WOMEN'S REFUGEE COMMISSION

Reproductive Health in Jordan: Follow-Up Report
November 2009

BACKGROUND:

The crisis in Iraq has produced one of the world's largest current displacements of people, uprooting millions.[1] To date as many as 161,000 to 500,000 refugees are living in Jordan today.[2] Of those living in Jordan, 46,500 are now registered with the United Nations High Commissioner for Refugees (UNHCR).[3] The Women's Refugee Commission undertook a field mission to Jordan in June 2007 to increase international awareness of the reproductive health (RH) needs of women and youth in the Iraqi crisis; highlight the RH needs of conflict-affected women and youth globally; identify broader Iraqi protection needs where possible to bring to the attention of policy-makers, donors, humanitarian actors and others; and, identify local community activists and leaders as key contacts for engagement. A follow-up mission was also conducted in October 2008 to explore whether the recommendations set forth in the 2007 assessment report were implemented.

The Women's Refugee Commission conducted the third in a series of RH missions to Jordan in November 2009 to determine whether the recommendations set forth in the 2008 follow-up report were implemented, to identify remaining gaps in RH programming and to continue advocacy for the implementation of the priority RH services established in the Minimum Initial Services Package (MISP), a standard of care in humanitarian assistance, and comprehensive RH services for Iraqi refugee men, women and youth. The team met with 26 representatives from 12 UN, international and local agencies.

Overall, important gains have been made in expanding the protection space of Iraqi refugees in Jordan. Fewer Iraqis are being arrested and detained for immigration violations,[4] Iraqis now have access to public schools,[5] and roughly half of Iraqis are engaged in work in the informal sector despite legal restrictions on employment without a residency or work permit.[6] In addition, the Jordanian Ministry of Health has improved the availability of primary health care, including key RH and social services, by making these services free to Iraqi refugees.[7] However, as the conflict in Iraq continues, international funding support to Jordan and other countries hosting Iraqi refugees is expected to decline.[8]

In 2010, UNHCR expects to scale down funding to its operational partners.[9] As UNHCR funding to the Jordanian Government supports Iraqis' access to public health and social services,[10] it is unclear to what

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[1] Iraqi resettlement update. Briefing Notes. UNHCR. 16 October 2009. http://www.unhcr.org/4ad84e7c9.html. Accessed January 22, 2010.
[2] UNICEF Humanitarian Action: Iraq. *Vulnerable Iraqis in Jordan, Syrian Arab Republic, Lebanon and Egypt in 2009*. UNICEF. http://www.unicef.org/har09/files/har09_Iraq_countrychapter.pdf Accessed January 22, 2010.
[3] 2010 UNHCR Country operations profile: Jordan. http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e486566. Accessed January 22, 2010.
[4] Crisp, J. et al. *Surviving in the City: A Review of UNHCR's Operation for Iraqi Refugees in Urban Areas of Jordan, Lebanon and Syria*. UNHCR. July 2009.
[5] Jordan: Iraqi refugee children start school. Briefing Notes. UNHCR . 21 August 2007. http://www.unhcr.org/46cab8284.html . Accessed January 22, 2010.
[6] UNHCR Jordan. Iraqis in Jordan: Assessment of Livelihoods and Strategy for Livelihoods Promotion. July 2, 2009.
[7] *UNHCR grants US$11 million to boost health services in Jordan*. News Stories. UNHCR. November 19, 2007. http://www.unhcr.org/4741af032.html Accessed January 22, 2010.
[8] Women's Refugee Commission interview with Muna Idris, Assistant Representative, UNFPA. Amman, Jordan. Saturday November 7, 2009
[9] Women's Refugee Commission interview with Noel Calhoun, UNHCR 'Senior Community Services Officer, Amman, Jordan Monday November 9, 2009
[10] Women's Refugee Commission interview with Noel Calhoun, UNHCR 'Senior Community Services Officer, Amman, Jordan Monday November 9, 2009

extent Iraqis will have access to them in 2010 and beyond. While the majority (about sixty percent) of Iraqis use health services from the private sector,[11] poorer members of the community will suffer from decreased funding. The Ministry of Health will not be able to absorb the costs of serving the Iraqi population alone.[12]

According to a survey UNHCR conducted in 2009, the majority of Iraqis have "no plans to return to their country in the foreseeable future."[13] As instability continues in Iraq and resettlement numbers remain low[14], Iraqis will most likely stay in Jordan for the next few years, if not longer. In light of expected funding cuts for Iraqis, this could prove detrimental to the progress gained in RH services over the past two years and could prevent the implementation of critical services, including remaining service gaps, specifically, delivery care, management of OBGYN complications, and clinical care for survivors of sexual assault.

The following is an update of developments and existing challenges based on components of the MISP and comprehensive RH. The purpose of the 2009 site visit was to follow-up on specific recommendations with key service providers and policy makers and did not involve an RH assessment. Therefore the updates below do not provide a complete picture, but a summary of developments in RH activities, policies and services for Iraqi refugees as reported by agencies with whom the team met.

