WOMEN'S
REFUGEE
COMMISSION

Progress and Gaps: Reproductive Health among Iraqi Refugee Women and Youth in Jordan

Follow-up Report

Women's Refugee Commission

February 2009

EXECUTIVE SUMMARY

The Women's Refugee Commission* (the Commission) traveled to Amman, Jordan in October/November 2008 and met with representatives from 19 United Nations, international and local agencies. The purpose of the mission was to assess the progress and gaps in reproductive health services for Iraqi refugees since its June 2007 visit to the region. Findings and recommendations from that trip were documented in the report *Iraqi Refugee Women and Youth in Jordan: Reproductive Health Findings.*[1]

Significant progress has been made in the availability of health services since the summer of 2007; however, the Commission found that reproductive health has not been prioritized and substantial gaps in care remain.

CONTEXTUAL UPDATE

In June 2007, the humanitarian response to the Iraq crisis in Jordan was in its early stages. Health services for Iraqis were severely lacking, access was limited, and with the exception of Caritas, the Jordanian Red Crescent, and some government-funded clinics, very few organizations were providing any reproductive health services for this vulnerable refugee population.

Sixteen months later, however, significant advances had been made. More than 20 agencies are providing some form of health care, ranging from primary health care to orthopedics to cancer treatment and psychosocial support, and most Iraqis can access these services for the same minimal fee paid by uninsured Jordanians. With the support of the United Nations High Commissioner for Refugees (UNHCR), free services are also provided through Caritas and the Jordanian Red Crescent to approximately 7,000 extremely vulnerable Iraqis. The International Medical Corps (IMC) and the Jordanian Health Aid Society have established mobile clinics to reach Iraqis who are unable to access a health facility due to poverty, disability, illness or fear. The International Relief and Development (IRD) conducts door-to-door visits throughout Amman in an attempt to reach the most vulnerable and isolated. And many agencies are now expanding their services to towns outside Amman as an increasing number of Iraqis are moving out of the capital to less expensive areas.

Yet although progress has been made, many health providers have not considered reproductive health care a priority. Services supported by international agencies are relatively scarce and are primarily limited to family planning, antenatal care and psychosocial support for survivors of gender-based violence. The Noor Al Hussein Foundation's Institute for Family Health, a local organization, is the only agency identified by the Commission that provides comprehensive reproductive health services to Iraqi refugees. Despite these challenges, several critical factors are in place to support the implementation of reproductive health services.

This follow-on report focuses on the progress and gaps in the reproductive health recommendation set forth in the 2007 report:

2007 Recommendations: Refugee women and girls need immediate access to priority reproductive health services, including prevention of sexual violence and care for survivors, services for women with obstetric emergencies and the prevention of HIV transmission, as well as good quality comprehensive reproductive health care. The Ministry of Health (MOH) and the international community should therefore ensure that these reproductive health services are readily available to Iraqi refugees and that they meet the guidelines on reproductive health care in emergencies that have become the standard for humanitarian response.

REPRODUCTIVE HEALTH COORDINATION

As outlined in the Minimum Initial Service Package (MISP) for Reproductive Health, an international Sphere standard, the priority for health-implementing agencies must be to designate a lead agency to establish reproductive health coordination.

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* *Formerly the Women's Commission for Refugee Women and Children*

Gaps Identified in 2007: A lead agency had not been identified at the time of the field mission and, consequently, coordination had not been established. The UN Population Fund (UNFPA) tried to secure support for a reproductive health coordinator through the September 2007 Health Appeal for Displaced Iraqis in Neighboring Countries but it did not receive any funding through the appeal.

Components of the MISP

- Coordination of the MISP
- Prevent and manage the consequences of sexual violence
- Reduce the transmission of HIV
- Prevent excess maternal and newborn morbidity and mortality
- Plan for comprehensive reproductive health services

Progress Since 2007: Since the field mission—and despite the lack of dedicated funding—UNFPA stepped forward to take the lead on reproductive health coordination in Jordan.

Next Steps: 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.

