<th>Modern use vs. Traditional</th>
<th>No prenatal care</th>
<th>Home birth vs. Hospital birth</th>
<th>Taught FP at health facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jordan</td>
<td>Haiti</td>
<td>Jordan</td>
<td>Haiti</td>
</tr>
<tr>
<td>Camp</td>
<td>1.170*</td>
<td>0.929</td>
<td>1.353</td>
<td>1.537**</td>
</tr>
<tr>
<td>Woman’s education</td>
<td>1.059**</td>
<td>1.019*</td>
<td>0.943*</td>
<td>0.832**</td>
</tr>
<tr>
<td>Woman’s age (15-24)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-39</td>
<td>0.565**</td>
<td>0.455**</td>
<td>1.228</td>
<td>0.715**</td>
</tr>
<tr>
<td>40-49</td>
<td>0.187**</td>
<td>0.077**</td>
<td>1.213</td>
<td>0.737</td>
</tr>
<tr>
<td>Employed</td>
<td>0.728**</td>
<td>1.010</td>
<td>0.658</td>
<td>0.721**</td>
</tr>
<tr>
<td>Living children</td>
<td>1.261**</td>
<td>1.069**</td>
<td>1.190*</td>
<td>1.100**</td>
</tr>
<tr>
<td>Wealth index</td>
<td>1.076**</td>
<td>0.845**</td>
<td>0.580**</td>
<td>0.834**</td>
</tr>
</tbody>
</table>

*Significant at p ≤ 0.05
**Significant at p ≤ 0.01

*The reference category is in parentheses. All variables are dichotomous except woman’s education, number of living children, and wealth index
Figures
Figure 2: Jordan- Predicted Probability of Severe DV by Age and Residence
Figure 3: Jordan- Predictive Probability of Mild Domestic Violence by Education and Residence
Figure 4: Jordan- Predicted Probability of Mild DV by Age and Residence
Figure 5: Haiti- Predicted Probability of Mild DV by Education and Residence

Mild Domestic Violence

Educational Attainment

- no education
- incomplete primary
- complete primary
- incomplete secondary
- complete secondary
- higher

non-camp

camp
Figure 6: Haiti- Predicted Probability of Mild DV by Age and Residence
Figure 7: Predicted Probability of Adequate Prenatal Care by Education and Residence
Figure 8: Haiti- Predicted Probability of Adequate Prenatal Care by Education and Residence

- Adequate Prenatal Care
- Educational Attainment

- no education
- incomplete primary
- complete primary
- incomplete secondary
- complete secondary
- higher

- non-camp
- camp

Bars indicate 95% confidence interval.
Dissertation Conclusion

“We are facing the biggest refugee and displacement crisis of our time. Above all, this is not just a crisis of numbers; it is also a crisis of solidarity”

*(Ban Ki Moon, United Nations Secretary General, Refugees, 2016 pg 5)*.

Newspapers and websites are scattered with stories of the 65 million individuals who are displaced from their homes. Scholarly work, though recently increasing, has not been able to focus as heavily on this humanitarian issue. Whether the limitations be data driven, time, resources etc. there is little research on the consequences of displacement for women and children. One main challenge is that cultural, political, and historical traditions of the sending and receiving countries narrow treatment and prevention programs to a targeted population, suggesting that refugee research and policy must address all needs specifically. This is a highly complex task, given the vast number of refugee groups and locations of resettlement. Yet it is worth considering to what extent it is possible to extrapolate from specific knowledge about these women and children in Jordan to all refugees. The challenge is to determine what configurations of factors play a role in protecting or harming refugee women and children in certain conditions, acknowledging that it may be difficult to extrapolate from specific knowledge about a particular group to all refugees. While acknowledging this challenge, I added the comparison to Haiti, a country about as different from Jordan as possible, with very different refugee circumstances, in order to see how the title of “refugee” might alter ones life across contexts. With that, this dissertation sought to look at the implications of displacement in a society where there is a long-standing history of refugees and an institutionalized resource for refugees to receive help and then use those ideas to inform a framework for future refugee research. As Ban Ki Moon says, this is a crisis of solidarity, and it is my job as a scholar to contribute to this conversation.