Summary

The table reflects attention to specific areas of RH programming measured against global guidelines and standards[15] for RH as noted by the Women's Refugee Commission since 2007. Explanation of the symbols used in the table follows.

Select RH Issues	2007	2008	2009
1. RH Coordination	■	●	★
2. Prevention of sexual violence and care for survivors	■	●	●
3. Maternal and Newborn Health Services	■	▲	▲
4. Preventing HIV transmission	NA	NA	NA

[11] Johns Hopkins Bloomberg School of Public Health, UNICEF and WHO. The Health Status of the Iraqi Population in Jordan. May 2009. Pg.13

[12] Women's Refugee Commission interview with Dr. Iman Shehadeh and Dr. Ruawaida Rashid, Jordanian Ministry of Health, Amman, Jordan Monday November 9, 2009.

[13] 2010 UNHCR Country operations profile: Jordan. http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e486566 . Accessed January 22, 2010

[14] Human Rights Action and Human Rights Institute, Georgetown Law. *Refugee in Crisis in America: Iraqis and Their Resettlement Experience*. October 2009.

[15] Global guidelines and standards include:

- *WHO/UNHCR/UNFPA Reproductive Health in refugee situations: An Inter Agency Field Manual.* Inter Agency Working Group on Reproductive Health in Crises. 1999 http://www.iawg.net/resources/field_manual.html
- *WHO/UNFPA/UNHCR Reproductive Health in Humanitarian settings: An Inter Agency Field Manual. (INCOMPLETE DRAFT)* Inter Agency Working Group on Reproductive Health in Crises, 2010 http://www.iawg.net/IAFM_2009_DRAFT_21Jan2010.pdf
- *Sphere Humanitarian Charter and Minimum Standards in Disaster Response.* The Sphere Project, 2004. *http://www.sphereproject.org/component/option,com_docman/task,cat_view/gid,17/Itemid,26/lang,english/*
- *Health Cluster Guide: A Practical Guide for Country-Level Implementation of the Health Cluster* Inter Agency Standing Committee Global Health Cluster, WHO, 2009. http://www.who.int/hac/global_health_cluster/guide/en/index.html

5. Planning for and/or providing comprehensive RH services.	■	●	↑
6. Domestic Violence	■	↑	↑
7. Family Planning	NA	NA	↑
8. Sexually Transmitted Infections	DK	DK	DK

Attention is based on RH activities, policies and/or services against established international guidelines and standards for RH in crises settings within the country context. It does not reflect funding or access to services by displaced persons as that was not assessed. The table is designed to provide a quick picture of what services the Women's Refugee Commission learned that the MOH, humanitarian workers and others are currently providing or not.

■ Denotes insufficient attention to the issue as compared to international standards at baseline.

● Denotes sustained good practice

● Denotes no noted change in practice

NA Denotes "Not Assessed"

↓ Indicates negative or inadequate attention

↑ Indicates positive or enhanced attention

★ Reflects an international standard has been met

1. Reproductive Health Coordination

2008 Recommendation:
Donors should fund UNFPA through the Iraq Consolidated Appeal (CAP) to build its capacity to coordinate reproductive health services in Jordan. UNFPA should identify a reproductive health program officer to liaise within the health sector, with other sectors and the Ministry of Health (MOH). In addition, UNFPA should continue to work with the MOH to ensure a multi-sectoral response and provide guidance to the MOH to develop standardized policies that support the MISP and comprehensive reproductive health.

1.1 Reproductive Health Coordination has commenced:

UNFPA received funding from Australian Government to coordinate RH service providers serving the Iraqi community in Jordan. A key objective of UNFPA 's coordination work is to increase accessibility and

demand for to RH services provided free of charge by the Ministry of Health by building the capacity of the health workers and raising Iraqi's awareness about RH issues through NGO outreach programs.[16] UNFPA chairs the Reproductive Health Sub Working Group and coordinates the efforts of members to meet these shared objectives. Members of the Reproductive Health Sub-working Group include the Institute for Family Health, International Relief and Development, UNHCR, UNFPA, the Jordanian MOH, the World Health Organization (WHO), the Jordanian Higher Population Council, and the International Medical Corps.[17] The group meets on a monthly basis and routinely reports to the larger health sector coordination group which coordinates the provision of general health services to Iraqis. The RH coordination sub-working group is working on identifying gaps in RH programs currently implemented in the country and addressing these gaps by raising awareness on RH and available services, doing necessary advocacy, capacity building of MOH and other RH service providers as well as establishing an information repository on RH.

Recommendation:

The RH sub-working group should continue its laudable coordination efforts. Members should jointly ensure RH needs are fully reflected in funding appeals and that the funding levels requested are commensurate with the need and advocate to donors for continued funding.

