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# Sexual and reproductive health and reproductive rights regulatory frameworks across the Arab states region:

## Current status and future outlook

Policy guidelines document

## Iraq

2021

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# Acknowledgement

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# Disclaimer



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# A. Acronyms

| | |
|---|---|
| **AIDS** | Acquired Immunity Deficiency Syndrome |
| **ANC** | Antenatal Care |
| **AUB** | American University of Beirut |
| **BCC** | Behavioural Change and Communication |
| **CPR** | Contraceptive Prevalence Rate |
| **EOC** | Emergency Obstetric Care |
| **FGM** | Female Genital Mutilation |
| **GBV** | Gender-based Violence |
| **GDP** | Gross Domestic Product |
| **GII** | Gender Inequality Index |
| **HIV** | Human Immunodeficiency Virus |
| **HPV** | Human Papilloma Virus |
| **IEC** | Information, Education and Communication |
| **IPV** | Intimate Partner Violence |
| **IUD** | Intrauterine Device |
| **IDP** | Internally Displaced Population |
| **ISIS** | Islamic State of Iraq and Syria |
| **IWJF** | Iraqi Women Journalists Forum |
| **KRI** | Kurdistan Region of Iraq |
| **MENA** | Middle East and North Africa |
| **MHPSS** | Mental Health and Psychosocial Support |
| **MICS** | Multiple Indicator Cluster Surveys |
| **MMR** | Maternal Mortality Ratio |
| **NGO** | Non-Governmental Organizations |

| | |
|---|---|
| **OECD** | Organization for Economic Co-Operation and Development |
| **PEP** | Post-Exposure Prophylaxis |
| **PHCC** | Primary Health Care Centre |
| **PNC** | Postnatal Care |
| **PPP** | Purchasing Power Parity |
| **PSEA** | Protection Against Sexual Exploitation and Abuse |
| **SBC** | Social and Behavioural Change |
| **SDG** | Sustainable Development Goals |
| **SOWC** | State of the World's Children |
| **SGBV** | Sexual and Gender-based Violence |
| **SRH** | Sexual and Reproductive Health |
| **SRHRR** | Sexual and Reproductive Health and Reproductive Rights |
| **STIs** | Sexually Transmitted Infections |
| **UN** | United Nations |
| **UN DESA** | United Nations Department of Economic and Social Affairs |
| **UNFPA** | United Nations Population Fund |
| **UNHCR** | United Nations High Commissioner for Refugees |
| **UNICEF** | United Nations International Children's Emergency Fund |
| **UN OCHA** | United Nations Office for the Coordination of Humanitarian Affairs |
| **WGSS** | Women's and Girls' Safe Spaces |
| **WHO** | World Health Organization |
| **WHO EMRO** | World Health Organization Regional Office for the Eastern Mediterranean |

# B. Introduction

This document is annexed to the regional sexual and reproductive health and reproductive rights (SRHRR) policy guidelines report that defines its scope and the context of its development.

The proposed policy guidelines are classified by SRHRR priorities of interventions as deduced from the conducted prioritization exercise noted in the regional report, and, based on the different elements of the socio-ecological model, are deemed appropriate and relevant. (Refer to the regional report)

Some of the proposed policy guidelines relevant to all the 15 countries and covered by the noted regional report are also relevant to Iraq. Accordingly, they are also proposed within this report to ensure a comprehensive and holistic coverage of all necessary SRHRR policies that are essential for promoting SRHRR in Iraq and to ensure the inclusiveness of this report if consulted independently from the regional report.

# C. Iraq country overview

In the past 25 years, the population of Iraq has increased by more than 50% to reach about 40.2 million in 2020 according to the United Nations Population Fund (UNFPA) World Population Dashboard. It is estimated that by 2030 the population will have grown by another 50%. Today, the population density reaches 93 persons per square kilometre, and about 30% of the population live in rural settings (UNFPA, 2020; Worldometer, 2020; WHO EMRO, 2018; WHO, 2015).

Although Iraq is considered as a middle-upper income country with a GDP of 234.094 billion US dollars for the year 2019 and a GDP per capita of 5,955 (ppp in USD), regional and local conflicts, vulnerable oil infrastructures and government debts are continuous challenges to Iraq's socio-economic development (World Bank, 2020; The Washington Institute, 2004).

The Iraqi population is young, with a median age of 21.0 and with 37.7% of the population being under 15 years of age (UNFPA, 2020). Women of reproductive age (15–49) represent 24.7% of the total population (WHO, 2015; WHO EMRO, 2018). Currently, around 15.4% of the population are children under the age of 5, and 46% are below the age of 18. By 2030, the population of young people between 15 and 24 years is projected to double, with an increase of 3.2 million young people (UNFPA, 2020; Worldometer, 2020).

The fertility rate in Iraq in 2020 was 3.5 births per woman, with a 1.29% decline from 2019 (UN DESA, 2020; Iraq Fertility Rate 1950–2021, 2021). Also, Iraq is among the highest countries in the Eastern Mediterranean Region in terms of total fertility and adolescent fertility rates (82 per 1,000 15–19 year-old girls) (WHO EMRO, 2018; UNFPA, 2020; World Bank, 2020).

The United Nations High Commission for Refugees (UNHCR) estimates that more than 3 million Iraqis have been displaced across the country since the start of 2014. About 260,000 Iraqis are refugees in other countries and over 11 million Iraqis are currently in need of humanitarian assistance. More than 1.5 million people have taken refuge in the Kurdistan Region of Iraq (KRI), where one in every four is either a refugee or an internally displaced person (UNHCR, 2021). In 2019, 4.5 million people were assessed to be in need of at least one type of protection assistance, and higher prevalence of poverty-related protection risks was observed among the internally displaced population and returnee children compared to past years (UNOCHA, 2019).

Iraq's health sector is largely dependent on the government (63%), and it is mostly managed and financed by the Ministry of Health (73%). However,

government spending on the health sector has been decreasing over the last few years. The public spending on health amounts to 5.5% of the GDP, less than its counterparts in the region (Jordan 7.5%, Tunisia 7.0% and Lebanon 6.4%) and much lower than the Organization for Economic Co-operation and Development's (OECD) average (8.9%). The households' spending on public health and medicines rose from 25.2% in 2008 to 39.7% in 2014, exceeding the international average. Health, in fact, represents a growing burden on families (Ministry of Planning of the Republic of Iraq, 2019).

