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Research article

Midwives and women's perspectives on family planning in Jordan: human rights, gender equity, decision-making and power dynamics

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ABSTRACT

Objectives: This study explored midwives' and Jordanian and Syrian women's perceptions towards family planning (FP) counseling and the process of FP decision making mechanism to provide evidence for expanding the access and improving the quality and utilization of FP services in Jordan.
Methods: Explorative qualitative study that purposively recruited 24 women for 4 focus group discussions (FDGs) and 17 midwives for in-depth interviews from two governorates in Jordan. The transcribed narratives were subjected to deductive content analysis.
Results: Two themes were extracted from the narratives: The power dynamics in FP decision-making process and the barriers and motivators of FP decision making. The first theme was built on the perceived influence of gender equity and social pressures and gender-based violence on FP decision making. The second theme was constructed on the respondents' beliefs about reproductive health including FP as a human right and their perceptions of the obstacles and facilitators of FP Decision Making. Overall, husbands have an influential role, and perhaps the final say, in deciding whether to use FP services or not as well as the type of method to use. However, wives must initiate the family planning conversation with her husband and do so in a way that will be pleasing to the husband. Whether the husband agrees with the wife's idea to use family planning and gives her permission and funds for use, depends largely on her presentation of the idea, her husband's education level, and his personality.
Conclusions: This study revealed several relevant issues that play a role in Jordanian and Syrian women's decision to seek FP services. While cultural and social norms related to family planning and decision making continue to exert pressure on women, women have a deep interest in continuing to broaden their knowledge about family planning services. Engaging men and incorporating digital technology in family planning counselling has the potential to improve shared FP decision-making process among Jordanian couples and overcome some of the barriers.

1. Introduction

Jordan's fertility rate showed only minor decline from 3.7% in 2002 to 3.5% in 2012 and further decline to 2.7% in 2017 (Department of Statistics (DOS) & ICF, 2019a). This drop was significant considering the noticeably high birth rates among Syrian refugees, which could have indirectly increased the overall Jordanian fertility rates in the last decade (Krafft et al., 2018; Sieverding et al., 2018). The main factor attributed to the reduction in fertility rate in Jordan was the adoption of family planning strategies among Jordanian families (Al-Massarweh, 2013). Yet, the use of any family planning (FP) method has fallen from 61% to 52% between 2012 and 2017 with more reduction in traditional FP methods (from 23 percent to 11 percent) (Department of Statistics (DOS) & ICF, 2019a). With this definition of modern contraception methods,

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the various products and approaches can be easily categorized. The methods that do not fit under the definition of modern can be labeled as "Non-Modern Methods". Surprisingly, more than half of Jordanian women of childbearing age reported not using any type of modern family planning method (MFPM) (Almalik et al., 2018), which highlights the gap between the reality and the Sustainable Development Goals' objective of improving the use of MFPM to 80% (Health Policy Initiative, 2010).

Available literature identified multiple factors that affect the decision to use MFPM in Jordan. The husband's beliefs and preferences as well as the mother-in-law's interference in the final decision concerning MFPM use have been identified as the most influential people regardless of the women's own preference (Almalik et al., 2018). Other factors such as cognitive, socioeconomic, socio-cultural factors as well as the type of MFPM have been also reported as important determinants in using MFPM among Jordanian women of childbearing age (Eltomy et al., 2013; Shafiqullah et al., 2018).

According to a recent national survey, several factors were reported to predict the use of MFPM over traditional methods such as younger women, location in the central region, number of children, and residence in urban areas (Almalik et al., 2018). However, there are documented predictors that could force Jordanian women to choose traditional methods over MFPM such as the distance from health center and number of alive children (Komasawa et al., 2020).

While recent literature reported that the most common reasons for MFPM use were birth spacing, preventing pregnancy, and lack of resources to have more children, side effects and influence of male partners were the main reasons for not using any method as perceived by women (Truong et al., 2020). Physicians, on the other hand, perceived that the main barriers to use MFPM include adverse effects, misconceptions about FP methods, and lack of women's autonomy (Truong et al., 2020). In particular, a 2016 study found that 42% of married Syrian refugees living in Jordan have never used modern contraception (UNFPA: United Nations Population Fund, 2018), and the latest DHS population survey showed that the unmet need for contraception among Syrian refugees was 19%, compared to 14% among Jordanian women (Department of Statistics (DOS) & ICF, 2019b). While, some unmet needs relate back to service barriers as stated in a recent UNHCR report (Tanabe et al., 2017; United Nations High Commissioner for Refugees/Women's Refugee Commission, 2011), barriers to contraceptive use among refugees globally include accessibility, acceptability, and availability of FP services (Casterline and Sinding, 2000). Discrimination and other biases from the providers could impact the quality of care (Family Planing 2016, 2020).

The lack of women's autonomy could be an outcome of unequal power between husbands and wives, which is the most prominent in FP decision making process (Nankinga et al., 2016). In order to understand gender power relations that directly influence maternal health care access and utilization, one must investigate how power is established and negotiated in regards to social norms, access to resources, and decision-making process (Morgan et al., 2017).

Although traditional gender roles generally place greater constraints on women's access to FP, men, too, face gender-related barriers as it relates to gender equity (MEASURE Evaluation, 2017). Thus, men's participation is crucial to the success of FP, women's empowerment, and better outcomes in contraceptive acceptance and continuation. Active involvement of affected populations has been recognized as one of the key principles in ensuring human rights in the provision of FP and in improving quality of care (Jordan Communication and Policy, 2016).

Although each generation becomes more accepting compared to the one before, the decisions in many societies are still determined by men. Thus, decisions are usually forced upon household females as they are not given the right to choose. This is true for FP practices followed in homes (Chandra-Mouli et al., 2014). Stark gender differences can be seen in FP programs when comparing couples' usage of different contraception methods and in the fact that the majority of users are females. Gender inequalities favor men as sexual and reproductive health (SRH) decisions are usually made through them. The FP program relies mainly on women as clients. In designing programs, there is often a lack of information about men's perspectives as they are viewed as irresponsible or not appropriate clientele at reproductive health services (World Health Organization, 2014a, 2014b).

Therefore, this qualitative study aimed to explore midwives and Jordanian and Syrian women's perception in regard to the process of family planning (FP) counseling as well as human rights in reproductive health issues, gender equity, the process of decision making and power mechanism.

