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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

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A. Acronyms

AIDS	Acquired Immunity Deficiency Syndrome
ANC	Antenatal Care
BCC	Behavioural Change and Communication
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CMR	Clinical management of rape
EC	Emergency Contraception
EOC	Emergency Obstetric Care
FDA	Food and Drug Administration
FGM	Female Genital Mutilation
FP	Family Planning
GBV	Gender-based Violence
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
IPV	Intimate Partner Violence
LGBTQI+	Lesbian, Gay, bisexual, Pansexual, Transgender, Genderqueer, Queer, Intersex, Agender, Asexual and Ally community
MHPS	Mental Health and Psychosocial Support
MISP	Minimum Initial Service Package for SRH in crisis
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
PEP	Post-Exposure Prophylaxis

PNC	Postnatal Care
PPP	Purchasing Power Parity
PSEA	Protection against Sexual Exploitation and Abuse
RH	Reproductive Health
SBC	Social and Behavioural Change
SDG	Sustainable Development Goal
SGBV	Sexual and Gender-Based Violence
SRH	Sexual and Reproductive Health
SRHRR	Sexual and Reproductive Health and Reproductive Rights
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
WGSS	Women's and Girls' Safe Spaces
WHO	World Health Organization

B. Introduction

This document is annexed to a 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, as 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 Jordan. Accordingly, they are proposed within this report to ensure a comprehensive and holistic coverage of all necessary SRHRR policies essential for promoting SRHRR in Jordan and also to ensure the inclusiveness of this report if consulted independently from the regional report.

C. Jordan country overview

Jordan's total population, as reported in 2019, is estimated at 10,554,000 with a population density of 119 persons per square metre (Jordan Department of Statistics, 2019). The United Nations High Commissioner for Refugees (UNHCR) estimates that at least 1.35 million people from Syria currently reside in Jordan out of which 669,497 are registered with the UNHCR. Most of these people are unable or unwilling to return back to Syria because of danger, instability and political threats (UNHCR, 2021a; UNHCR, 2021b; Tobin et al., 2021).

Although Jordan is considered as a middle-upper income country (with a GDP of 44.5 billion US dollars for the year 2019 and a GDP per capita of 4,405 (ppp USD), regional conflicts and limited natural resources, including scarce water supplies, are continuous challenges to Jordan's socio-economic development.

The Jordanian population is young, with a median age of 22.4 years and 34% of the population being under 15 years of age. The absolute majority of Jordanians live in urban cities with only 10% in rural areas. The overwhelming majority of Syrian refugees (84%) in Jordan live in non-camp based rural and urban areas across the country; accordingly, only 16% of Syrian refugees live in camp-based settings (UNHCR, 2019).

The total fertility rate is estimated at 2.7 for Jordanian women, with the population expected to double in the next 30 years. The fertility rate, however, is quite higher among refugees with an estimate of 4.7 for Syrian refugee women. Illiteracy among the Jordanian population has decreased significantly over the years to reach 5% in 2019. The unemployment rate among Jordanians aged 15+ has increased from 12.5% in 2010 to 19.1% in 2019, with it being 27% among females compared to 17% among males (Jordan Department of Statistics, 2019).

The health sector in Jordan consists of service providers (public, private, international and charity sectors) as well as councils and institutions working on the development of health policies. Though the sector is quite advanced in terms of specialisation, the number of physicians per capita and the services offered, among other factors, as well as the sector's fragmentation pose a lot of challenges associated with governance that lead to ineffectiveness and inefficiency. These include increased running costs, the lack of an effective referral system, a weak sense of ownership by service providers and patients regarding the use of health services, poor coordination between the public and private sectors, a weak use of primary health care services, the lack of treatment protocols, the lack of consistency of services across sectors and the lack of capacity building of specialised staff (Jordan High Health Council, 2016).