Apart from the impact of the low and reduced spending, the health sector has been severely weakened with years of conflict and occupation which have left the health infrastructure of the country fragile and inadequate. Today, access to health services is suboptimal and geographical disparities are significant. In recent years, effects have been especially devastating for women and children, with routine immunisations reduced, with pregnant women unable to reach hospitals for delivery and with essential medical supplies limited. Southern Iraq has been particularly affected, with some of the worst maternal, newborn and child health indicators in Iraq and among the surrounding countries (Al Hilfi et al., 2013).

In the public sector, health services are provided through a network of primary health care centres (PHCCs) and public hospitals at very low charges. The PHCCs provide preventive and basic curative services. The main centres are located in urban areas with smaller centres in rural areas. Poor organization and shortage of staff and medications are significant impediments to delivering adequate services in PHCCs. Despite this, PHCCs are recognised as very important sources of health care provision, particularly for the poor (United Kingdom Home Office, 2019).

When it comes to SRHRR indicators, a decline of infant mortality rate to reach 22.918 deaths per 1,000 live births in 2020 has been noted, with a 2.52% decline from 2019 (UN DESA, 2020). Maternal mortality ratio fluctuated substantially in recent years; it tended to decrease through the 1998–2017 period reaching 79 deaths per 100,000 live births in 2017 (UNFPA, 2020).

On the other hand, underage marriages still represent 28% of all marriages in Iraq. According to the UN Human Development Index, Iraq ranked 121st out of 188 countries in 2017; Iraq also ranked 123rd on the UN Gender Inequality Index (GII), becoming one of the lowest GII rankings in the Middle East and North Africa (MENA) region (UN Women, 2018). Violence against women and girls, and most notably domestic violence, has been consistently prevalent in Iraq in the last few decades. While there are no statistics available on sexual harassment in Iraqi society, a survey published by the Iraqi Women Journalists Forum (IWJF) in 2015 found that 8 in 10 women surveyed in Iraq report having suffered some form of sexual harassment (UN WOMEN, 2018; Iraqi Women Journalists Forum, 2015).

The legal environment surrounding important elements of SRHRR, such as safe abortion, gender-based violence care and prevention, HIV care and discrimination and access to reproductive health services, among others, still constitute an important impediment. Laws, in several instances, are highly restrictive and discriminatory.

Last but not least, in Iraq, years of repression caused by a strongly conservative culture, by economic sanctions and by armed conflicts have led to a deterioration in the quality of life for women and have had a direct impact on their SRHRR, with women being marginalised and unable to fully participate economically, socially or politically.

# D. SRHRR prioritized themes

## D.1 Theme 1: maternal health care to ensure safe pregnancy and childbirth

The following methods were adopted to develop the regional youth SRHRR overview report.

### D.1.1 Maternal health in Iraq: indicators, problem areas and opportunities

The UN Inter-Agency Group's estimate for maternal mortality ratio (MMR) shows a decline in MMR from 107 to 79 per 100,000 live births during the period between 1990 and 2017 in Iraq (Hossain et al., 2018; UNFPA, 2020). Also, the United Nations' estimates for under-5 child mortality show a decline between 1990 and 2017 from 54 to 30 deaths per 1,000 live births (WHO EMRO, 2018). Despite this decline in mortality, incurred losses are preventable with high-quality, evidence-based interventions delivered before and during pregnancy, during labour and childbirth and in the crucial hours and days after birth (WHO EMRO, 2018).

Decades of conflict, sanctions and political instability have adversely affected reproductive health services in Iraq whereas they also slowed Iraq's progress in reducing child and maternal mortality (Hossain et al., 2018; WHO EMRO, 2018).

According to the latest published Multiple Indicator Cluster Survey (MICS) in Iraq for 2018, 74.5% of births in Iraq were attended to by skilled birth attendants, with the percentage being close to 90% in the Kurdistan Region compared to 71.5% in central and south Iraq (MICS, 2018).

The coverage of antenatal care (ANC) visits is still suboptimal, with 13.4% of pregnant women not receiving any ANC in Iraq. This percentage grows to more than 22% among the poorest and the least educated women (MICS, 2018). This level of disparity with regards to socio-economic status is also noted in postnatal care (PNC) where the proportion of women and children who received PNC after delivery was highest for urban compared to rural respondents, for the most educated compared to the least educated and among the rich and richest compared to the poor (Hossain et al., 2018). The Iraq Woman Integrated Social and Health Survey (I-WISH) data also showed that while ANC coverage may be high, only 20% of pregnant women (32% in KRI) got PNC after delivery, and only 35% of pregnant women reported getting counselling on birth spacing and modern family planning methods during ANC visits (I-WISH, 2012).

With regards to the perceived quality of ANC in Iraq, a study conducted by Shabila et al. in 2014 revealed a number of problems and concerns expressed by

women with regards to their ANC experiences. These concerns related mainly to the inadequate provision of information and to poor interpersonal communication (Shabila, Ahmed and Yasin, 2014). In fact, health education and the provision of information to women at ANC services are not formally defined within the job description of nurses and midwives in Iraq (Shabila, Ahmed and Yasin, 2014). To compensate for the lack of information obtained through physicians and antenatal clinics, women appeared to rely mainly on social sources for information (Nasir and Amir, 2017).

Maternal health services in Iraq also suffer from lack of funding and scarcity of resources as well as from inefficiency and suboptimal efficacy. In fact, the 40 million inhabitants of Iraq are served only by 7.4 physicians per 10,000 individuals of the population. Iraq has also some of the lowest number of nurses and midwives in the MENA region with an average of 2 per 1,000 people compared to 2.8 nurses and midwives per 1,000 people in Jordan for example (World Bank, 2018). Many gynaecologists and other female medical staff have fled the city or the country during the Islamic State in Iraq and the Levant's (ISIS) rule (Doctors Without Borders – MSF, 2019). More specifically, the health care system in Basra has been chronically underfunded and is run by overworked doctors and nurses (Aboulenein and Levinson, 2020).