2. Methods

In this study, we chose a qualitative approach to get a deeper understanding of the midwives and women's experiences. We conducted one-to-one face-to-face in-depth interviews with all the midwives (n = 17) who provide FP services in 9 different health centers in two major governorates in Jordan: Irbid and Mafraq. The two governorates were purposively selected because they include the majority of Syrian refugees' population. The 9 comprehensive health centers were randomly selected from a complete list of Ministry of Health comprehensive health centres in Irbid and Almafrag. We ended up interviewing all midwives in the 9 health centres chosen. Data saturation was reached and adequate information was obtained. Two of the 9 health centers primarily provide services for Syrian women. The midwives aged from 27 to 57 years and had 1 month to 25 years of experience. All the midwives were previously trained to provide FP counseling and services. The midwives were interviewed individually by two trained female investigators for around 30–45 min depending on the midwives' level of interaction and sharing of experiences.

The research team has also recruited a purposive sample (n = 24) of married women of reproductive age through the midwives who work at the International Rescue Committee (IRC) and Comprehensive Health Centers (CHC) in two governorates in northern Jordan. A total of four focus group discussions (FGDs) were conducted among women attending the IRC clinics and Ministry of health (MoH) primary care facilities. Each FGD included a total of six women (three Jordanians and three Syrians). To obtain a broader view of the participants' perceptions about FP, women of different ages and different level of education were included. Focus groups were conducted until data saturation was reached. In regards to women's educational level, all Syrian women had a very low educational level (Primary schooling) and about half of Jordanian women had only secondary school or less. The other half had a bachelor degree or higher.

All the interviews and FGDs were held in a quiet setting at a convenient place after obtaining the participants' approval and consent. The researchers informed the women and midwives that their participation was very confidential and voluntary, and that, at any point of the interview or the FGD, if participation causes any discomfort or stress for them, they had the right to withdraw. However, none of the women or midwives asked to be withdrawn.

An experienced researcher moderated the interviews and FDGs in the local Arabic dialect and assured the midwives and women that their responses would be kept confidential. The researcher used FGD and Interview guides that were designed by the research team based on the literature. The guides contained open-ended questions to facilitate discussion and encourage the participants to talk freely and spontaneously. The questions covered four major topics that were raised during the interviews: The concept of FP; human rights and reproductive health; dynamics of FP decision-making process; gender equity and power dynamic. Other more specific questions were also asked, as appropriate, but were not initially included in the interview guide but arose from the active discussions. A digital voice recorder was used as it allowed for easy management of interviews and the FGDs recordings and it recorded high quality audios, which facilitated the transcription.

Directed content analysis, also called Deductive content analysis approach, was used in the current study, in which analysis was based on predetermined questions that needed to be answered by the participants during the interviews (Hsieh and Shannon, 2005). This approach was useful in focusing on the research questions written in the interview guide and helped in determining the initial coding and relationships between codes (Hsieh and Shannon, 2005). According to Elo and Kyngäs (2008), this approach can be used when a researcher has some idea about the responses from the participants. After transcribing all the interviews, data analysis began by identifying key concepts as initial coding categories. The interview questions were used as a guide to analysing data, in which researchers identified all examples of a particular predetermined code. Coded data were then categorized into themes and categories. Researchers conducted the thematic analysis in its original Arabic to maintain trustworthiness and credibility of the findings, which could be lost by inaccurate translation. Translation into English was commenced after themes were generated. Preliminary analysis was conducted after each interview and FDG to get a general impression of the results, which allowed for early identification of the areas that needed additional clarifications and the point of reaching data redundancy. Analysis of the transcribed data was undertaken manually through identifying the meaning units, followed by condensation and coding process then generating categories and themes.

Ethical approvals were obtained from the human research Ethics Committee at the Jordan University of Science and Technology as well as the Jordanian Ministry of Health (Ref.: 6/127/2019, September 12, 2019). During recruiting participants before Commencing data collection, participants were given verbal and written information about the study aims and objectives. Additionally, they were informed that their participation in the study was voluntary and confidential, and that they could withdraw at any stage without any negative consequences or penalties. All participants voluntarily signed an informed consent, which included the consent to audiotape the focus groups and interviews.

3. Results

Common patterns embracing the midwives and women's views and perceptions about FP were identified in all the interviews and FDGs under the following themes and categories that are listed in Table 1.

3.1. The power dynamics in FP decision making process

3.1.1. Gender equity and FP decision-making

The midwives were asked about what influences a woman when she decides to make a choice about FP. Most midwives at all centers agreed that the husband and his preferences and attitude for a certain method has the largest impact on the woman's decision. In particular, the majority of midwives' answers evolved around the fact that the husband has a large influence on whether or not to use any FP method and on the type of method itself, however, a few midwives perceived less influence of the husband on the women's decision. As described by a midwife at an urban HC:

"Of course the husband has to agree on using a certain method, as she won't be able to use it without his permission."

In addition, according to a midwife at a rural HC:

"some husbands come to the centers to make their wives remove the IUD devices and put a short-term method instead such as contraceptive pills, as they want them to be able to get pregnant again without having to use a long term method."

Interestingly, two midwives from two rural HCs explained that some men do not allow their wives to leave their home or give them a ride to the health center to seek counseling or to get the FP methods, due to the exaggerated distrust and jealousy acquired from the customs and traditions that restrict women freedom of movement especially outside their homes. However, one midwife argued that the husband does not have a considerable influence on FP, except when it comes to some types of methods (e.g., "*…some husbands don't like using the condom*") that have side effects influencing women ("*…such as heavy menstruation, nervousness and mood swings*). Similarly, another midwife at an urban HC gave an uncommon answer;

"men don't negatively affect the FP-related decisions, given the increasing awareness of husbands and wives in the region close to the health center." She added: *"final decision of FP depends on the socio-economic status of the couple as well as their educational level"*.

Nonetheless, midwives agreed that some men still have the absolute power to impose their opinion in some situations, especially when there is no mutual understanding or balanced levels of communication between the couples (usually between Syrians, because of their culture that prefer large family and women's low education). One midwife working with Syrian women said:

"Syrian women, mostly very young, are accustomed to the idea of having many children, so she doesn't even argue with her husband about using FP methods."