In relation to SRHRR indicators, a sharp decline is noted with regards to infant mortality rate (IMR) which reached 17 children per 1000 in 2019 compared to 28 per 1000 in 1999. Improvement in maternal mortality ratios (MMR) has also been noted by recent estimates to reach 29.8 per 100,000 in 2018. This is consistent with the increased coverage of prenatal and postnatal care as well as the fact that almost 100% of births are attended by skilled health personnel (Jordan Department of Statistics, 2019). On the other hand, underage marriages represent 13.4% of all marriages in Jordan according to a study issued by the Higher Population Council in 2018. Also, gender disparities have led to Jordan having one of the lowest rankings in the region on the Gender Development Index (0.864), the Gender Inequality Index (111/188) and the Global Gender Gap Index (134/145). This has been reflected by the high prevalence of violence against women in the country — one in three ever-married women aged 15 years and above reported having been exposed to physical violence in 2018 (UNFPA CPD, 2018).

The situation is even more challenging for Syrian refugees in Jordan. A recent systematic review on the use of the minimum initial service package (MISP) for sexual and reproductive health (SRH) published in October 2020 indicated a number of barriers to the access, utilisation and implementation of SRH services, including the lack of reliable information on sexual and gender-based violence (SGBV), the aggravation of early marriages by crisis settings, gaps in the knowledge and use of family planning services, inadequate sexually transmitted infections (STIs) and human immunodeficiency virus (HIV) coverage and some other limitation issues around the provision of maternal health services for this target group (Amiri et al, 2020).

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

Last but not least, the patriarchal structure of the society and gender stereotypes within the Jordanian context constitute key elements that hinder women's advancement and access to resources and opportunities, and they therefore have a direct impact on SRHRR.

SRHRR is, therefore, an area of special concern in Jordan, particularly in rural and remote areas and within disadvantaged and vulnerable groups, including refugees among others. This makes SRHRR a highly relevant area for health improvement within the framework of the nation planned initiatives and undertaken endeavours.

D. SRHRR prioritized themes

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

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

According to the national maternal mortality report published in 2018, the maternal mortality ratio (MMR) in Jordan is calculated at 29.8 per 100,000 live births. While the numbers are low, they still account for a high proportion of preventable deaths. In these maternal deaths reported in 2018, obstetric haemorrhage was reported as the most common direct cause and the most frequent cause-specific maternal mortality factor in 30.5% of the cases. This is consistent with data observed in other countries where obstetric haemorrhage is considered the leading cause of maternal deaths. Fortunately, a significantly high proportion reaching 72–90% of the morbidity of obstetric haemorrhage cases are also considered to be preventable with proper prevention, diagnosis and management (USAID, 2018).

According to the latest published population and family health survey for 2017/2018 in Jordan, all deliveries were performed by a skilled provider (100%) and 98% were delivered in a health facility. The proportion of pregnant women receiving antenatal care (ANC) is also very high, increasing from 82% in 1990 to 98% in 2018. Around 75% of these women have had seven or more ANC visits. The majority of pregnant women received the basic components of ANC (over 95% for all components) and 78% percent of women took iron supplements during their pregnancy. In terms of postnatal care (PNC), results showed that 83% of mothers and 86% of newborns had PNC services within the first 2 days after birth (Jordan Department of Statistics, 2019).

Despite the positive indicators of the coverage of essential maternal health care for both ANC and PNC, to pinpoint the existence of a high utilisation rate of maternal and child health care services does not necessarily reflect a high quality of care. In fact, two recent studies, one conducted by Khader et al. (2018a) and another by Alyahya et al. (2019), assessing the quality of maternal and childcare services across the country have highlighted key areas for improvement.

In the study conducted by Khader et al. (2018b), where a total of 32 main hospitals that provide maternity services in Jordan were assessed, a significant level of inconsistency among these hospitals was observed, and the inconsistencies were related to their geographical locations and to whether they were public or private entities. Also, a wide range of deficiencies was noted in the assessed

hospitals including shortages of skilled and competent birth attendants, lack of optimal and thorough ANC and lack of necessary supplies, drugs, equipment and resources during labour and early PNC. The study also revealed that some health care professionals are not regularly trained in the routine and special care needed for labour and for the early postpartum period in both normal and complicated births; it also revealed the lack of pivotal protocols, policies and guidelines necessary for ensuring an optimal care (Khader et al., 2018a).