In fact, the National Development Plan of 2018 highlighted a range of challenges to the health sector, particularly those pertaining to the delivery of sexual and reproductive health (SRH) services including the following: the weak modernisation of primary health care (PHC); the low efficiency of service delivery mechanisms as medical and health staff work in the public and private sectors simultaneously; the weak coverage of the full range of women's health care needs with inadequate attention given to adolescent girls, PNC and family planning programmes; the shortage of female medical staff, particularly in rural areas; the weak role of civil society organizations in sexual and reproductive health services across the country (Ministry of Planning of the Republic of Iraq, 2018).

With regards to tertiary care, a study conducted in 2014 in a large maternity and child teaching hospital located in Nasiriyah, the capital of the Dhi Qar Province, showed that medical staff was lacking essential training on several topics, including basic emergency obstetric and newborn care, as well as evidence-based clinical guidelines, such as indications for caesarean section, triage, danger signs, etc. The study also found that lower-level referring facilities in the region lacked essential training, which jeopardises the speed and quality of referral to tertiary care (Ahamadani et al., 2014).

With regards to the experience of health care providers, a study published in 2015 on the perspectives of Iraqi Kurdish nurses in maternity services reported severe

occupational stress where the heavy workload and fatigue negatively impacted the quality of their service. Additionally, participants in the study stated that the lack of a clear schedule for nurses and the absence of educated midwives threatened patient safety. Nurses had countless responsibilities, including both nursing and midwifery tasks, which were performed without adequate training (Piro et al., 2015).

In summary, while Iraq has made maternal health a national priority, strategic interventions and improvements are needed at several levels to address challenges resulting from the following: budget constraints; lack of trained health care professionals across the country especially female ones; limited availability of PHCCs that offer the full coverage of maternal health services; poor availability of maternal health education and services accessible to the poorest and least educated; lack of referral systems between primary, secondary and tertiary health care centres; limited involvement of civil society organizations in SRHRR service provision.

### 1.2 Access to contraception

The use of modern contraceptive methods has stagnated since 2012 in Iraq, hovering between 28% (I-WISH, 2012) and 36% (MICS, 2018), with a significant percentage (11–17%) using traditional methods. Meanwhile, surveys showed that the 'unmet family planning needs' category was around 25%, with its consequence the 'satisfied needs for modern family planning' registering around 53.8 %. In other words, only slightly more than half the women wishing to space or limit their pregnancies were using or had access to modern contraception (MICS, 2018).

There are several constraints to contraception access and use (refer to section C.3.1 of this report on Theme 3) resulting in a high incidence of 'unintended pregnancies' reaching 24% of all pregnancies, with the percentage being higher among women who are 30 years old and above (I-WISH 2012). The I-WISH survey also showed that around 24% of married women had at least one miscarriage/abortion during the five years preceding the survey (28% in KRI) (I-WISH 2012).

On the other hand, among women who are using family planning to avoid pregnancy, several still fail for a variety of reasons. Those women may not have received clear instructions on how to use the method properly, could not have used a method properly suited to them or could have run out of supplies (Ismail, Al-Tawil and Hasan, 2014). Many external factors also influence the choice of contraceptive method including cultural practices, religious beliefs, attitudes and personal preferences, cost, effectiveness, misinformation, practicality of the method and self-esteem (Ismail, Al-Tawil and Hasan, 2014).

In summary, the high level of the unmet need for contraception use in Iraq results in an increased rate of unintended pregnancies; this, coupled with the social, structural and legal barriers to safe abortion, increases the likelihood of unsafe abortions and the morbidity and mortality associated with it. It is therefore important to address access and use of modern contraception as well as to fill the gaps in knowledge and research around the subject in order to be able to develop the needed interventions.

## D.1.2 Policy guidelines associated with theme 1: maternal health

### I. Overarching elements

### First priority area of intervention

### Policy strategic objective 1: to increase access and utilisation of maternal health care services

**Policy statements**

To achieve a comprehensive access to and utilisation of maternal health care services including antenatal care (ANC), emergency obstetric care (EOC) and postnatal care (PNC), key actors shall commit to the following:

#### 1. Enabling environment

**a. Regulatory framework**

- Review and amend regulatory frameworks including laws, policies and strategies to ensure the rights of persons to accessing and utilising SRHRR services including maternal health without any discrimination.
- Develop and activate regulations and processes allowing to guarantee legislated access to a comprehensive package of essential SRHRR interventions and services including maternal health.
- Identify problems and bottlenecks associated with the seven building blocks of the health system: service delivery; health workforce; information; medical products, vaccines and technologies; financing; leadership and governance (stewardship) (WHO, 2007). This will help the country improve maternal health through recognising the priority areas to address.
- Strengthen health systems at the national, district and community levels in order to expand coverage. This will contribute to sustainable improvements in health at the population level and in underserved regions. Accordingly, ensuring the sound functioning of PHC centres and hospitals within districts is essential to improving maternal and newborn health. Particular attention should be provided to strengthening public health entities as well as public–private partnerships.

- Ensure that SRHRR-related programming and interventions, including maternal health and HIV and AIDS prevention, treatment and care, are fully integrated into and in line with the national health strategies, plans and budgets. This is important to avoid fragmentation of services.
- Ensure the existence of SRHRR national initiatives and interventions supporting country-led processes that bring together key stakeholders to develop, budget and implement national plans and strategies for improving maternal health services within a broader health systems framework.
- Ensure that comprehensive and integrated SRHRR services including maternal health are delivered to all people with no discrimination, including vulnerable and marginalised persons, and with particular attention to displaced populations and refugees.

**b. Resources**

- Ensure the availability of the needed human resources within public and private health entities including nurses and midwives, particularly in remote and rural areas and within PHCCs. Emphasis should be placed on the availability of female health care professionals.
- Increase financial support to SRHRR programmes as part of the national budget.
- Explore alternative financing mechanisms for SRHRR services to alleviate the financial burden from individual households.
- Establish support programmes favouring the affordability of the needed maternal health services.
- Guarantee the availability of adequate SRHRR-related supplies, equipment and infrastructure.