Many cases of disagreements and divorces happen because husbands and wives want different things regarding FP. For example, a midwife at a rural HC said that:

"a man once divorced his wife because she used a contraception method behind his back." Another midwife work with Syrian women told a similar story about a man who divorced his wife immediately after he knew that she was using the IUD device. More depressing stories were told by the midwife work with Syrian women about two women who could not use FP methods because of their bad health condition:

"the first was a 20-year-old woman who underwent four cesarean deliveries but wasn't able to use the FP methods as her husband did not want to". She added: *"the second one was a 25-year-old woman who underwent 6 cesarean deliveries and had five boys…she doesn't want to have more children but her husband is against family planning and didn't allow her to use and method…her mental and physical condition was pathetic and heartbreaking"*.

Wanting one or more male children is another factor mentioned by the midwives that influences the woman's decision, and it is a quite a common one, especially in traditional societies *"some men decide not to use FP methods because they want male children "*said a midwife from a rural HC. On the other hand, some men act careless towards FP and let the women decide freely. Luckily, some men like to make a joint decision

Table 1. Themes and categories of midwives' and women's perceptions about FP in Jordan.

Themes	Categories
The power dynamics in FP decision making process	• Gender equity and FP decision making • Gender-Based Violence and FP Category • Social pressures and FP decision making
Barriers and motivators of FP decision making	• Perceptions of FP as a human right • Perception of the obstacles of FP decision making • Facilitators of FP decision making

with their wives, accompany them during the counseling and support them to access the contraception methods, as stated by two midwives.

Conversely, the women were asked how a married couple could most effectively prevent pregnancy if they are not interested in having children at that time. Most answers described a *"mutual agreement between the husband and his wife."* In contrast, few women mentioned that they trick their husbands and use FP behind their backs:

> *"I took pills without him knowing and when he asked me what was that I said pain killer."* When asked who in their household is most responsible for deciding if to have children, when, and how many, all women said, *"men and women, respectively."*

However, few women stated that the decision to have more children, after a first baby, rested with their husbands. The women also mentioned that they discussed their choice of contraception with their husbands, and that the decision of which method to use was more often made jointly, if agreed by the husband. There was no consensus among the women about who makes the final decision to have more children. However, in several cases, women stated that the final decision is left to the husband.

Typically, when women are asked about gender equity and power dynamic, the answers vary based on experience, culture, education, and community, which was explained by women who participated in the FGD. For instance, one woman remarked that:

> *"women living in the rural areas don't have much power and equality compared to women living in the city."* Another woman said, *"When women become educated and have a job, they have a better chance of power and equality."*

Moreover, the women elaborated that those who have given birth to a desired number of children easily fulfill their social and marital obligations. These obligations hold a critical gendered power dynamic in that women who marry early are particularly unlikely to negotiate the use of contraception or make independent decisions related to fertility control because they feel they must bear children.

All women agreed that the husband fills his role as *"Head of the family"* and financial provider for the family. Thus, in some cases the husband either supports FP or does not support it. For instance, women explained:

> *"In our culture, it is the man's responsibility to financially support the family and spend money on what he wants,"* and when it comes to FP, *"the husband's decision (on FP) takes priority, the wife can only beg."*

Moreover, the consequences of not agreeing with the husband's decision were grave to a women's future; they could involve either another marriage or divorce. For example, a woman said*:*

> *"If the husband and wife disagree on the number of children, the husband will get married to another woman."* Additionally, one woman said, *"If the wife says no more to childbirth, the husband can overrule her decision and if she disagrees, she may be threatened with divorce."* Similarly, another woman said, *"The man has more power than the woman to decide on the number of children to have but sometimes the woman wields more influence because she could determine which pregnancy happens."*

The interviewed women shed light on gendered and power imbalance context related to FP. Although the man is expected to decide on the number of children, it is the woman who carries the pregnancy and bears the burden of childbirth. She is also the one who has more options in terms of FP methods. Given her position of carrying the pregnancies and delivering the children, she is expected to be the one to initiate the FP discussion in the house; however, her use of FP is ultimately dependent on her husband's acceptance of her delivery of a FP discussion, as he has more power. women explained that:

> *"if the husband doesn't agree to FP use, the wife is left with few options," which usually result in no FP use.* However, if a woman chooses to use FP without her husband's agreement, she does so with great risk: *"If her husband finds out she is using FP without his permission she might suffer from him taking a second wife, or divorce"*.

3.1.2. Gender-based violence and FP

The midwives were asked if they experienced or know someone who experienced gender-based violence (GBV), actual or perceived, when seeking FP services. A total of 13 out of 17 midwives answered 'no' along with some comments. One midwife thinks that cases of violence exist even if she has not witnessed them directly. Two other midwives at an urban HC provided encouraging answers when they said that they never noticed any FP-related violence, as people in the surrounding society are conscious, strong, and well educated.

Midwives who gave 'yes' as an answer had different distressing stories told by a midwife at a rural HC:

> "*There was only one case of a woman who was a victim of violence. We thought that it happened with her approval, but she said that he hit her. We asked her about the reason, and she answered that she doesn't want to get pregnant and he's forcing her to, provided that he doesn't work and consume illegal drugs.*" She added: *"The woman doesn't want to get pregnant again as she already has 5 children and she spends most of the time at her parents' house and her brother would 'shoot her' if she brings another child."*

The midwife tried to solve the problem by using the Depo injection to stop her from getting pregnant for three months. The midwife added:

> *"The husband got suspicious and came to the center to ask if they gave her any FP method, but the midwife didn't tell him anything.*" In another similar situation, *"A woman came saying that her husband hit her because he found out that she used a contraceptive injection,"* told by the midwife about a 40-year-old Syrian woman.