Overview

Article 1

Article one acknowledges that conflict and displacement are associated with poverty, disruption of services, loss of identity, reduced care for reproductive needs, and reduced provision of maternal care, among other things. Considering these challenges, the goal was to test how refugee and native status influenced utilization of reproductive and maternal health services in a context of high refugee inhabitants and strong refugee-focused NGO presence. Findings suggest that refugee women serviced by UNRWA have greater access to health related resources (family planning, contraception, and birth centers), but they have weaker positions in the family as evidenced by domestic violence experiences. I speculate that provisional resources are the easiest for an aid organization to provide while the complications of identity loss and the loss of a sense of space pose a challenge for refugees and aid organizations.

Article 2

Article two turns to refugee children in Jordan and the ability of UNRWA to replace critical social institutions that are broken down upon displacement. The aim of this paper was to compare individuals residing in a refugee camp to the population outside the camp to assess risk and protective factors for refugee children and the effectiveness of support communities. Findings suggests that outside organizations can ease some of the provisional burdens that refugee children encounter, but it is not able to protect them from the difficulties of social
integration. Refugee children may be protected, thanks to immunizations, but they are at risk for delayed education, increased illness, increased violence, and increased physical punishment from parents.

**Article 3**

The final article acknowledges that there is a lack of comparative research on refugees, and a lack of a conceptual framework to understand the consequences of displacement and effective programs to address these consequences. This paper aims to initiate discussion of issues that need to be considered in building a framework to understand the effects of displacement by comparing Haiti and Jordan, two very different types of displacement and two different consequences. This paper examines the role of refugee status, country context, and social characteristics in women’s experiences with health and domestic violence. Findings suggest that there is not a reproductive health disadvantage, but there is a domestic disadvantage. Second, although context matters for overall wellbeing, it does not have a big effect on the relative disadvantage. I suggest that if social disadvantage is evident in these two disparate settings, there may be a general pattern. And third, relative disadvantage is evident in all social characteristic sub-groups, implying that displacement exposes women to the risk of violence regardless of setting or social characteristic. This pattern has important implications for types of services that are needed.

**The Emergent Story**

A consistent story emerges from the three articles in this dissertation. No matter the refugee- woman, child, externally displaced in Jordan, or internally displaced in Haiti- the story is much the same. There is an ambivalence of camp membership that is consistent- camp membership provides a health security and a social liability. In all instances involved in this research, the camps are able to provide provisional resources on par with or better than the host country while simultaneously making the refugees vulnerable to abuses. So what does this potential pattern mean for other refugees and other scholars? First and foremost, it shows that domestic violence must be addressed in refugee camps. I can only speculate why violence appears to be higher in refugee camps, nevertheless, it must be dealt with. Whether the violence stems from a lack of social control, stress, fear, cultural normalcies, a lack of violence awareness, or another reason altogether- further research needs to evaluate the source of the violence and then move forward to implement a solution into aid efforts. Aid efforts show promise, they are effectively altering the health of the refugees that they service, and this effort needs to transition to the social sphere as well.