**c. Communication, collaboration and coordination**

- Ensure the availability of an efficient and effective system of communication, referral and transport, which is essential to preventing the risks of maternal mortality and morbidity.
- Ensure more regular interactions with the health system, including prenatal and postnatal visits, in order to provide women with consistent support in family planning, preventing unwanted pregnancies and decreasing the unmet need for contraception.
- Activate the role of civil society organizations in SRHRR services across the country.

### 2. Awareness and social and behavioural change

- Develop and conduct awareness and social and behavioural change (SBC) public campaigns and interventions, which are to be compounded with the development and distribution of information, education and communication (IEC) material to communities, mainly young people and adolescents, in order to empower populations and to create demand for and increase utilisation of SRHRR services including maternal health. Particular attention should be provided to influencing social norms and behaviours that influence women's attitudes and behaviours in seeking SRHRR services including maternal health.
- Ensure the proper and adequate provision of SRHRR information to women, with particular attention to the poorest and least educated.
- Conduct a continuous dialogue with and ensure a proactive engagement of community and religious entities. This is important to guarantee that cultural and religious practices are in line with the government's commitment to the achievement of SRHRR goals.

## Policy strategic objective 2: to ensure the provision of essential SRHRR services including maternal health at all levels of the health care system

**Policy statements**

To ensure an effective provision of SRHRR services including maternal health, key actors shall commit to the following:

### 1. Supply of maternal health services

- Increase the number of health care providers to properly and adequately meet the SRHRR demand for services.
- Expand quality SRHRR services including maternal health within public and private facilities, with an emphasis on public facility and community-based entities including PHCCs.
- Promote an equal and even distribution of skilled staff in urban, suburban and rural areas and at the community level while ensuring the availability of female health care providers.
- Strengthen referral and communication between the different levels of care.
- Promote the provision of adequate basic SRHRR equipment and supplies to all concerned facilities with emphasis on public and primary health care entities.
- Ensure the delivery of comprehensive maternal health services to marginalised populations, including refugees and displaced populations.

### Policy strategic objective 3: to improve the quality of maternal health services

**Policy statements**

To achieve delivering effective SRHRR interventions of the highest quality including maternal health, key actors shall commit to the following:

1. **Quality of maternal health care**
   - Develop and implement a human resource capacity development strategy to orient and train as well as to deploy and retain health system workers, particularly SRHRR health workers.
   - Increase the capacity of service providers at different levels to meet the increasing demand for SRHRR services including maternal health by providing quality pre- and in-service education and training. Particular emphasis is to placed on basic emergency obstetric and newborn care and on inter-personal communication skills, allowing for the proper provision of reproductive health counselling.
   - Upgrade the performance of service providers to meet national and international standards through regular monitoring, on-the-job supportive supervision and performance appraisal.
   - Equip and periodically supplement all SRHRR facilities with adequate drugs, commodities and other essential supplies.
   - Maintain compliance with the national accreditation system (if available) for the delivery of SRHRR services including maternal health.
   - Establish quality assurance programmes to continuously monitor and guide further improvements in the quality of SRHRR services including maternal health.
   - Invest in training, recruiting and retaining skilled birth attendants including midwives to reduce MMR.

## Second priority area of intervention

### Policy strategic objective 1: to ensure the availability of maternal health-related guidelines and operating procedures and evidence-based data

**Policy statements**

Compounded to the above, to achieve delivering effective and quality SRHRR services including maternal health, key actors shall commit to the following:

### 1. Quality of maternal health care

- Develop and roll out operational guidelines and service standards for managers at central and district levels, including hospitals, primary health care centres and other public and private entities. These guidelines and standards shall specify who is responsible for reproductive health-related activities at the different levels, how these should be planned, implemented and monitored and what human, logistic and financial resources are required.
- Develop and roll out clinical protocols for staff training and quality improvement, which aims to standardise clinical diagnosis and treatment procedures for a rapid and quality response. These protocols shall reflect contemporary international practices adapted for the region in general and for Iraq in particular.
- Develop separate protocols and operational guidelines for each of the concerned staff teams. These include medical officers, nurses/ midwives, health assistants, staff nurses, auxiliary health workers, maternal and child health workers and community health workers.

### 2. Evidence-based data and information on maternal health

- Develop mechanisms for the compilation of accurate and routine data and information about maternal health in general and about the causes of maternal deaths in particular.
- Develop, coordinate and implement a multi-sectoral research agenda for SRHRR including maternal health, with particular emphasis on social behaviour and health systems research.
- Strengthen the coordination between national and regional research institutions, and establish a national data bank on SRHRR including maternal health.
- Strengthen the national capacity for multi-disciplinary research in SRHRR including maternal health.
- Encourage the dissemination and utilisation of relevant findings of SRHRR research including maternal health.
- Conduct research on the special needs of adolescents, youth, refugees and other marginalised groups in order to improve the design and execution of SRHRR interventions including maternal health.

## II. Particular maternal health-related subject areas

### Policy strategic objective: to decrease maternal mortality and morbidity

To decrease maternal and newborn mortality and morbidity, key actors shall commit to the following as classified below by particular maternal health subject areas:

### 1. Safe motherhood

- Ensure the provision of quality antenatal care for the prevention, early detection and management of pregnancy complications leading to maternal mortality.
- Ensure the provision of proper support to ensure that antenatal care and safe delivery are attended to by skilled health personnel.
- Establish and maintain appropriate structures and infrastructures within the health care system in order to provide integrated safe motherhood services.
- Ensure the availability of a range of basic equipment that is necessary to deliver quality safe motherhood services.
- Encourage postnatal care attendance for early detection of risks of maternal death after delivery.
- Reduce MMR to less than 70 per 10,000 live births by 2030 (SDG target 3.1).

### 2. Maternal nutrition

- Promote public information on women's nutritional needs.
- Advocate for the integration of nutrition education, essential nutrition actions and food supplementation programmes with SRHRR services and training.