The same midwife also witnessed many cases of verbal violence as the husband wants his wife to keep giving birth and to act like a servant to his children and mother. Moreover, a midwife at a rural HC heard about a case in which the woman convinced the doctor that her husband is fine with using the IUD device. She said:

> "*The husband discovered the IUD later, hit her violently at home then dragged her into the center in front of everyone and asked the doctor to remove the device or he'll sue her.*"

In addition, the midwife working with Syrian women told another pathetic story about a 30-year-old woman who had 6 boys and 1 girl and underwent 4 successive cesarean deliveries. She said:

> *"I decided to give her an injection as it can't be discovered by the husband… however, he knew something was wrong when she didn't get pregnant after three months and she was forced to confess…the next day, she came to the center with her right eye swollen as he hit her…after that, she fell pregnant twice with no spacing at all between the two pregnancies; one died after 7 months of pregnancy."* The midwife added, *"The doctor had no choice but to convince the husband that she needs to use a contraception method, or she'll be in a very critical health condition."*

Despite all of the upsetting stories about power imbalances and violation, some of the interviewed midwives declared that husbands and wives make a joint decision regarding the use of the FP methods most of the time.

On the other hand, women were asked if they have experienced or known someone who has experienced gender-based violence (GBV), either physically or perceived, when seeking FP services. Most women

answered "*No*" to personally experiencing GBV but "*Yes"* to knowing someone who has experienced GBV as stated by one woman:

"*A neighbor I know was physically abused by her husband because she was taking pills."*

Another woman said, "*My sister was once physically abused by her husband because she did not want to get pregnant."*

Women consistently agreed that GBV is present in the society regarding FP. They remarked that mild beating is permissible for correctional purposes because:

"*in our religion, men are allowed to discipline their wives for good purposes, says in the Quran."*

They also mentioned that men have several forms of disciplining the women, such as withholding sex, screaming, threatening, and divorce. Surprisingly, a few women mentioned that:

"*it's the woman's fault for having her husband hitting her because no man would hit his wife if she does not provoke him.*"

In contrast, some women generally rejected violence for any reason, even at the level of threatening or screaming. Other women rejected violence and severe beating but said that:

"*yelling and threatening could be tolerated to preserve their children and household in line with the prevailing customs and traditions in the society."*

Moreover, some women indicated that the husband could resort to physical violence if the wife declines to use FP methods, refuses to bear children, or uses FP methods without the husband's consent. Women also mentioned that if their husband violates them, they are unable tell anyone due to being ashamed and embarrassed, even when it comes to specialized, confidential, and supportive services of GBV. One woman said that:

"*women are more likely to tell family members, rather than service providers or the police,*"

and many felt more comfortable reaching out to a religious official to resolve such matters discretely.

3.1.3. Social pressures and FP decision making

Overall, the midwives perceived the mother-in-law to have the second place after the husband in the influence on FP decisions; yet there were different opinions regarding this matter among the midwives. Some midwives believe that the mother-in-law even has a larger influence than the husband. One midwife from a rural HC said:

"in the surrounding community, women usually live in their in-laws' houses, who tend to interfere in the women's decisions",

while another midwife at an urban HC thinks that mothers-in-law rarely or never intervene, but when they do, they annoyingly interrupt the process of FP and impose their opinions.

A midwife working with Syrian women described a frequent situation, in which the mother-in-law speaks in place of the woman when asked about her opinion regarding FP because of the woman's young age and low educational level. She said:

"many women come with their mothers-in-law, but I ask them to wait outside to give the women a full privacy, which makes the women really happy…sometimes the mother-in-law says that the woman won't be able to express herself, but I insist that she can…".

Another midwife told a story about a woman who was forced by her mother-in-law to use the IUD device without asking for the husband's opinion.

Who said women cannot change the mind of each other's? This question was answered by a midwife at a rural HC: "

A woman came to the center convinced that she wants to put the IUD, then she talked for a few minutes to another woman who told her to not to use it for many reasons. She was about to back off before I gave her a full counseling, which helped her to regain confidence.

Other influencers mentioned by the midwives included, father-in-law interference and the woman's social status and family support. Preconceptions by her social circle and rumors about certain MFPM all perceived to contribute to the process of decision-making.

Women mentioned that mothers-in-law are influential in FP and family size decisions. The degree to which family members exerted influence and pressure on women depended on the size of their own families, the sex of other children and how many, and if they hd family members who had been unable to have children in the past. For example, one woman:

"wanted her daughter to have children quickly since she had been an only child and did not want this for her grandchild." Another woman stated, *"My family and the people around me kept saying to me, 'God willing you will have a boy' because I only had girls."*

When probed about societal influences of FP, all women mentioned that their female friends and neighbors are supportive of FP, as all women experience the same thing. However, non-relative individuals have no say in or impact on FP. As for broader societal expectations, all women mentioned:

"We live in an extremely gendered society. How society defines a man and a woman and their behaviors, are very important." One woman said, *"A man should act like a man, and a woman act as society has described a woman."*

3.2. Barriers and motivators of FP decision-making

3.2.1. Perceptions of FP as a human right

All the midwives were asked about women's rights as related to reproductive health and family planning. Almost all of them answered that women have the right to take care of their mental and physical health. For example, according to a midwife:

"family planning is a way of providing a complete relief to the women by giving them the chance to care for their health and body".

Other reported rights were women's right to enjoy their social life, to look after their children, to maintain a good relationship with their husbands. One midwife stated:

"*some couples prefer to use the FP method as it gives them a better sexual experience"*.

In addition, some midwives mentioned that women should be the ones who decide to use a safe FP method or stop using the method at any time. Some midwives believed that women should have the final word when it comes to FP because they suffer a lot during pregnancy and delivery in addition to raising children. A midwife at an urban HC said:

"the decision should be made by both the husband and wife, but she has the right to make the final decision as it's her own body and she's the one who gets pregnant".

Midwives also stated that women have become more aware of their rights due to TV shows and social media and they also make their own decisions about pregnancy nowadays, even if they choose not to tell their husbands.

When the facilitator asked the women in FDGs if they are aware of their rights related to reproductive health and FP; most of the women answered with "*yes*" women have the right to decide if they want to seek FP services. In fact, two women answered:

> *"I told my husband that I want to take the birth control pill after our first child."*

Another woman stated that *"I know that my body is tired, so I need to take care of it, and I came here to get pills,"* while two others said, *"My right is to seek help when needed during and after pregnancy."*

Another stated, *"My right is to have as many children as I want without the criticism from anyone in my family."*

Most women mentioned that their rights are related to their bodies, physical health, and mental health. The discomforts they face during pregnancy and delivery give them the right to decide the number of children and the birth spacing. However, some women explained their right not to seek FP services and have children one after another due to their love of motherhood and the pleasant feeling they have when pregnant:

> "*My right is to have children within limited time after each delivery and not to take any contraceptive methods.*"

Such discussions demonstrated the women's level of understanding of their reproductive and FP rights; thus, leading them to make decisions about FP.