For more information on the RH sub-working group, contact the chair of the RH sub-working group, Muna Idris, Assistant Representative, UNFPA
at: **Idris@unfpa.org**

[16] Women's Refugee Commission interview with Muna Idris, Assistant Representative, UNFPA. Amman, Jordan. Saturday November 7, 2009
[17] Women's Refugee Commission interview with Muna Idris, Assistant Representative, UNFPA. Amman, Jordan. Saturday November 7, 2009

2. Prevention of and Care for Survivors of Sexual Violence

2008 Recommendation:

- Prevention:
  Recognizing that Iraqi women will work regardless of legal status as a means for survival, the Government of Jordan should grant Iraqis temporary legal status that would provide, at a minimum, renewable residence and work permits to minimize the risk of sexual exploitation and abuse. UNHCR and partnering NGOs should develop livelihoods programs for refugee women that promote safe work women can do from home or in other locations of their choice, which would help alleviate the widespread fear of arrest and harassment. All UN, international and national staff working with the displaced population should be oriented to a Code of Conduct against sexual exploitation and abuse. Awareness-raising on domestic violence among Iraqis should also address sexual violence within families.

- Response:
  Short-term - Women and girls should be referred from the start to an adequately equipped medical facility to receive clinical care after rape. They could be referred to the Noor Al Hussein Foundation/ Institute of Family Health, which has been successful in establishing culturally sensitive programs. The Institute should be supported to provide these services as well as provided with rape kits. At the same time, the reproductive health coordination sub- working group can develop a plan to start training health providers in the clinical care of survivors of sexual assault. The International Rescue Committee's (IRC) recently developed multi-media training tool is a useful resource. The WHO also developed a useful interactive tool for use online. In addition, all health providers should be informed about the availability of these services and requested to refer women presenting with signs of sexual assault to the designated facility. UNHCR should inform all agencies and the refugee community of where to report incidences of sexual violence and access available services. UNHCR should include this information in their booklet that is distributed to refugees. The established hotline should have a referral process in place to refer rape survivors to receive appropriate medical and psychosocial care.
  Long term – UNFPA, UNICEF and WHO should continue to work with the MOH to develop national protocols on medical response to sexual violence. Once national guidelines are finalized, they should be rolled out to build the capacity of UN, national and international NGO staff working in the direct provision of health services to provide comprehensive clinical care, including post-exposure prophylaxis, emergency contraception, prophylactic antibiotics and other care as needed, to women and girls surviving rape. This rollout should be closely monitored and supervised with regard to both the competency and the professionalism of providers and the availability of appropriate drugs and supplies. All medicines in the post-rape treatment protocol, including post-exposure prophylaxis, should be available for women and girls surviving rape.

Care for Survivors of Sexual Violence

2.1 UNHCR developed Standard Operating Procedures for Prevention and Response to SGBV:[18]

UNHCR's Standard Operating Procedures (SOPs) for Jordan include comprehensive protocols for the reporting, referral and case management of gender-based violence survivors. The SOPs clearly outline UNHCR's responsibilities for the prevention and response of sexual and gender-based violence (SGBV). They also outline coordination mechanisms for its SGBV partners at the local and national levels. Finally

[18] See UNHCR Standard Operating Procedures for Prevention of and Response to SGBV, Amman, Jordan UNHCR. May 6, 2009.

the SOPs include indicators for monitoring and evaluating service delivery among partners. While the protocols are comprehensive, they are not fully implemented by UNHCR or its partners. Monthly SGBV meetings are being held to enhance the cooperation, facilitate referrals and address gaps in implementation.

2.2 Survivors of sexual violence still do not receive appropriate clinical care due to a lack of a national MOH policy framework for survivors of sexual violence; a lack of health provider training on clinical care for survivors of sexual violence; and confidentiality concerns.

Jordan does not yet have a comprehensive national MOH policy framework in place for the care of survivors of sexual violence. As a result, there is no structure in place to dictate how to respond appropriately to survivors when they come forward. Sexual violence is not believed to occur at the same magnitude when compared to the prevalence of DV on a large scale, particularly in relation to domestic violence. However, when survivors—whether a Jordanian national or an Iraqi—come forward, they do not receive the clinical care they need, particularly with regard to preventing unwanted pregnancy and HIV. In the absence of national protocols and procedures, the UNHCR SOPs are very difficult to successfully implement. For example, the SOPs state that medical treatment should be the priority for cases involving sexual violence, including access to emergency contraception (EC) and post exposure prophylaxis (PEP) to prevent the transmission of HIV. However, these dedicated products are not yet registered on the market in Jordan.[19]

The referral agencies listed in the UNHCR SOPs for medical treatment of survivors of SGBV do not have the capacity to provide clinical care for survivors. The primary medical referral agency listed in the UNHCR SOPs is the Family Protection Department (FPD). The FPD is a branch of law enforcement specifically trained to address family violence by implementing a holistic model combining law enforcement and social work. The FPD also includes a forensic clinic. The forensic clinic is equipped for physicians to conduct a forensic exam—or the collection of forensic evidence, from a survivor before referring her to a gynecologist at a public hospital for free follow-up medical care.[20] If a survivor does not report the assault within a time period considered by a forensic physician to be a priority or emergency case, the survivor will not be seen in a timely manner to be referred for appropriate clinical care.[21] According to the first female forensic physician in Jordan, although some gynecologists and other physicians may know to substitute a higher dosage of birth control for EC, it is unlikely that referrals for follow-up clinical care will consistently include this treatment. Regular access to dedicated products for EC and PEP will not be possible for survivors of sexual violence without an MOH policy in place.