### 3. Family planning

- Provide a full range of contraceptive methods, including long-term and emergency contraceptive methods, in accordance with the national requirements.
- Endorse the principle of informed choice for individual women and men and for couples to determine their method of contraception, including long-term methods.
- Provide emergency contraceptives for the prevention of unintended pregnancies, particularly for rape survivors as part of post-exposure prophylaxis (PEP) as per the national directives.

- Increase access to family planning services by strengthening community-based family planning provision.
- Advocate for public support of family planning programmes.
- Increase public awareness about family planning, including contraceptive methods.

### 4. Reproductive tract diseases (STIs/HIV/AIDS)

- Promote research on STIs/HIV/AIDS cure.
- Develop protocols and guidelines for the management of reproductive tract diseases.
- Plan and conduct programmes aiming to reduce the spread of STIs/HIV/AIDS. This includes the promotion and dissemination of appropriate information, education and communication (IEC) and of social and behavioural change (SBC) on reproductive tract infections at all levels of care.
- Advocate for a continuous supply of affordable drugs and alternative therapies for reproductive tract diseases.
- Promote the testing of HIV and syphilis to pregnant women during antenatal care.
- Provide STI services and integrate them in all types of care services including primary, HIV, reproductive health, family planning, antenatal and postnatal care services
- Deliver HPV vaccines through the national immunisation programme.

### 5. Infertility

- Provide appropriate services for overcoming infertility barriers to the achievement of SRHRR.
- Integrate services for the prevention and management of infertility.

### 6. Other reproductive health issues

- Develop strong awareness campaigns for the screening and early management of cancers related to reproductive health.
- Plan and conduct programmes for the prevention, screening and treatment of cervical and breast cancer for females and prostate cancer for males.
- Plan and conduct awareness programmes for women on menopause.
- Provide information and management services for women going through menopausal problems.

## D.2 Theme 2: Gender-based violence including harmful practices

### D.2.1. Gender-based violence in Iraq: indicators, problem areas and barriers

In Iraq, women and girls are noted to have experienced incidents of gender-based violence (GBV) four times more than males. Emotional abuse, denied access to needed resources and domestic violence constituted the vast majority of GBV incidents. Nearly 63% of all the GBV incidents were noted to be perpetrated by intimate partners, brothers, fathers and/or mothers (UNFPA, 2019). These findings are consistent with the I-WISH of 2012, where 73% of Iraqi women aged 15–45 years old reported that the main GBV perpetrators include husbands followed by fathers (53%), other family members (43%), co-workers (20%) and health workers (18%) (I-WISH, 2012).

War and displacement have exacerbated pre-existing systematic violence against women and girls in Iraq and Iraqi Kurdistan. Unmet humanitarian needs, the erosion of community networks, a lack of livelihood opportunities and restrictions on movement have rendered women more vulnerable to violence and exploitation (UNFPA, 2019).

#### Domestic violence

According to a study conducted by Al-Atrushi et al. (2013), the prevalence of the overall lifetime and the overall past year intimate partner violence against women in Iraq was 58.6% and 45.3%, respectively. The proportions of women who experienced at least one form of lifetime intimate partner violence were 52.6% for emotional abuse, 38.9% for physical violence and 21.1% for sexual violence, while 43.3%, 15.1% and 12.1% of women experienced at least one form of emotional, physical or sexual violence, respectively, in the previous year. Among those who experienced lifetime physical violence, 11.6% were subjected to more serious injuries like stab wounds, broken teeth or broken bones (Malik, Shabila and Al-Hadithi, 2016; Al-Atrushi et al., 2013).

When asked about the places where women were most vulnerable to violence, home topped the list of the most likely places (64%), followed by the street and public places (Puttick, 2015).

The level of violence differs by governorate. For example, in Al-Anbar, 30% of men refuse to let their wives go to health centres without company; in Al-Qadesiah, 40% of men insist to know where the wife is all the time; in Diyala, one-quarter of men insulted their wives at least once during the year that preceded the survey;

and in Missan, one-fifth of married women were victims of physical violence (I-WISH, 2012).

It is important to mention that laws in Iraq provide protection from domestic violence only in Kurdistan, for as per the Iraqi law, the punishment of a wife by her husband is considered to be a legal right elsewhere in Iraq (Annex phase 1 report).

## Minimum age of marriage

The latest State of the World's Children (SOWC) report in Iraq, which was published in 2019 for data from 2012–2018, reported that 7% of girls were first married before they were 15 years old and 28% were first married before they were 18 years old. The primary drivers for early marriage in Iraq are poverty, the ongoing conflict and the strict religious and cultural traditions. The increased financial hardship in Iraq resulted in increasing the number of child brides (UNICEF, 2019).

According to Iraq's Personal Status Law of 1987 and its amendments, the minimum legal age for marriage is 18 years. However, individuals can marry at 15 years with judicial consent. Article 41 of the Iraqi Permanent Constitution (2005) enables every sect and religious community to follow its own religious teachings and laws regarding marriage and affects attempts to standardise a legal age in line with international standards (Girls Not Brides, 2021).

## Honour crimes

In Iraq and the KRI, there is a history of men who were accused of killing women or girls for being perceived to have brought shame to the family but who, nonetheless, escaped justice entirely. Even though such acts are illegal, their prosecution, in practice, is sometimes dealt with as a 'family matter'.

An assessment on GBV in Iraq done by the UNFPA in 2019 reported that disclosure of sexual violence, including the honour-killing of a sexual violence survivor by her family members (the most stigmatised form of GBV), is rare but can have very serious, at times tragic, repercussions for survivors (UNFPA, 2019).

Iraq lacks proper legislation to prevent and punish honour killings. Article 409 of the Penal Code permits 'honour protection' as mitigation for crimes of violence committed against family members. In connection herewith, while sexual assault is criminalised, article 398 of Penal Code provides that charges may be dropped if the assailant marries the victim. It appears that this provision can also be applied in case the victim is a minor. This creates a situation whereby the victim risks her

life either way, for in case she marries her assailant, she may become a victim of lethal domestic violence, and in case she does not, she may fall a victim to honour killing by her family or tribe (Human Rights Council, 2018).