Moreover, a few women from all four centers mentioned that their rights can go beyond the wish of their spouse. If, for example, a husband does not want a pregnancy in the first year of marriage, while the wife wants the opposite because:

"*a woman earlier in life is in good health and is better able to get pregnant without becoming tired or sick or facing other health issues and complications,"* then the woman's rights supersede the husband's wishes. Alternatively, sometimes women cannot make any decisions related to reproductive health and FP without their spouse's consent, even if they know their rights:

> "*I have to tell him about my decision before I make any move even if he doesn't agree with it."*

Even though some women are unable to make FP decisions, they may create ways to ensure an outcome they want:

> "*I trick my husband by agreeing to have more children, and later he changes his mind after he experiences the discomfort of having more children."*

Furthermore, the women were asked which of those rights when seeking reproductive health and FP services are violated in their house and community. Most women stated that husbands usually interfere with the woman's right to determine the number and timing of children, to go to the health center alone, and the type of contraceptive method to use and for how long. For instance, one woman said:

> "*My husband won't allow me to come here alone, he has to be with me."*
> Another said, "*When I told him I want to take pills, he said no and forbid me from going to the health center to get some."*

A pregnant woman said, *"My husband wants me to have another baby right after I give birth to this one, and I said 'no'; he shouted."*

Interestingly, some women replied that midwives at the health center violate their right to obtain contraception stating,

> "*I came here and asked her to give me pills …, the midwife asked me if I have had children before, I said, 'no, I am newly married.' The midwife did not agree to give me pills and said, 'You cannot have any methods before your first pregnancy.'"*

Another two women described asking midwives for IUDs before having children, but *"the midwife[s] refused and said, 'if you put one now, you won't get pregnant ever.'"*

The women stated that the midwives' rejection to help them caused confusion and created a fear of not getting pregnant. Thus, they decided against any methods of FP:

> *"When I heard the midwife saying I won't get pregnant ever, I changed my mind of getting the method because she must know for sure."*

3.2.2. Perception of the obstacles of FP decision making

When asked about the challenges that midwives face while providing FP services to women, the majority of midwives pointed out a difficulty in communicating with some women either because of their low educational level, their young age, or the effect of culture and the surrounding environment. Women's insistence on some FP methods that are not suitable for their health condition also perceived to be very challenging to provide effective FP counseling, as told by the interviewed midwives. Women's own beliefs and preferences and choosing an efficient method that has no negative effect on their health, weight, breastfeeding, menstruation, and children also were perceived by the midwives to have a fundamental effect on FP choices. For example"

> "*an old woman with a single child who still wanted to get pregnant, while her husband sent her to the center to get a contraception method. She insisted on her own decision with the help of the midwife"* proudly told by a midwife at an urban HC.

When asked about barriers they think might hinder their seeking FP services, most women responded that the main barrier to FP use was the husband's disapproval of FP. It is the women's responsibility to first talk about FP, but it is subject to their husbands' approval. Once they oppose, it will be very difficult for such women to use FP methods as agreed by most women.

One woman said: *"If her husband is pleased with it, he can tell her to go for it. On the other hand, he may not allow her to take up FP if he is not.*" A second barrier to FP use was contraceptive side effects. The IUD came under scrutiny by women because IUDs increase bleeding and pain, and the pill contributes to feelings of stress, nervousness, and weight gain. Interestingly side effect related barriers were more likely to be noted by women using FP, as they expressed that:

> *"their husband may not agree with them [to use FP] because he may want more children now and he is scared that FP methods may permanently hinder their opportunity to have children in the future."*

Another barrier to FP use mentioned was a fear of another marriage or divorce. This barrier was mentioned most often by women who were newly married, as one of them said"

> *"Some husbands will not support their wives' decision for FP and threatens them to get married or leave them."*

3.3. Facilitators of FP decision-making

All of the interviewed midwives were then asked if they encourage women to make autonomous choices about their reproductive and sexual health freely, and most of them answered 'no' as they do not want to cause trouble for themselves or for the women. In case women insist on making a solo decision despite the midwives' advice or the husbands' willpower, some midwives ask women to sign a disclaimer and refer them to a specialist, especially when the chosen method do not suit the women's health condition. Nonetheless, some other midwives prefer to give the woman the right to decide by respecting her privacy and not

allowing anyone to accompany her during the counseling session or by providing her with the contraception method she wants, regardless of her husband's' preferences (e.g., a midwife work with Syrian women said:

> *"a woman hides the contraception method under the carpet and uses it secretly without telling her husband, and I agree with her decision as her mother-in-law knows and she already has young children that she can't afford to get pregnant again without spacing…"*).

In general, midwives stated that they can encourage women to make a joint decision with their husbands by suggesting some FP methods that the husbands may like or by encouraging them to bring their husbands to the center to talk directly to the midwife/doctor. Other ways of negotiating with the husbands, as recommended by the midwives, include seeking the doctor's advice and help if the woman prefers a certain method that her husband is against, convincing the husband through focusing on the benefits of the chosen method and on the increasing emotional and financial needs of children, and most importantly that women should choose the right time and circumstances to talk to men about family planning. They should also try to create a peaceful home environment to make their husbands feel relieved before discussing the matter with them (e.g., preparing a special dinner). In addition, many midwives said that women should prevent anyone other than their husbands from interfering in their own private decisions. One midwife at an urban HC said:

> *"I try to give some ideas to women to bargain with their husband on using MFPM…I even encourage them to use the "pillow talk" when the husband is relaxed and easy to convince."*

As this study aims to try to cover all the possibilities and methods available to deliver the FP-related knowledge to women of different cultural, educational or social conditions, the midwives were asked about the alternative communication channels that could be used to increase access to FP services. The most common answers provided by midwives were Facebook groups, and smart digital applications with Q & A sessions.

As for women, most of them mentioned that IUDs and the pills are their most preferred FP method. They recommended that couples should be counseled with respect of privacy settings and confidentiality by the health care providers. They also mentioned their need for effective counseling and credible information about FP methods side effects, especially on the long term and how contraceptives affect future pregnancy. Women preferred to have information through a website or a mobile application.