If a woman presents at an MOH clinic, she will follow the same path. According to a MOH official, "…we can't really treat a victim of rape but instead refer cases of sexual violence to the police as part of a mandatory reporting policy.[22] Similarly, once referred to the Family Protection Department, she will be referred to the forensic clinic for treatment".[23]

The only known NGO in Amman which is (partially) equipped to treat survivors of sexual violence, is the Institute for Family Health (IFH). The IFH is currently funded by UNHCR only to provide psycho-social support services. One sign of progress is that UNFPA plans to pilot a dedicated EC product for family

[19] Women's Refugee Commission interview with Dr. Iman Shehadeh and Dr. Ruawaida Rashid, Jordanian Ministry of Health, Amman, Jordan Monday November 9, 2009
[20] Women's Refugee Commission interview with Dr. Isra, Forensic physician, Family Protection Unit. Amman, Jordan. Wednesday November 11, 2009.
[21] Women's Refugee Commission interview with Dr. Isra, Forensic physician, Family Protection Unit. Amman, Jordan. Wednesday November 11, 2009.
[22] Women's Refugee Commission interview with Dr. Iman Shehadeh and Dr. Ruawaida Rashid, Jordanian Ministry of Health, Amman, Jordan Monday November 9, 2009
[23] Women's Refugee Commission interview with Dr. Iman Shehadeh and Dr. Ruawaida Rashid, Jordanian Ministry of Health, Amman, Jordan Monday November 9, 2009

planning purposes in a select group of MOH clinics in the coming year. This could potentially lead to increasing the availability of a dedicated EC product for clinicians treating survivors of sexual violence.[24]

The MOH recently completed protocols for the care of women who are survivors of violence including referral information and recommended procedures for those who have experienced sexual violence. However these protocols do not contain explicit provisions for clinical treatment. As there is no national treatment protocol in place for responding to survivors of sexual violence, health care providers do not receive training on how to properly care for them. Physicians with whom the Women's Refugee Commission staff met showed a great deal of interest in establishing a "Training of Trainers" model on clinical care for rape survivors, particularly by a leading forensic physician who is often referred cases of sexual assault. She expressed frustration that most physicians in Jordan and other health providers in emergency rooms were neither sufficiently trained nor equipped to give survivors the care they need. **"We need rape kits and training on how to use them properly."**[25] The physician expressed enthusiasm for leading an initiative to receive training and to undertake "training of trainers" sessions with other forensic physicians. The International Rescue Committee recently developed a proposal together with a number of partners, including the National Center for Forensic Medicine, to train public and private health care providers on clinical care for the survivors of sexual violence.

Despite growing outreach about services for survivors of domestic violence, sexual violence reporting is very low. In a society where honor killings still take place, sexual violence remains a very sensitive topic for Iraqis and Jordanian's alike. Concerns over confidentiality remain an obstacle to women coming forward because women are at risk of further violence, shame and isolation. Key stakeholders interviewed expressed concern over the mandatory reporting policy, stating that women are afraid to make reports as they know they will have to report the incident to the police. While some said that confidence in the FPD is slowly growing, others reported that due to the demands on their time they cannot always effectively protect women—the consequences of which could be grave. Practitioners want more guidance as to when to report a case and how to still protect a woman's confidentiality. The Women's Refugee Commission was unable to determine if once an incident was reported to the FPD or police, the survivor is required to pursue legal justice or has a choice to refuse, thus maintaining confidentiality between the survivor and health care provider.

Prevention of domestic violence and treatment for survivors

2.3 There has been an increase in attention and programming and the psychological care of survivors of gender based violence, particularly domestic violence.

Domestic violence is at the forefront of the GBV agenda in Amman. Those interviewed by the Women's Refugee Commission shared an understanding that domestic violence is common within the Iraqi community in Amman and within Jordan as a whole. The Jordanian royal family has made family violence a priority issue and has generated much publicity around combating this issue.[26] The majority of GBV survivors the Family Protection Department sees are due to domestic violence.[27] There are far fewer cases of sexual violence.[28] The FPD can intervene in cases of domestic violence by offering family mediation, referring survivors for counseling or medical care, sending women who need safe shelter to the government-funded Dar Al Wifaq shelter (Ministry of Social Development), or pursuing legal justice by

[24] Women's Refugee Commission interview with Dr. Iman Shehadeh and Dr. Ruawaida Rashid, Jordanian Ministry of Health, Amman, Jordan Monday November 9, 2009

[25] Women's Refugee Commission interview with Dr. Isra, Forensic physician, Family Protection Unit. Amman, Jordan. Wednesday November 11, 2009.

[26] Women's Refugee Commission interview with Guilia Ricciarellie-Ranawat, UNHCR Senior Protection Officer, Amman, Jordan. Sunday November 8, 2009.

[27] Women's Refugee Commission interview with Mohammed A. Al Zu'bi Director of the Family Protection Unit. Tuesday, November 10, 2009.