PREVENTION OF SEXUAL VIOLENCE AND CARE FOR SURVIVORS

Gaps Identified in 2007: None of the agencies with which the field team met systematically addressed prevention of sexual violence—programming focused overwhelmingly on domestic violence and psychosocial support. Care for survivors of sexual violence—including emergency contraception to prevent unwanted pregnancy and post-exposure prophylaxis to minimize HIV transmission—is also not available. Many health workers, including doctors, were unaware that emergency contraception and post-exposure prophylaxis even existed or were legal. Worsening the situation is the fact that, according to Jordanian law, doctors must report rape survivors to the police and survivors may be forced to marry their rapists. And since Iraqis are considered illegal by the Jordanian government, many will not come forward to report rape for fear of deportation (even though the risk of deportation is low). Iraqi women and girls are also at high risk for exploitation and abuse as they try to find employment in order to feed and care for their families. Having no legal status in the country, they are left without the right to work and without access to legal recourse. Although IRD reports that the figures are low, some women have turned to sex work to help support their families.

Progress Since 2007: CARE International was one of the first agencies to establish psychosocial services for Iraqi refugees in Jordan, starting in 2005, and UNHCR continues to refer refugee rape survivors to the organization. In April 2007, CARE also conducted a training for 100 refugees and 10 national and international NGOs on complaints mechanisms for refugees to report sexual abuse and exploitation, then developed and distributed a booklet on the issue. UNFPA supports the Family Violence Project (created at the MOH), and is working with both UNICEF and the MOH to develop guidelines on medical response to sexual assault. In addition, a hotline has been established for women who have experienced gender-based violence, and a few women's shelters have been established in Amman.

Next Stepss:

1. Prevention

Iraqi women will work regardless of legal status as a means for survival. To minimize the risk of sexual exploitation and abuse, the Government of Jordan should grant Iraqis temporary legal status that would provide, at a minimum, renewable residence and work permits. To help alleviate the widespread fear of arrest and harassment, UNHCR and partner NGOs should develop livelihoods programs for refugee women that will promote safe work. All UN, international and national staff working with the

displaced population should be knowledgeable about and abide by a Code of Conduct against sexual exploitation and abuse.

2. Response
Short term – Women and girls who have been raped should be referred immediately to an adequately equipped medical facility to receive clinical care. The Noor Al Hussein Institute for Family Health has been successfully establishing culturally sensitive programs and providing comprehensive services and rape kits for victims. The Institute merits strong support. At the same time, the reproductive health coordination group–now led by UNFPA–should immediately develop training for 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 refugee community and all local and international agencies also need to know where to report incidents of sexual violence and access services–UNHCR should include this information in its materials distributed to refugees. In addition, the established hotline should have a referral process in place to refer rape survivors to crucial medical and psychosocial care.

Long term – UNFPA and UNICEF should continue to work with the MOH to develop a national protocol on the medical response to sexual violence. Once finalized, the national guidelines should be rolled out to build the capacity of UN, national and international NGO staff working to provide comprehensive clinical care to women and girls who have survived rape. The rollout should be closely monitored and supervised–focusing on the competency and professionalism of health care 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 victims of rape.

SERVICES FOR WOMEN WITH OBSTETRIC EMERGENCIES

Gaps Identified in 2007: Delivery services, including emergency obstetric and newborn care (EmONC), are not provided for free by either governmental or NGO-supported clinics and hospitals. Iraqi women and girls who cannot afford basic delivery care may give birth outside of a health facility with a midwife, unlicensed Iraqi doctor or traditional birth attendant, putting the mother and her newborn in danger if she has an obstetric emergency. Unmarried pregnant women and girls are at even greater risk. Sex outside of wedlock is considered a crime and, by law, Jordanian doctors can choose to deny care and turn unmarried women in to the police. This rarely occurs in practice, however, since poor, unmarried expectant mothers generally do not seek care at a health facility unless they are having an obstetric emergency. Under those circumstances, no health facility would deny care. Ultimately, the law applies primarily to poor unwed mothers since women with the financial means can go to a private clinic where they will likely not be reported to the police.