4. Discussion

4.1. Decision making process in FP counselling

Our findings suggest that husbands have an influential role, and perhaps the final say, in deciding whether to use FP services or not as well as the type of method to use. However, wives must initiate the family planning conversation with her husband and do so in a way that will be pleasing to the husband. Whether the husband agrees with the wife's idea to use family planning and gives her permission and funds for use, depends largely on her presentation of the idea, her husband's education level, and his personality. Previous studies have conflicting findings about the role of husband in the process of FP decision-making depending on several factors including socio-economic status and level of education of women and husbands, as well as knowledge and awareness about various MFPM. Decision-making processes between husbands and wives are not straight forward and determined by continuous changes in attitudes and situations (Downey et al., 2017). Male partners often make the final decision about contraceptive use (Truong et al., 2020). In Nigeria, for example, wives with lower socioeconomic status are less empowered to overtly use contraceptives when their husbands oppose family planning; however, they still use it covertly (Adanikin et al., 2019). Recent literature reported that both the influence of male partners and lack of women's autonomy were the main reasons for not using any MFPM (Truong et al., 2020).

A literature review indicated that males were more likely to disagree to make FP decisions although their decisions dominated at the end (Vouking et al., 2014). In Ethiopia for example, only half (52%) of women had enough autonomy in the decision making of using MFPM especially if they were of a young age, actively participating in family-related decisions, and have both favorable perception and adequate knowledge about FP (Dadi et al., 2020). Another Ethiopian study showed that only less than half (42.2%) of husbands were involved in the decision of FP with women who previously used MFPM, received professional FP counseling, and have a high level of women's awareness to FP enhanced husbands' engagement in the decision making process of FP (Chekole et al., 2019). An Iranian study found that women's reproductive empowerment is influenced by employment status and husbands' educational level (Alishah et al., 2019).

In our study, women's socio-economic status and level of education were perceived to have different levels of autonomy in the decision-making process. In Pakistan, for example, older women with higher education level and higher socio-economic status reported higher empowerment regarding MFPM (Hameed et al., 2014). Another study conducted in Mozambique found that husbands' dominance in decisions regarding women's health care lessened with women living in rural areas, women having awareness and knowledge of MFPM, and having three or more children (Mboane and Bhatta, 2015).

Husbands' disagreement to use FP methods has been attributed to lack of awareness and misunderstanding about FP side effects as well as their predominance within the marital relationship (Kriel et al., 2019). Yet, availability of social support, appropriate family planning awareness, and shared responsibility were identified as factors that could enhance husbands' participation in FP decisions (Kriel et al., 2019). Women who reported shared FP decision making had higher levels of satisfaction compared with those who reported provider-driven decision (Dehlendorf et al., 2017). The use of digital/mobile technology in the provision of FP services could be one good user-centered approach to allow couples to see themselves as more empowered owners of their decisions rather than going with a provider-driven decision, as may be perceived by them. Improving men's knowledge can enhance their perception and attitude regarding FP (Vouking et al., 2014). Also, in Angola, couples' discussion about MFPM could improve husbands' approval to use them (Prata et al., 2017).

However, the attitude that "contraceptive use is a woman's issue" was common among service users. Moreover, concerns related to male partners' lack of understanding of and shared responsibilities in reproductive life were raised by women in most groups.

In Jordan, only 45.1% of husbands reported that their wives used MFPM, although the majority (93.5%) were aware of FP. In addition, almost all (93.3%) of men preferred a minimum of two years spacing period, two thirds (71.2%) agreed to start contraception soon after delivery, 90.2% preferred that FP decision should be shared by the couple (Mansour et al., 2016). However, similar to our findings, this Jordanian study found that FP use is significantly affected by men's level of education and previous use of contraception (Mansour et al., 2016).

4.2. Gender equity and FP decision-making process

Women in our study were perceived to be curious about how to properly use MFPM and their positive consequences, side effects, and complications. But most importantly, several midwives raised the point that women are usually worried about specific side effects of the methods such as nervousness, length of menstrual period, mood swings, and weight gain. Of these side effects, many are attributable to hormonal pills. This may account for the reason Syrian refugee and Jordanian service users rated the risk of pills nearly equally as risky as the IUD,

whereas IUD use is, in fact, riskier. Several midwives said that women sometimes are forced to discontinue using any method just to satisfy their husbands' preferences. All of these side effects reflect the husband's power dominance indirectly as women do not want their marital relationship to be threatened. It seems that unequal power is the most prominent in the FP decision making process (Nankinga et al., 2016).

Previous literature highlighted the need to focus on the issue of power balance as it is somehow connected with the use of MFPM (Grady et al., 2010). It has been found that contraception discontinuation is partly due to the method itself and switching among different types in an attempt to find a suitable one (Lessard et al., 2012) similar to the husband's preference as husbands' fear of MFPM side effects and misconceptions about these methods lead to discontinuation of using any method (Geleta, 2018). Again, level of education is an important factor in the degree of power dominance by the husband. For example, partners (husband or wife) with higher level of education, occupational status, and income, exert more power and control in the decision making process and choices regarding contraception use and preferred methods (Lachance-Grzela and Bouchard, 2010). Similarly, women with higher educational levels and power have more involved and responsible husbands in fertility choices and are more likely to use contraception methods compared to their less educated counterparts (Lachance-Grzela and Bouchard, 2010). Interaction and negotiation dynamics between husbands and wives are very important particularly when their level of education is similar (Lachance-Grzela and Bouchard, 2010).

Our findings highlighted the differences within Jordanian women with different backgrounds and place of residence and Syrian women in regard to socio-economic status, attitudes, power dominance, as well as knowledge of FP services. In particular, our findings of women with lower socio-economic backgrounds and Syrian women are similar to those documented in low income countries. In Ethiopia, for example, multiple femininity and masculinity practices were impediments for family planning (Geleta, 2018). The great power of decision-making of men on FP issues is due to several factors including perceiving children as social prestigious power due to cultural beliefs, lack of appreciation of wives' knowledge, low position of women, restricting the responsibility of wives to only household work, and the control of husbands on households (Geleta, 2018). Furthermore, our study found that Syrian refugee and Jordanian women included the emerging need to keep the extended family happy and the need to continue making the husband proud among his family and peers as barriers to FP decision-making. All of these factors lead to limitations of the role of wives on family planning decision-making to only accepting her husband's preference (Geleta, 2018).