[28] Women's Refugee Commission interview with Mohammed A. Al Zu'bi Director of the Family Protection Unit. Tuesday, November 10, 2009.

bringing abusers to court.[29] UNHCR partners with the FPD which is conducting an awareness and media campaign about their role in Jordan, including for the Iraqi population. At the same time, UNHCR has a referral agreement with Dar Al Wifaq shelter where survivors are provided protection, legal and psycho-social support. While technically workers are required by law to report survivors who present at the Dar Al Wifaq to the police, it is understood that in certain instances they accept cases who don't want to report the incident to the police, the FPU, or to pursue legal action. A doctor visits the clinic twice weekly and would refer survivors of sexual violence in need of clinical care to the forensic clinic at the FPD.

The MOH has also established family protection committees in select comprehensive health centers and hospitals. The family protection committee comprises the director of the center/hospital, a pediatrician, gynecologist, family health doctor, and a committee coordinator (nurse or midwife). The committees were established in order to address cases of domestic violence identified when presenting for medical care. The committee is charged with: responding within twenty four hours to high risk cases of domestic violence identified; assess all confirmed or suspected cases referred to them by health workers; prepare a follow up and safety plan for cases identified; consolidate referred cases and prepare monthly reports; and provide legal counseling as needed.

The Institute of Family Health (IFH) is UNHCR's primary referral center for the psychological care of survivors of GBV. The IFH operates a trauma center where psychological and clinical services, if needed, are provided to patients in one setting.[30] IFH also provides counseling to women residing in the Dar Al Wifaq shelter. In addition, they are also equipped to provide specialized services for survivors of torture.[31] In conjunction with UNFPA, the IFH plans to train volunteers to conduct outreach on these services within the Iraqi community and refer survivors to the center for treatment.[32] IFH will also train physicians and clinic/hospital staff to screen for GBV and provide treatment or referral in 70 hospitals throughout Jordan. In addition to the Family Health Institute, the Women's Refugee Commission met with three additional agencies providing psychological care for Iraqi survivors of domestic violence. One practitioner expressed satisfaction in the community's growing capacity to respond to GBV: "we use these words [GBV] now that were not part of our vocabulary two years ago".

Recommendations:

A national policy on clinical care for survivors of sexual violence should be established.

Training by the MOH for healthcare providers on clinical care for survivors should be continued and strengthened.

Clinical care including the provision of EC and PEP should be available to all survivors of sexual violence. Forensics teams, emergency room clinicians and gynecologists, and NGO service providers should be extensively trained on proper use of rape kits and given sufficient supplies to meet the need. The international community should assist in a training of trainers for forensic doctors utilizing new training materials for survivors of sexual violence. Agencies that provide appropriate clinical care for survivors of sexual violence must be the primary referral organizations.

Community-based awareness raising, targeting both Jordanian nationals and Iraqi refugees, on benefits to clinical care must be implemented once services are in place. Iraqi and Jordanian women should have access to information on the benefits of clinical care and where to access it. This

[29] Women's Refugee Commission interview with Mohammed A. Al Zu'bi Director of the Family Protection Unit. Tuesday, November 10, 2009.
[30] Women's Refugee Commission interview with Dr. Manal Tahtamouni, Director, Noor Al Hussein Foundation Institute for Family Health. Monday, November 9, 2009.
[31] Women's Refugee Commission interview with Dr. Manal Tahtamouni, Director, Noor Al Hussein Foundation Institute for Family Health. Monday, November 9, 2009.
[32] Women's Refugee Commission interview with Dr. Manal Tahtamouni, Director, Noor Al Hussein Foundation Institute for Family Health. Monday, November 9, 2009.

information should be included in SGBV leaflets distributed by UNHCR to all persons of concern. These messages should be reinforced in all community outreach and awareness raising campaigns around RH.

Reporting should not deter women from seeking care. A woman must be able to report a sexual assault confidentially and receive life saving clinical care without fear. Confidential police reporting and clinical care must be made available to women who do not want to pursue legal action.

Recognizing the time it takes to build the capacity of Jordanian national health systems to provide clinical care for survivors of sexual violence, some funding should be retained for NGOs that currently have the capacity to provide clinical care to survivors.

More outreach should be done to involve men in the community to address the issue of gender based violence.

Additional training on models of care, best practices and psychological care for survivors of domestic violence should be available for practitioners.

3. Maternal and Newborn Health Services

2008 Recommendations:

- A cost-sharing program could be established to support free delivery services, including Emergency Obstetric and Newborn Care (EmONC), for poor Iraqis and Jordanians. The current gender-based violence hotline can be expanded to include information on where to receive free, anonymous delivery and EmONC services. This information can be included in the UNHCR booklet that is distributed to Iraqis.