In 2002, the parliament of KRI removed the Penal Code provisions protecting the perpetrators of 'honour killings' (UNFPA, 2019).

## Female genital mutilation

Although the prevalence of female genital mutilation (FGM) in Iraq as a whole is relatively low compared to other countries where it is practiced, FGM is particularly common in the KRI. A prevalence of around 40% had been recorded for such a practice (Ahmed, Shabu and Shabila, 2019; Wadi, 2012). This prevalence varies by geographical location. A prevalence of 4% was recorded in Duhok governorate compared to 58% in Erbil governorate and to almost 70% in some specific rural areas of Sulaimania governorate (Ahmed, Shabu and Shabila, 2019; Yasin, Al-Tawil, Shabila and Al-Hadithi, 2013; Saleem, Othman, Fattah, Hazim and Adnan, 2013).

In general, the prevalence is noticeably lower among females aging below 20 years old (23%), which could indicate a decreasing trend of this practice. However, this rate remains considerably high and needs to be dealt with as a significant health concern (Ahmed, Shabu and Shabila, 2019). The most prevalent type of FGM in Iraqi Kurdistan context is type I (Yasin, Al-Tawil, Shabila and Al-Hadithi, 2013; Ahmed, Shabu and Shabila, 2019). It is not clear why this particular type is common in the region. While there is some belief in the region that FGM is required, there is a general agreement that FGM should be limited to the mildest form (Yasin, Al-Tawil, Shabila and Al-Hadithi, 2013). While the cutting and injuring types of FGM are known to be practiced in the region, infibulation or type III is not known in the Kurdish culture (Ahmed, Shabu and Shabila, 2019).

In Iraq, FGM is not prohibited by a separate law; yet, it is stated under the Domestic Violence Law and criminalised in KRI. (Refer to phase 1 report)

## Problem areas and barriers

GBV is reinforced through entrenched social norms and reinforcing attitudes and beliefs. According to women aged 15–54 years surveyed in the I-WISH, the main reasons for the prevalence of GBV in Iraq are the prevailing misconceptions in the Iraqi culture, the misconceptions of families about the ways to bring up boys and girls, the misconceptions of religion, the lack of awareness amongst men and women, the lack of knowledge amongst women about their rights and women

giving up and accepting violence. The results also confirmed that any effort to combat violence might start from home by changing behaviours and concepts held by family members about women's rights and by encouraging opposition to GBV (I-WISH, 2012).

The survey's results also indicated that most of the surveyed women do not consider some aspects of GBV, such as preventing a woman from political participation, controlling a woman's mobility by her husband and beating daughters if they misbehave, as GBV (I-WISH 2012).

With regards to FGM, a recent study on the practice in KRI revealed that more than one-third (34.4%) of mothers supported FGM for their daughters, and the prevalence of this support was 1.45 times higher for uneducated mothers than for educated mothers. The good news, however, is that 94.4% of women supported having FGM prevention programmes in their villages (Abdullah et al., 2019). Community and religious leaders may also play an important role in deciding about FGM. The same study found that although most mullahs and mokhtars believed that religion supported the practice of FGM, 70.8% of mullahs and 94.5% of mokhtars supported NGO and government programmes on the prevention of FGM, and 44.8% of mullahs and 88.7% of mokhtars supported abandoning the practice of FGM (Abdullah et al., 2019).

When it comes to child marriage, we note that while poverty and economic vulnerability are primary reasons for a family's decision to marry a child, this practice is in fact enshrined in traditional social and cultural norms in Iraq. Some families are convinced that girls 'need to be taken care of', which translates into pushing them to get married as soon as possible as a way to preserve the honour of the family. Imams (Muslim religious leaders) often conclude child marriage contracts without any form of formal registration, thus further complicating the legal aspect of the marriage and leaving the child spouses without any legally recognised status and rights (UNFPA, 2016a).

Beyond social norms that exacerbate the prevalence of GBV, the reporting, management and care for GBV survivors are also affected by social, structural and behavioural barriers, especially for the most vulnerable groups.

For GBV survivors, family is considered as the first shelter. It was noted that 82% of GBV survivors did not report incidents to the police. It was also found that GBV survivors are most open to talk about psychological violence and seeking psychosocial help but quite reluctant to report sexual violence (UNFPA, 2019).

In KRI, women go to police more than any in other area of Iraq. Nearly 48.9% of women in Kurdistan believe that GBV survivors should go to police compared to 34.7% of women in other governorates (I-WISH, 2012). Women do not

report violence by family members because they are ashamed, are scared of repercussions or are concerned with protecting husbands or family members. GBV survivors are often afraid that if they report GBV by a family member, they will lose access to resources or will be kept away from their children. When violence is perpetrated by someone outside their families, internally displaced populations (IDP) and refugee women would rarely reveal it. They are predominantly scared of the stigma and shame tied to the status of GBV survivors. In the case of sexual assault, the fear of honour killing is a major factor (UNFPA, 2019).

According to the GBV Assessment conducted by the GBV Sub-Cluster chaired by UNFPA, IDP and refugee GBV survivors suffer from restrictions on women's mobility in public spaces, cultural (specifically linguistic) and physical isolation, erosion of social networks and shortage in personal time which limits IDP women's chance to seek help (UNFPA, 2016b).

Social and structural barriers prevent GBV survivors from seeking help. In fact, 51% of GBV survivors reported that they had no access to women and youth centres (UNFPA, 2019).

Access to services was reported the lowest amongst returnees (31%) followed by the host communities (49%) and the IDPs in camps (64%) (UNFPA, 2019).

Iraq also suffers from inter-community (sectarian or ethnic) tensions, which results in the reluctance of GBV survivors to rely on the assistance provided by staff who belong to other religious or ethnic groups. This factor is strong in Baghdad and Kirkuk (UNFPA, 2019).

For GBV survivors who do access GBV services, the level of satisfaction with the services varies depending on the GBV survivor population. In fact, it is noted that the level of satisfaction with health, psychosocial support, safety, legal and referral pathway services was the lowest amongst the returnee survivors (35%) followed by the refugees (54%) and the host communities (59%) (UNFPA, 2016b).