Progress Since 2007: Ambulances and paramedics are available at all times to transport women with obstetric emergencies to a health facility, for a fee. None of the health agencies with which the Commission met reported an obstetric death within the Iraqi community. As many more health providers are now operating in Jordan, community awareness on maternal and child health has risen and antenatal care is available at some facilities.

Next Steps: A cost-sharing program to support free delivery services, including EmONC, for poor Iraqis and Jordanians should be considered. The current gender-based violence hotline should be expanded to include information on where to receive free, anonymous delivery and EmONC services. This information should be included in the UNHCR booklet that is distributed to Iraqis.

PREVENTING HIV TRANSMISSION

Gaps Identified in 2007: Although HIV prevalence is low in both Jordan and Iraq, conditions are rife for transmission. Knowledge and awareness of HIV are very low among both Jordanians and Iraqis. An increase in new and often transitional populations due to the Iraq crisis contributes to increased vulnerability to HIV transmission. Little outreach has been done to most at-risk populations, such as sex workers, although one agency has undertaken work-

shops on HIV prevention with this population. Knowledge of post-exposure prophylaxis among health workers was extremely low.

Progress Since 2007: Standard precautions have been well integrated within the Jordanian health system for many years and are respected by health workers. Blood for transfusions is routinely screened. A national AIDS strategy has been developed and is being implemented. CARE International, in collaboration with the MOH, conducted an awareness-raising training on HIV for 35 refugees and five Jordanian and CARE counselors. IRD has conducted outreach on HIV to both Jordanian and Iraqi sex workers in Amman.

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

COMPREHENSIVE REPRODUCTIVE HEALTH SERVICES

Gaps Identified in 2007: A lack of funding for reproductive health services is one of the biggest barriers to service provision in Jordan. UNFPA is poised to support the implementation of such services, but has received very little funding to do so. Agencies have found it difficult to convince donors that reproductive health is a priority activity in emergency response and further complicating issues is the difficulty of collecting baseline information on Iraqis in Jordan. The size of the displaced population is, for the most part, unknown. Estimates range from 54,000 (the current number of Iraqis that have registered with UNHCR) to 450,000 (the figure often used by the Jordanian government). Finally, reproductive health in general is a sensitive issue among both the Jordanian and Iraqi populations. Culturally appropriate programming on sexual violence, adolescent reproductive health and sexually transmitted infections is often difficult to implement effectively.

Progress Since 2007: A National Reproductive Health Action Plan is currently being developed by the MOH with a number of local and international actors, and some international agencies and government supported clinics have begun to provide reproductive health care, including family planning, psychosocial services for gender-based violence, awareness-raising on domestic violence, and outreach and care on breast cancer, among other services. Government supported clinics also provide similar reproductive health services, and the MOH is currently developing a National Reproductive Health Action Plan, with a number of local and international actors. Finally, the Noor Al Hussein Foundation's Institute for Family Health should be championed as a model for good practices. Its comprehensive and culturally-appropriate programming for all aspects of reproductive health should be shared with other agencies working to support women and girls, and their families.

Next Steps: 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 young people. The reproductive health program officer should collaborate with the health coordinator to assure that 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 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. Participation is recommended in the Interagency 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.)

Note

[1] www.womenscommission.org/pdf/jo_rh.pdf

Mission Statement

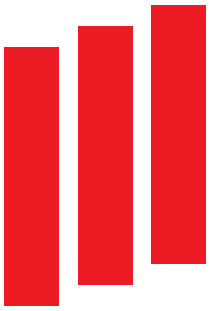
The Women's Refugee Commission works to improve the lives and defend the rights of refugee and internally displaced women and children. The Women's Refugee Commission is legally part of the International Rescue Committee (IRC), a non-profit 501(c)(3) organization. It receives no direct financial support from the IRC.

Acknowledgments

This report was researched and written by Sarah Chynoweth, reproductive health program manager, and Ada Williams Prince, senior advocacy officer, Women's Refugee Commission.

Special thanks to the Iraqi refugee women and youth who participated in our meetings and interviews. This report is dedicated to all displaced Iraqi women, men and children.

The Women's Refugee Commission is grateful for the support of an anonymous donor.



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