3.1 Hospital deliveries, including emergency obstetric care (EmOC), are now available for Iraqi women free of charge at select hospitals in the region:
Refugees who are registered with UNHCR can access free delivery at any government hospital and the following Caritas affiliate hospitals:

- Amman: Italian Hospital, Al Basheer Hospital
- Zarqa: Qasr Shabeeb Hospital, Zarqa Government Hospital
- Irbid: Rosary Missionary Sisters Hospital, Princess Basma, Princess Badea Hospital

Emergency obstetric care is provided free of charge up to a cost to UNHCR of 1,500 JD per person/per year (about 2,110 USD).[33] Care is covered for both registered and non-registered refugees at these facilities.[34] Women who choose to deliver in other public health facilities can do so but must pay for services at the rate of an uninsured Jordanian.

Despite this, most Iraqi women choose to deliver in private facilities at increased expense. Of the 94 percent of Iraqi women who have delivered in a health facility since arriving in Amman,[35] 68 percent delivered in a private facility at increased expense while 23 percent gave birth in a public facility and 6.3 percent in an NGO facility. [36] The median expenditure for a delivery in a private facility is about 200 JD

[33] Women's Refugee Commission interview with Dr. Sameh Youssef, UNHCR Senior Public Health Officer , Amman, Jordan Wednesday November 11, 2009
[34] Women's Refugee Commission interview with Dr. Sameh Youssef, UNHCR Senior Public Health Officer , Amman, Jordan Wednesday November 11, 2009
[35] Johns Hopkins Bloomberg School of Public Health, UNICEF and WHO. The Health Status of the Iraqi Population in Jordan. May 2009. Pg.13
[36] Johns Hopkins Bloomberg School of Public Health, UNICEF and WHO. The Health Status of the Iraqi Population in Jordan. May 2009. Pg.13

(about 284 USD); at a public facility 89 JD (about 125 USD); and at an NGO facility, the median expenditure is 0 JDs.[37] EmOC and any other additional services rendered would increase this fee. According to several sources, Iraqis seek care in private facilities because they perceive public facilities to be of lesser quality. Complaints expressed have included a lack of specialists, poorer conditions than those in private sector, and long waiting periods for treatment.[38]

3.2 For unregistered, poor Iraqi women, access to delivery and EmOC services can still be challenging.

Although 94 percent of births among Iraqi refugees occur in health facilities,[39] poor and unregistered Iraqi women still face obstacles accessing delivery and EmOC. Delivering in a health facility without the assistance of UNHCR, particularly when EmOC is needed, can be very expensive for women with limited economic resources. Even within a MOH facility, the average expenditure for a delivery is approximately 89 JD (25 USD) which would be difficult for those with limited resources. Emergency transportation to the hospital, particularly in an ambulance, is a further expense.

3.3 Post natal care services are underutilized.

According to the recent Johns Hopkins Bloomberg School of Public Health study commissioned by WHO and UNICEF, while 90 percent of Iraqi women sought antenatal care, less than half of women sought post-natal care.[40] One physician explained, "…Iraqis rarely get the complete spectrum of services from pre-natal to delivery to post-natal care in one facility…they may come here for pre-natal care but then have to go to Caritas for delivery and don't come back here for post natal care".[41] Another factor impacting this statistic may be cost. The Johns Hopkins study found thirty-three percent of women interviewed cited cost as the primary reason why they did not seek post-natal care. Ante- and post-natal care is now offered free of charge at MOH facilities, potentially increasing women's access to this care.[42] The Institute for Family Health integrated post-natal care for mothers into newborn care services packages in an effort to address this gap.[43]

Recommendation:

More research should be done to learn if unregistered and poor Iraqi women are accessing free maternal health services as needed. Barriers to accessing free services should be identified and addressed.

Iraqi women should have access to information on the benefits of post-natal care and where to access it. This information should be included in the RH services booklet to be distributed by the RH coordination group. These messages should be reinforced in all community outreach and awareness raising campaigns around RH.

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[37] Johns Hopkins Bloomberg School of Public Health, UNICEF and WHO. The Health Status of the Iraqi Population in Jordan. May 2009. Pg.24

[38] Women's Refugee Commission interview with Dr. Nada Al Ward, Sub-regional EHA coordinator, WHO, Amman, Jordan. Tuesday November 11, 2009.

[39] Johns Hopkins Bloomberg School of Public Health, UNICEF and WHO. The Health Status of the Iraqi Population in Jordan, May 2009.

[40] Johns Hopkins Bloomberg School of Public Health, UNICEF and WHO. The Health Status of the Iraqi Population in Jordan. May 2009. Pg.13

[41] Women's Refugee Commission interview with Dr. Manal Tahtamouni, Director, Noor Al Hussein Foundation Institute for Family Health. Monday, November 9, 2009

[42] Women's Refugee Commission interview with Dr. Iman Shehadeh and Dr. Ruawaida Rashid, Jordanian Ministry of Health, Amman, Jordan Monday November 9, 2009

[43] Women's Refugee Commission interview with Dr. Manal Tahtamouni, Director, Noor Al Hussein Foundation Institute for Family Health. Monday, November 9, 2009

4. Preventing HIV Transmission

2008 Recommendations:
All agencies should make male and female condoms available to humanitarian staff and refugees. Condoms can be made available at UNHCR registration, community centers, health facilities and mobile clinics, among other places. WHO should work with the MOH to include post-exposure prophylaxis PEP on their list of essential medicines, ensuring health workers are trained on how to administer it for occupational and non-occupational exposure. Information about HIV prevention could be included in the UNHCR booklet.