Finally, several gaps were identified in the organization of coordinated GBV response among the key sectors including health care, law enforcement, judiciary support and psychosocial help. The gaps result in generating additional barriers that stop GBV survivors among IDP/refugees to seek and receive assistance (UNFPA, 2019).

In summary, preventing, mitigating and managing GBV is a complex challenge for any country, especially one like Iraq where norms, attitudes and the environment of conflicts constitute major barriers and where each governorate has its own social fabric and vulnerable population. It is therefore important to balance between a national perspective that addresses cross-cutting social, structural and behavioural

barriers and the need for a decentralised approach that effects targeted change in each governorate in response to the local context, needs and barriers.

### D.2.2. Policy guidelines associated with theme 2: gender-based violence

#### First priority area of intervention

#### Policy strategic objective 1: to promote GBV essential prevention, protection and response services

**Policy statements**

To promote GBV prevention, protection, response and coordination, key actors shall commit to the following:

**1. Enabling environment**

**a. Regulatory framework**

- Review and amend regulatory frameworks providing protection to sexual violence perpetrators in general and to rape and honour crimes perpetrators in particular.
- Eliminate child marriages and ensure the commitments of religious courts and the Iraqi Authority's Sharia judges to abide by the legal requirement of a minimum age for marriage specified at 18 years for both men and women.
- Develop policies and strategies that would ensure the availability and accessibility of comprehensive services for survivors of GBV/SGBV, including the collection of medico-legal evidence, PEP and emergency contraception.
- Develop policies and strategies which ensure that the most excluded women and girls, with particular emphasis on displaced persons and refugees and those in remote and rural areas, have equal access to GBV prevention and response.
- Ensure that community-based protection systems are effective at protecting women and girls from GBV including early and forced marriage, rape, intimate partner violence, honour crimes, FMG and domestic violence. Emphasis shall be made on the outreach to remote and rural areas and to the Kurdistan region for FGM.

**b. Communication, collaboration and coordination**

- Strengthen collaboration and coordination among the health, social and legal sectors for early reporting and treatment as well as for long-term legal, medical and psychosocial support for survivors and prosecution for perpetrators.
- Promote and maintain coordination with relevant gender and GBV national and regional coordination bodies and agencies.
- Provide technical support to integrate GBV risk mitigation into all aspects of SRHRR national and community-based interventions.

## 2. Quality of GBV services

- Ensure that health workers have the necessary knowledge, skills, and resources to (i) properly deal with sensitive GBV-related information, (ii) act with respect, sympathy and confidentiality with GBV survivors and (iii) adopt a survivor-centred approach for the provision of services.
- Upgrade health services and providers' capacities to provide a comprehensive response to sexual violence and its consequences, including counselling, shelters, women's and girls' safe spaces (WGSS), hotlines, prevention and treatment of STIs, collection of medico-legal evidence, prevention and treatment of HIV, post-exposure prophylaxis, emergency contraception, treatment and care for women with traumatic fistulas and pregnancy-related care.
- Increase the capacity of the police, prosecutors and judiciary actors for handling GBV issues.

## 3. Supply of GBV services

- Review the modalities of key-actor programming to provide services for GBV survivors and those at high risk in order to ensure that the do-no-harm principle is respected.
- Consider adapting standard UNFPA interventions such as WGSS and safe shelters to decrease the risk of GBV and to protect the survivors.
- Review and scale up approaches adopted for GBV service delivery, including those adopted for case management and psychosocial support in remote and rural areas. This shall be compounded with training, staff support and quality of care.
- Provide technical support to ensure that GBV prevention, clinical management care and referral systems are functioning according to the national guidelines.
- Prioritize reinforcing the response capability of national hotlines, if available.

- Increase remote access to mental health and psychosocial support as well as to safety planning opportunities through trained service providers.
- Ensure an effective access to justice, legal aid and remedies for survivors of GBV, including compensation and rehabilitation.
- Ensure that clinical management of GBV, such as forensic kits, sutural kits for cervical and vaginal tears, post-rape treatment kits and dignity kits, are available.
- Ensure that GBV referral pathways and information are updated and disseminated regularly to all GBV actors in order to facilitate access to GBV services.
- Establish a system for reporting sexual violence to facilitate the appropriate management of GBV/SGBV cases.

### 4. Awareness and social and behavioural change

- Raise the awareness of at-risk women and girls about their rights to protection from GBV and to seeking related services from credible service providers.
- Raise the awareness of mothers about SGBV and its implications on the wellbeing of their children.
- Encourage schools to incorporate information on SGBV and domestic violence prevention into health education curricula.
- Ensure concerned service providers are aware of protection from sexual exploitation and abuse measures and requirements.
- Engage men and boys to mitigate GBV and to foster positive masculinity, and promote gender equality to prevent GBV.
- Engage religious actors to influence the change of existing gender social norms and habits that reinforce GBV practices in general and honour crimes in particular.
- Promote advocacy and social mobilisation aimed at reducing GBV/SGBV.

### 5. Evidence-based and documented data and information

- Support ongoing research on the causes and possible preventions of GBV for decision-making.
- Promote and protect the ethical and safe collection and use of gender- and GBV-related data throughout any GBV response.
- Promote confidential reporting for GBV cases.

## D.3. Theme 3: contraceptive information and services in Iraq

### D.3.1. Theme overview

#### Contraceptive information and services in Iraq: indicators, problem areas and barriers

About 51% of married women aged 15–49 use a method of contraception in Iraq. Modern methods of contraception are used by 33% of women while 18% use traditional methods. The pill is the most common modern contraceptive used in Iraq reaching 15%, followed by the intra-uterine device (IUD) which is used by 10%. Among the traditional methods, the most common contraceptive method is withdrawal (14%), while only 2% of women rely on the lactational amenorrhea method as a contraceptive method, and only 1% on periodic abstinence (Rutgers, 2016).

The latest I-WISH survey data published in 2012 shows significant disparities in the contraceptive prevalence rate, with younger women having the lowest rate and a large disparity showing across different governorates ranging from 17% in Nineveh to 41% in Dhi Qar (I-WISH 2012).