The study conducted by Alyahya et al. in 2019 offered qualitative data on maternal health care with a deep and rich insight into the social norms, behaviours and challenges that might affect Jordanian women's ability to take optimal advantage of the available maternal and newborn health care services. This study highlighted a degree of fragmentation of maternity care services in Jordan. Women reported that they are more likely to seek ANC in private sector clinics that, in comparison to public clinics, ensure a longer consultation time, higher quality services, better interpersonal and communication skills of the health care providers, more advanced equipment and devices, a more constant availability of female doctors and more flexible appointment times. However, most women cannot afford to give birth in private hospitals; accordingly, they choose to receive ANC at a private clinic but give birth in a public facility. This can significantly impact the continuum of services and can increase the fragmentation in care. Another concern was the services sought and received during the PNC visit. In fact, and while positive attitudes towards PNC were noted among the interviewed women, the findings of the noted study have revealed that women usually only seek health care settings after delivery to check on their infant's health (i.e., routine tests and vaccines) rather than on their own health. Women reported seeking postnatal facilities only to receive contraceptives or in cases of serious health conditions. Also, although the PNC rate is 83% for women in Jordan as reported above, there is little evidence on the utilisation patterns and predictors of full PNC services in Jordan (Alyahya, 2019).

In relation to the maternal health of Syrian refugees in Jordan and according to a health service assessment conducted by UNICEF, it was revealed that many Syrian mothers and their infants in Jordan lack access to appropriate maternal and newborn health care (UNICEF, 2017b). Additionally, 23% of Syrian women in camps were unaware of reproductive health services, 28% had experienced unplanned pregnancies and 17% did not access antenatal care for pregnancy (Kohler, 2014; Samari, 2017). Despite having a law that requires antenatal coverage in Jordan, most refugee women do not have a complete coverage (Kohler, 2014; Samari, 2017). Even though some maternal health services are available for use, refugee women are either unable to access these services or unsatisfied with the quality of care provided (Doocy et al., 2016; Samari, 2017).

As for refugees residing outside the camps, they face the same health care challenges faced by Jordanians (Samari, 2017).

Access to contraception

Unmet needs for family planning, broadly defined as the number of women who want to avoid or postpone a pregnancy but are not using any method of contraception, continues to persist despite having declined. In Jordan, according to the latest published population and family survey, after declining from 27% in 1990 to 12% in 2012, the unmet need for family planning increased to 14% in 2017–2018. While there is a clear indicator of a declining unmet need for family planning, there is no indicator on the status of the unmet contraceptive need among unmarried sexually active women in Jordan.

To mention that, unmarried women face challenges related to contraceptive use that differ from those of married women, and their needs are sometimes harder to determine. Strong taboos against sexual activity outside marriage make it more difficult to collect and assess unmet needs data — surveys do not always ask unmarried women about their recent sexual activity, which is the case in Jordan, and even when they do, women tend to underreport their sexual activity and contraceptive use (Sedgh et al., 2016).

A recent report published in 2019 by Amnesty International on Jordan details that access to contraception is unavailable in the public health system to unmarried women. This report highlighted that the concerned service providers at the Ministry of Health in Jordan ask women for their “family book” and deny family planning services to women who are not married. Providers of sexual and reproductive health services (SRHSs) in Jordan often wrongfully believe that it would be illegal to provide contraception to unmarried women (Amnesty International, 2019).

Another form of contraception is emergency contraception (EC). It is often referred to as the morning-after pill and is equally important to consider when addressing safe abortion. The World Health Organization (WHO) recommends several forms of EC to prevent an unwanted pregnancy within three days of intercourse. Emergency contraception medication is not approved by the Jordanian Food and Drugs Administration (FDA) and is not available on the market except through the clinical management of rape (CMR) concept. Also, EC is not available in public hospitals and cannot be purchased in pharmacies (Amnesty International, 2019).

In summary, while Jordan has made great progress on maternal health care indicators, further improvements are needed when it comes to the quality of obstetric care, to the consistency of maternal health care services across sectors

and geographic locations and to the continuity of care, with a need for improved communication between private and public health care providers and a more integrated service between ANC, intrapartum and PNC settings.

As for access to contraceptives, it is noted to be highly controversial for sexually active women outside of marriage, besides, emergency contraception is mostly not available, increasing both the likelihood of unwanted pregnancies and of unsafe abortions.