Given the dominant role of husbands in the process of FP decision-making, it is of paramount importance to develop equitable gender dynamics for FP interventions that actively include men in order to promote contraception use within communities, especially disadvantaged ones (Truong et al., 2020). This is particularly important given the lack of women empowerment interventions aimed at improving FP and maternal health that engaged men in both health and household matters to support women (Nasreen et al., 2012).

In order to understand gender power relations that directly influence maternal health care access and utilization, one must investigate how power is established and negotiated in regards to social norms, access to resources, and decision-making process (Morgan et al., 2017). Similarly, to be able to design appropriate interventions, we need to recognize this unequal power within the FP decision making process, and how it interconnects with gendered power relationships, as it helps in understanding men's attitudes towards being a father, and their perceptions of pregnant women's attitudes and behavior (Nankinga et al., 2016).

On one hand, evidence suggests that gender-integrated interventions can improve FP and maternal health outcomes (Muralidharan et al., 2015). A systematic review found that evaluations of gender-integrated FP and maternal health interventions lack a clear description of how gender influences FP and overall maternal health outcomes or even contain validated measures about gender (Mandal et al., 2017). Yet, there is a challenge in investigating the paths through which women's empowerment interventions lead to changes in FP and maternal health outcomes (Mandal et al., 2017).

A review of gender-integrated interventions in reproductive and maternal child health found that while gender inequities have a harmful influence on both maternal health and maternal health care access and utilization (Kraft et al., 2014), addressing social and structural factors within maternal and child health interventions, such as gender norms and inequalities, is beneficial for effective intervention outcomes. Thus, developing appropriate interventions that tackle the role of gender inequities and relations in maternal health access and utilization are urgently needed (Morgan et al., 2017) with a focus on facilitating behavioral change among husbands, ensuring gender and reproductive health rights, and empowering women with enhanced negotiation skills to use with their husbands (Adanikin et al., 2019).

Nonetheless, the findings of the current study highlighted the lack of FP counseling provision for husbands due to several reasons but most importantly the reluctance of either the husband or the midwife to engage in an open and thorough discussion about the use of MFPM due to cultural barriers and embarrassment from the midwife in some cases.

Interestingly, lack of adequate contraceptive knowledge was reported among the main factors responsible for men's opposition to FP methods (Adanikin et al., 2019). Fruitful discussion among husbands and wives, therefore, is vital as it helps in recognizing each other's attitude to FP, and make shared-decision regarding the use of contraception methods (Kamal and Islam, 2012). Women, therefore can be taught different bargaining strategies to adopt while communicating the reasons and justifications for using contraception to their husbands including persuasion skills and positive expression of feelings (Adanikin et al., 2019).

4.3. Gender based violence and FP

A few midwives in our study shared depressing stories about how some women are exposed to violence from their husbands because they took the decision to use certain MFPM to avoid pregnancy without the knowledge of husband, who is against using any FP methods at all. According to participating midwives, the told stories happened with women with low socio-economic status, low educational level, and less empowerment.

Available literature, especially from low income countries, reported similar findings where women tend to get exposed to physical and sexual violence by a partner who consequently has control over reproduction decisions and choice, resulting in unwanted pregnancy (Miller et al., 2010).

In Sudan, for example, the use of FP increased in a covert manner among young women who decided to use FP methods themselves while facing resistance from their husbands (Kane et al., 2016). Also, a correlation was found between sexual marital violence and the use of MFPM, with more violence among women using contraception pills than those using condoms (Raj et al., 2015). This could be explained by the side effects attributed to hormonal pills such as mood swings and nervousness, leading to husband's agitation, as perceived by the midwives in our study. To confirm this, a Jordanian study reported that the level of quality of life among women who used the intrauterine device and those who their husband used condoms was better in all domains as compared to those who used oral contraceptives (Alyahya et al., 2019).

Another case-controlled study showed that inter partner violence was reported by almost a third (29%) of women seeking to terminate pregnancy and a quarter (22%) seeking contraceptive counselling (Öberg et al., 2014). In India, the level of education and awareness as well as

women empowerment could influence physical violence in regards to the use of contraception (Singh and Shukla, 2017). In Sweden, 27% of women with low educational level seeking FP services experienced sexual violence (Öberg et al., 2019). Conflicting with our findings, a meta-analysis found a negative relationship between the use of MFPM and inter partner violence with a reduction in the use of condoms among women experiencing violence (Maxwell et al., 2015). Not surprisingly, threatened marital relationships have been related to more contraception use reflecting less commitment from one partner (Grady et al., 2010).

4.4. Factors promoting the use of FP services

Almost all midwives in our study believed that physical and mental discomforts during pregnancy make the woman want to take care of her body and restore her health, which leads her to promote using FP services. Similar to our findings, previous literature included several factors that promote the use of FP services. While one major benefit of FP is to help couples limit the number of children within families, it also protects women's health and rights, conserves natural resources, and improve the economic status of families.

Other factors that promote and motivate FP use were the need for children spacing (94%) and sexual transmitted diseases prevention (84%) (Apanga and Adam, 2015). The use of MFPM was positively associated with working outside house, high educational level and income (Çalikoğlu et al., 2018). However, in developing countries, the role of husbands is again dominant when identifying the factors that promote the use of FP services. In Nigeria, the utilization of FP services largely depends on the approval of husband (84.4%), MFPM effectiveness (79%), cultural acceptance (75%), FP services access (75%) and awareness (63.5%) (Apanga and Adam, 2015). In Malaysia, women who discussed the use of MFPM with their partner were more likely to use them compared with those who did not (Najafi-Sharjabad et al., 2014). In the United Arab Emirates, women who had contraceptive awareness were found to be highly educated, with high income, and thus were able to influence their husband in the choice of MFPM (Abdulrahman et al., 2019). Finally, in Jordan, a recent study indicated that 74.8% of women reported the need for MFPM and it is largely dependent on husband's approval, awareness of FP, and distance from health center, and number of alive children (Komasawa et al., 2020).