Contraceptive pills are reported to be available in most pharmacies across Iraq (Abd, 2017). However, there are significant geographical disparities with less access in rural locations (Allami, 2015; Balinska et al., 2019).

Most of those who do not use contraceptives and family planning methods refrain from doing so out of social beliefs (Vilardo and Bittar, 2018). Women and youth often do not have access to sexual and reproductive health (SRH) information and services due to fear of discrimination or stigma (Tull, 2020). The key concerns for women seeking SRH health care include respect, trust, privacy and confidentiality — values that are often compromised in busy facilities (Allami, 2015).

Negative attitudes towards contraceptive methods have been found (Tull, 2020; Al Abedi et al., 2020). Health reasons and side effects were noted in almost 45% of people as a reason for not using contraceptives in Basrah (Tull, 2020). Perceived harmful effects of condoms were reported by 30.2% of men from Erbil (Tull, 2020). Patriarchal attitudes impede women's free access to family planning services (Allami, 2015). The husband's objection was also stated as a reason for women not using contraception (Tull, 2020).

These barriers become more significant among uneducated women, women who reside in rural settings and women who come from a low socio-economic status (Vilardo and Bitar, 2018).

Poor knowledge of contraceptives (including emergency contraception) has also been found among some general practitioners (Tawfeeq et al., 2020) and informally trained midwives (Aldabbagh and Al-Qazaz, 2020). Technological advances in family planning seem to be unavailable, and health care providers and women alike are unaware of newer family planning options (Aldabbagh and Al-Qazaz, 2020).

Besides the barriers and challenges faced in the provision of maternal health services as stated in the previous section of this report, poor information technology in PHCCs and poor leadership and governance are also important obstacles to family planning (Tull, 2020; Shabila et al., 2014). Although Iraq has had an official policy of providing family planning and contraception, it is unclear to what extent women are able to access those services as almost one-third of family planning institutions have been destroyed since 2003 (Allami, 2015). Also, research has shown a poor utilisation of public services as well as a general preference to use private services for women who can afford it (Shabila et al., 2014). This may be due to inadequate provision of information and poor interpersonal communication, particularly in PHCCs (Shabila et al., 2014). This, and other factors, lead to contraception use being higher for both men and women of higher socio-economic groups (Tull, 2020).

Information is scarce on the actual needs of adolescents and youth in Iraq, including the needs of the most vulnerable groups such as IDPs, refugees and returnees (UNICEF, 2018). Also, unmarried adolescents have reported difficulty accessing services as premarital sex is disapproved of (Tull, 2020; Tanabe et al., 2017). On the other hand, the latest I-WISH study stated that most girls between 10 and 14 years old expressed their need for more information about different matters concerning their health including reproductive health and family planning (I-WISH, 2012).

In summary, social, structural and behavioural barriers impede proper access and use of contraceptive information and services in Iraq. There is a lack of knowledge on modern family planning methods among health care providers as well as a need to improve interpersonal communication as a key factor in adequate counselling on family planning. Negative attitudes and misconceptions appear to be associated with limited contraceptive use among men and women. Uneducated women in rural areas with low socio-economic status, IPDs and refugees as well as adolescents are among the most affected by all barriers and thus need special attention.

## D.3.2. Policy guidelines associated with theme 3: contraceptive information and services

### Priority area of intervention

### Policy strategic objective 1: to ensure human rights in the provision of contraceptive information and services

**Policy statements**

To ensure human rights in the provision of contraceptive information and services, key actors shall commit to the following (as per WHO's guidelines and recommendations, 2014):

#### 1. Enabling environment

**a. Regulatory framework**

- Ensure that relevant laws and policies support programmes which ensure that comprehensive contraceptive information and services are provided to all segments of the population. Special attention should be given to disadvantaged and marginalised populations such as IDPs and refugees in their access to those services.
- Ensure that every individual has the opportunity to make an informed choice of their own use of modern contraception (including a range of emergency, short-acting, long-acting and permanent methods) without discrimination.
- Ensure that effective accountability mechanisms are in place and are effectively delivering contraceptive information and services, including monitoring and evaluation and remedies and redress, at the individual and systems levels.
- Ensure there is respect to women's and adolescents' rights to privacy and confidentiality, including respect to receiving advice and counselling on contraception.
- Ensure that women and adolescents are not deprived of any contraceptive information or services due to service providers' objections.

#### 2. Quality of services

- Introduce ongoing competency-based training and supervision of health care personnel on the delivery of contraceptive education, information and services with an emphasis on interpersonal communication. Competency-based training should be provided according to existing WHO guidelines.

- Ensure the incorporation of quality assurance processes, including medical standards of care and client feedback, into contraceptive programmes.

### 3. Supply of services

- Integrate contraceptive commodities, supplies and equipment that cover a range of methods, including emergency contraception, within the essential medicine supply chain in order to increase availability.
- Ensure that comprehensive contraceptive information and services are provided as part of maternal health care within both private and public health entities including PHCCs.
- Invest special efforts in providing comprehensive contraceptive information and services to displaced populations, to those in crisis settings and to survivors of sexual violence who particularly need access to emergency contraception.
- Recommend that mobile outreach services be used to improve access to contraceptive information and services for populations who face geographical barriers to access.
- Ensure the availability of follow-up services for managing contraceptive side-effects, and prioritize them as an essential component of all contraceptive service delivery.
- Ensure the availability of referrals for methods that are not available on site.

### 4. Awareness and social and behavioural change

- Ensure the availability of gender-sensitive counselling and educational interventions on family planning and contraceptives which are based on accurate information, which include skill building (i.e. communications and negotiations) and which are tailored to meet communities' and individuals' specific needs. Particular emphasis is to be placed on disadvantageous groups including IDPs and refugees as well as people residing in remote and rural areas.
- Ensure the provision of comprehensive and scientifically accurate sexuality education programmes that include information on contraceptive use and procurement within and outside of schools.
- Facilitate the elimination of social and financial barriers to contraceptive use by marginalised populations including adolescents and the poor, and make contraceptives affordable to all.
- Engage communities, particularly people who are directly affected, in all aspects of contraceptive programming and policy designing, implementation and monitoring.

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