Second, this research shows the power of camps to reach a vulnerable population. Refugees are arguably one of the most vulnerable populations; they are separated from their home, income, community, family, social roles, infrastructure, health care, political protection etc. Outcomes for refugees have the potential to be exceptionally devastating. In positive news, this research suggests that refugee outcomes can be as good as the native community if not better. Now, it is important to remember that Jordan is a very specific case. UNRWA has been institutionalized in Jordan more than, arguably, any other refugee aid organization. So this outcome may be more evident for refugees residing in areas serviced by UNRWA than those in other regions. However, the comparison with Haiti provides evidence that camp life does not have to be particularly harmful in other contexts as well. This is important for refugees because they need help, and putting money and effort into refugee aid organizations seems beneficial and worthwhile.
As for scholars, this research shows that comparative research is crucial to understand consistencies that span contexts. Refugee circumstances seem extremely isolated-different sending countries, receiving countries, customs, displacement circumstances, refugee demographics, duration, distance from home, permanent or temporary etc.-and the isolation can be crippling. As scholars we see that context is important, and solutions need to be specific to the context-this is very true-but we cannot disregard the fact that comparisons show patterns and deviations that are only possible to see when different contexts are put under the same lens. In this case, social liabilities have permeated into different refugee camps and I imagine that this is the case in many other refugee camp settings. Camps are able to provide provisional resources but unable to penetrate the collapsed social sphere-I speculate that this finding would be consistent across most refugee camp settings.

Speculated Solutions

The question remains, how do aid organizations increase their impact in the social sphere in order to reduce domestic violence? In the last few decades there has been a relatively recent focus on domestic violence; particularly the nature of perpetration, the cycle of violence, and the effect on families and children-but there is a need to focus on interventions that are effective with perpetrators and victims (Stover, 2005). This is true for domestic violence overall, and possibly truer within the refugee sphere where research is even more limited.

One important area of focus is to train aid workers, particularly those that work with the mental and physical health of the refugees, to identify victims of violence. It is important to properly train individuals to commit them to helping battered patients and identify victims of domestic violence in health care encounters. This involves training individuals following these five major themes as described by Gerbert and colleagues (1999): 1) how physicians frame screening questions to reduce patient discomfort; 2) patient signs that “switched on a light bulb” for physicians to suspect abuse; 3) direct and indirect approaches to identification, with an emphasis on facilitating patient trust and disclosure over time; 4) the rarity of direct patient disclosure; and 5) how physicians redefined successful outcomes of universal screening. Once the abuse is identified, proper training on abuse counseling and health services is crucial.

Another area of focus should be efforts to reduce justification of violence. This is particularly challenging because it deals with deeply instilled historical and cultural roots. This goes back to gender norms and family lifestyle which are often sanctioned under the garb of cultural practices and norms, or through misinterpretation of religious tenets (Uthman, Lawoko, & Moradi, 2009). Increasing female education and financial security of women are often seen as ways to reduce the justification of violence, though this research suggests that justification spans education and employment levels. I suggest culturally specific classes on gender roles and the unacceptability of violence may be a beneficial route to take.

Another way to reduce domestic violence is to focus on proper punishment of the act. One study that looked into reduction of domestic violence found that arrest was the most effective way to reduce violence in comparison to attempting to counsel both the husband and wife (Sherman & Berk, 1984). In contrast, another study found that increased policing of domestic violence was actually harmful and increased violence, thus harming the very people the laws seek to help. This increase occurred because there was decreased reporting of violence by victims and increased reprisal by perpetrators (Iyengar, 2009). These conflicting findings suggest that context is particularly important when determining solutions to this violence. In some cases, increasing community sanctions, through the reduction of acceptability of violence could help provide external controls to individuals prone to violence.
Future Plans

There are questions raised by this research that I cannot look into with this data. A few of those being:

• Are women more aware of domestic violence in the camps, thus more likely to report it on the survey?
• Is violence higher in the camps by other individuals (aid workers, policemen, fellow refugees, native community etc.) as well?
• What is the role of justification of violence? Is it strictly culture or something about refugee camp life?
• Do these patterns hold in other refugee camp contexts?

In future research, data willing, I hope to tackle a few of these questions. In particular, I would be interested to see if these patterns present themselves in other countries among other refugees. Are women particularly vulnerable to abuse across even more contexts? A part of this is researching the pervasiveness of abuse across different relationships in addition to the spousal one. This research has presented evidence for a pattern that is crucial to the wellbeing of refugees as they transition from a high conflict life to one of more normalcies. I hope to understand the implications of these things further and working to implement them fully into refugee relief efforts.
References