4.5. Obstacles of FP counselling

The findings in this study showed that women with strong negative beliefs about contraception or who are firmly against particular methods were the least likely to seek family planning services and therefore will likely be the population that is hardest to reach. Similar barriers were reported in the literature including adverse effects and misconceptions about FP methods (Truong et al., 2020), incorrect perceptions regarding MFPM (Apanga and Adam, 2015), socioeconomic factors, lack of adequate knowledge, gender roles, and social pressure were barriers for use of MFPM (Gele, 2020), the long distance to reach healthcare facilities, unavailability of preferred MFPM, and unfavorable behaviors of the healthcare providers, bad previous experience of MFPM side effects, as well as negative traditional and religious beliefs (Silumbwe et al., 2018). A literature review found that while knowledge about FP is considered a key in contraception services, women in developing countries have the desire to use FP services but they do not use them due to lack of recourses (Sultan, 2018).

In Lebanon, Syrian refugees marry early due to financial constraints and uncertainty, thus Syrian women reported that cost was the main factor that interfere with contraception use, whereas some of them did not know that the cost of sexual and reproductive services is provided for free (Cherri et al., 2017). In Saudi Arabia, 32.6% reported unmet needs, especially women with low educational level such as accessibility for MFPM (68%), lack of knowledge (59.5%), religious beliefs (49.6%), fear of side effects, and husband refusal (Khalil et al., 2018).

Although the majority of the midwives in our study mentioned that they are well-trained to provide effective and comprehensive FP counseling, women's perception towards the effectiveness of the counseling session may differ from those of midwives. Previous literature identified some concerns from women about the FP services provided. An Indian study found that less than half (43%) of the nurses have adequate knowledge about several MFPM, a quarter (22%) of medical trainees and nurses believed that MFPM should not be provided to women who come to the clinic alone, two thirds (69.5%) of nurses refused to demonstrate intrauterine contraceptive device insertion on a doll uterus, and 18.3% of nurses who accepted to demonstrate had failed (Gupta et al., 2019). In addition, unfavorable behaviors of the healthcare providers were among the constraints that face women who plan to use MFPM (Silumbwe et al., 2018).

When asked about FP counseling sessions, women reported that only 28.2% were appropriate, 58.9% did not provide privacy to women, 69% did not ask about women's worries in using MFPM, 74.2% did not provide counseling about possible side effects (Abdulreshid and Dadi, 2020). Yet, women with low educational level tend to report inappropriate FP counseling compared to those with higher level of education (Abdulreshid and Dadi, 2020). A literature review in Nepal found that the use of MFPM among adolescents was low and that inadequate friendly services, as well as lack of competency of healthcare providers to deal with adolescents were perceived to be reasons for low use of MFPM among adolescent women (Subedi et al., 2018). In Jordan, only 42.9% of FP counseling sessions were perceived appropriate especially those provided in the Jordanian Association for Family Planning and Protection (JAFPP) clinics as compared to the governmental clinics (Okour et al., 2017). Therefore, several implications and recommendations can arise from the findings. First, continuous efforts to strengthen healthcare system are needed to guarantee that hospitals and maternal and child healthcare clinics have enough resources and supplies to meet women's maternal health care needs, thus promoting access and utilization of free services (Morgan et al., 2017). Second, as women gain further knowledge, they need to be empowered to initiate productive discussion with their husbands as it helps in recognizing each other's opinion towards FP and in making shared decisions regarding the use of MFPM. Third, midwives and other healthcare providers can teach women to use several negotiation and bargaining strategies while communicating the reasons and justifications for using contraception to their husbands; this includes persuasion skills and positive expression of feelings. Finally, given the wide acceptance and enthusiasm among midwives and varied acceptance among Syrian refugee and Jordanian service users about the potential use of digital/mobile technology in FP services, mobile and digital technology can be developed in conjunction with the available FP services provided at medical health centers in Jordan to overcome some of the barriers and obstacles of using MFPM. It also may improve shared decision-making process among Syrian and Jordanian couples.

The findings of this study could be transferable to other similar settings, but they are confined with some limitations and cannot be generalized. Social desirability bias is a potential limitation in this study. The participants might have provided answers that they perceived the female interviewer wanted to hear. To avoid this potential problem, we employed triangulation of the informants which confirmed the findings from Jordanian and Syrian women and midwives. This contributed to the trustworthiness of this research. Another limitation is that the topic of verbal and physical violence against women is a very personal and sensitive issue. The authors thought that having them in a group may encourage them to talk about their struggles in this regard. Nonetheless, in most cases, women usually come to the health centre with their female friends, neighbors or sometimes a female relative who most likely have an idea of the nature of the women's relationship with their husbands. It's because women in Jordan tend to talk about these issues with someone who they trust. However, in the future there is a need to ask similar questions about women experience with violence and lack of power in taking a decision using a de-identified survey to ensure a more reliable

and credible data. Finally, conducing only four focus groups with women might not be an optimal number, however, we reached data saturation.

5. Conclusion

This study revealed several relevant issues that play a role in Jordanian and Syrian women's decision to seek FP services. While cultural and social norms related to family planning and decision making continue to exert pressure on women, they have a deep interest in continuing to broaden their knowledge about family planning services, different methods of modern contraception, and obtaining access to a broader range of general and specialized family planning services.

Declarations

Author contribution statement

Nihaya A. Al-Sheyab: Performed the experiments; Analyzed and interpreted the data; Wrote the paper.

Mohannad Al Nsour: Conceived and designed the experiments; Wrote the paper.

Yousef S. Khader: Conceived and designed the experiments; Contributed reagents, materials, analysis tools or data; Wrote the paper.

Hind Yousif: Performed the experiments; Analyzed and interpreted the data; Wrote the paper.

Mohammad S. Alyahya, Hana Taha, Mirwais Amiri: Contributed reagents, materials, analysis tools or data; Wrote the paper.

Marco Bardus: Conceived and designed the experiments; Contributed reagents, materials, analysis tools or data; Analyzed and interpreted the data; Wrote the paper.

Malika Al Kattan: Contributed reagents, materials, analysis tools or data; Analyzed and interpreted the data; Wrote the paper.

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Data availability statement

Data will be made available on request.

Declaration of interests statement

The authors declare no conflict of interest.

Additional information

No additional information is available for this paper.

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