4.1 Awareness about post exposure prophylaxis (PEP) has increased.

Health care providers with whom the Women's Refugee Commission met consistently referred to post exposure prophylaxis, or PEP. While this product is not yet available in Jordan, health care providers expressed an interest in training on how to use PEP and when. One physician noted, "we don't have PEP here. I am a gynecologist. I am prone to a lot of needle pricks. It should be available to doctors as well".[44] While awareness about PEP has increased, health care providers reported low HIV prevalence in Jordan. According to UNFPA, there has only been one documented case of mother-to-child transmission.[45] Transmission of HIV is primarily through sexual intercourse.[46]

4.2 Condoms are now available free of charge in the MOH clinics.

Increased condom availability could potentially increase condom use as practitioners report that condom use is still not a preferred method among Iraqis.[47] Female condoms are still not available.

4.3 Refugees found to be HIV positive can be deported under Jordanian Law.[48]

The Women's Refugee Commission did not hear of any cases in which an HIV positive refugee was deported. However, this policy presents a deterrent to HIV testing and treatment.

4.4 PEP should be made available to treat for possible occupational and non-occupational exposure to HIV.

Recommendation:

Consistent with international human rights law and the basic principles of non-discrimination and equality, the law requiring immediate deportation for HIV positive asylum seekers and refugees should be repealed.

Community based awareness raising, targeting both Jordanian nationals and Iraqi refugees, on the benefits of condom use should be conducted.

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[44] Women's Refugee Commission interview with Dr. Manal Tahtamouni, Director, Noor Al Hussein Foundation Institute for Family Health. Monday, November 9, 2009

[45] Women's Refugee Commission interview with Muna Idris, Assistant Representative, UNFPA. Amman, Jordan. Saturday November 7, 2009

[46] Women's Refugee Commission interview with Muna Idris, Assistant Representative, UNFPA. Amman, Jordan. Saturday November 7, 2009

[47] Women's Refugee Commission interview with Dr. Manal Tahtamouni, Director, Noor Al Hussein Foundation Institute for Family Health. Monday, November 9, 2009

[48] UNHCR Standard Operating Procedures for Prevention of and Response to SGBV, Amman, Jordan UNHCR. May 6, 2009

5. Planning/providing comprehensive RH services

2008 Recommendations:
All agencies working in the health and community services sectors should plan for comprehensive reproductive health services with the involvement of refugee women, men and youth to include the prevention and management of sexually transmitted infections, family planning, maternal and newborn care and gender-based violence programming. The reproductive health focal point should collaborate with the health coordinator to assure that reproductive health data are collected in a standardized manner, collated, analyzed and shared at regular health/reproductive health coordination meetings to ensure coordinated planning and appropriate response. Innovative comprehensive reproductive health programming by the Family Health Institute should be referenced and modeled as appropriate. Donors should provide funding for comprehensive reproductive health care to both international and local agencies. Local implementing partners should be encouraged to participate in the health and reproductive health coordination meetings. All actors could participate in the Inter-agency Working Group on Reproductive Health in Crises (www.iawg.net), which recently established a regional network for the North Africa/North East region. (Contact Carol El Sayed for more information - ELSAYED@unhcr.org.)

5.1 RH services are now available to Iraqi refugees.

In 2008, UNHCR provided funding to the Jordanian government for public health services for Iraqis.[49] Iraqis are now able to access primary care from the Ministry of Health (MOH) clinics at the same rate as an uninsured Jordanian. However, as basic RH services including ante-natal care, post-natal care, family planning, child health and testing for sexually transmitted infections (STIs) are provided to all Jordanians regardless of insurance status, so too are RH services provided free to all Iraqis.[50] Seventeen MOH clinics currently provide this complete range of services.[51] This agreement does not provide for secondary and tertiary care.[52] Iraqis in need of secondary and tertiary care can appeal to Caritas, a Catholic relief agency, for assistance.

UNFPA received funding from the Australian Government to promote Iraqi refugees' use of the available RH services and, with the Jordanian government's approval, will build capacity in thirty nine MOH health centers in areas where Iraqis are concentrated.[53] This will entail providing medical supplies, contraceptives and assisting the MOH to update their information systems.[54] The Noor Al Hussein Foundation/ Institute of Family Health (IFH) remains the only known agency with the capacity to provide the full range of comprehensive RH care in one facility and will also be supported by UNFPA through the funding received from the Australian Government.

[49] Women's Refugee Commission interview with Noel Calhoun, UNHCR 'Senior Community Services Officer, Amman, Jordan Monday November 9, 2009
[50] Women's Refugee Commission interview with Dr. Iman Shehadeh and Dr. Ruawaida Rashid, Jordanian Ministry of Health, Amman, Jordan Monday November 9, 2009
[51] Women's Refugee Commission interview with Dr. Iman Shehadeh and Dr. Ruawaida Rashid, Jordanian Ministry of Health, Amman, Jordan Monday November 9, 2009

[53] Women's Refugee Commission interview with Muna Idris, Assistant Representative, UNFPA. Amman, Jordan. Saturday November 7, 2009
[54] Women's Refugee Commission interview with Muna Idris, Assistant Representative, UNFPA. Amman, Jordan. Saturday November 7, 2009

International Relief and Development trained Iraqi refugee volunteers to become Community Health Workers (CHWs).[55] The CHWs are trained to disseminate health information on topics such as STIs, family planning, early breast cancer detection and referrals for RH services.[56]

5.2 There is still an unmet need for family planning

Many practitioners with whom the Women's Refugee Commission met agreed that there is still an unmet need for family planning for both Jordanians and Iraqis. The 2009 John's Hopkins Bloomberg School of Public Health study commissioned by WHO and UNICEF found that of the 32 percent of (married) Iraqi women who had given birth in Jordan, more than half (58 percent) of pregnancies were unplanned. The study shows the contraceptive prevalence rate was 40 percent, and nearly one quarter (24 percent) of Iraqi women of reproductive age reported an unmet need for family planning. According to UNFPA, this statistic is a result of women not having enough access to information about family planning and where to access it.[57] Increased access to family planning in MOH clinics as well as information on accessing family planning contained in the RH coordination group information booklet will help to address this gap.

Iraqi women tend to use contraceptive pills and the intrauterine device (IUD) as primary methods of birth control.[58] Condom use, according to practitioners, is not a preferred method of family planning. Regular methods such as birth control pills may not be meeting the needs of women with husbands who travel frequently back and forth to Iraq and are not interested in consistent use of birth control.[59] Some women look for temporary methods when their husbands return which can lead to ineffective use of birth controls pills.[60] This failed method has contributed to Iraqi women's high rates of unplanned births[61] and led one practitioner to remark: "…we really need emergency contraception!"[62]

Other practitioners with whom the Women's Refugee Commission met stated that many health care providers are also against giving family planning to newly married couples or those with only one child.[63] High rates of unplanned births are affecting the resettlement processes of some women and their families who now have to remove their application and renew registration with the birth of a new family member.

The above statistics do not reflect the need of unmarried women. Several practitioners feel that the policy of asking for a husband's name at the intake interview at MOH clinics when seeking family planning services underscores the sometimes prohibitive cultural sensitivities around the issue. In addition, an NGO representative noted that the quality of MOH family planning services was limited because appropriate counseling techniques were not used. Married couples without children or only one child, and unmarried young people would be challenged to access contraceptives from MOH providers.

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[55] Women's Refugee Commission interview with Dr. Uma Kandalayeva, Director of Programs; Mona Hamza, Proejct Coordinator; and Dawn Greensides, Deputy Country Director, International Relief and Development, Amman, Jordan. Wednesday, November 11, 2009.

[56] Women's Refugee Commission interview with Dr. Uma Kandalayeva, Director of Programs; Mona Hamza, Proejct Coordinator; and Dawn Greensides, Deputy Country Director, International Relief and Development, Amman, Jordan. Wednesday, November 11, 2009

[57] Women's Refugee Commission interview with Muna Idris, Assistant Representative, UNFPA. Amman, Jordan. Saturday November 7, 2009

[58] Women's Refugee Commission interview with Dr. Manal Tahtamouni, Director, Noor Al Hussein Foundation Institute for Family Health. Monday, November 9, 2009

[59] Women's Refugee Commission interview with Muna Idris, Assistant Representative, UNFPA. Amman, Jordan. Saturday November 7, 2009

[60] Women's Refugee Commission interview with Dr. Manal Tahtamouni, Director, Noor Al Hussein Foundation Institute for Family Health. Monday, November 9, 2009

[61] Women's Refugee Commission interview with Dr. Manal Tahtamouni, Director, Noor Al Hussein Foundation Institute for Family Health. Monday, November 9, 2009

[62] Women's Refugee Commission interview with Dr. Manal Tahtamouni, Director, Noor Al Hussein Foundation Institute for Family Health. Monday, November 9, 2009

[63] Women's Refugee Commission interview with Dr. Manal Tahtamouni, Director, Noor Al Hussein Foundation Institute for Family Health. Monday, November 9, 2009

As another practitioner stated, “Family planning is not forbidden for adolescents or the unmarried by law but it is simply not done.”[64]

Recommendations:

Emergency contraception as a dedicated product should be made available within family planning services or programs. Support for a UNFPA-MOH project to pilot emergency contraception should be evaluated and used as a case study to promote wider availability of a dedicated emergency contraception product in Jordan.

MOH staff should have refresher training on the provision of good quality family planning counseling services and ensuring access for all those who seek services, particularly adolescents and the unmarried.

Ensure Iraqi refugees are informed and educated about the benefits and availability of other RH services particularly safe delivery, EmONC services and family planning, through community-based IEC and behavior change communication (BCC) methods.

[64] Women’s Refugee Commission interview with Dr. Manal Tahtamouni, Director, Noor Al Hussein Foundation Institute for Family Health. Monday, November 9, 2009