D.1.2 Policy guidelines associated with theme 1

I. Overarching maternal health 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 including antenatal care (ANC), emergency obstetric care (EOC) and postnatal care (PNC) services, 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 individuals for accessing and utilising SRHRR, including maternal health services, without any discrimination.
- Develop and activate regulations and processes allowing to guarantee legislated access to a comprehensive package of essential SRHRR including maternal health interventions and services.
- Identify problems and bottlenecks associated with the six 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 to expand coverage. This will contribute to sustainable improvements in health at the population level and in underserved regions. Accordingly, ensuring a sound functioning of primary health care centres and hospitals within districts is essential to improve 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 are in line with national health strategies, plans and budgets. This is important to avoid fragmentation of services.
- Ensure that SRHRR national initiatives and interventions support country-led processes that bring together key stakeholders to develop and implement national plans and strategies for improving maternal health services within a broader health systems framework.
- Ensure comprehensive and integrated SRHRR including maternal health services to all people, including vulnerable and marginalised individuals with no discrimination.

b. Resources

- Ensure the availability of the needed human resources within public and private health entities, particularly in urban and rural areas.
- Guarantee the availability of adequate SRHRR-related supplies, equipment and infrastructure.
- Establish support programmes favouring the affordability of needed maternal health services.

c. Collaboration and coordination

- Ensure the availability of an efficient and effective system of communication, referral and transport that is essential to preventing the risks of maternal mortality and morbidity.
- Ensure more regular interactions with the health system, including prenatal and postnatal visits, to allow women to access consistent support related to family planning, preventing unwanted pregnancies and decreasing the unmet need for contraception.

2. Awareness and social and behavioural change

- Develop and conduct awareness and social and behavioural change (SBC) public campaigns and interventions, 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 a demand for and increase the utilisation of SRHRR including maternal health services. Particular attention should be provided to influencing social norms and behaviours that influence women's attitudes and behaviours in seeking SRHRR including maternal health services.

- 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 achieving SRHRR goals.

Policy strategic objective 2: to improve the quality of maternal health services

Policy statements

To achieve delivering effective SRHRR interventions, including maternal health, of the highest quality, 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 including maternal health services by providing quality pre- and in-service education and training.
- Upgrade the performance of service providers to meet national and international standards through regular monitoring, on-the-job supportive supervision and performance appraisals.
- Equip and periodically supplement all SRHRR facilities continuously with adequate drugs, commodities and other essential supplies.
- Maintain compliance with the national accreditation system (if available) for the delivery of SRHRR including maternal health services.
- Establish quality assurance programmes to continuously monitor and guide further improvements in the quality of SRHRR including maternal health services.
- Invest in training, recruiting and retaining 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 aiming 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 Jordan 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 including maternal health research.

- Conduct research on the special needs of adolescents, youth and other marginalised groups in order to improve the design and execution of SRHRR, including maternal health interventions.

Third priority area of intervention

Policy strategic objective 1: to ensure the provision of essential SRHRR including maternal health services 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. Supplying maternal health services

- Expand SRHRR including maternal health quality services within public and private facilities with emphasis on public facility and community-based entities.
- Promote an equal and even distribution of skilled staff in urban, suburban and rural areas and at the community level with a proper gender distribution.
- Strengthen communication and referrals between the different levels of care.
- Promote the provision of adequate basic SRHRR equipment and supplies to all concerned facilities with an emphasis on public entities.
- Ensure the delivery of comprehensive maternal health services to marginalised population groups including people with disabilities.

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 appropriately trained 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 the early detection of risks of maternal death after delivery.
- Ensure the quality and timely treatment of complications arising from unsafe abortions in a manner that protects women's privacy, confidentiality and dignity.
- 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.
- Provide commodities including contraceptives through concerned facilities in each country to every individual of reproductive age, especially to women without the consent of the spouse or partner.
- 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 cures.
- Develop protocols and guidelines for the management of reproductive tract diseases.
- Plan and conduct programmes aiming at reducing the spread of STIs/HIV/AIDS. This includes the promotion and dissemination of appropriate information, education and communication (IEC) and of behavioural change communication (BCC) on reproductive tract infections at all levels of care.
- Advocate for a continuous supply of affordable drugs and of alternative therapies for reproductive tract diseases.
- Promote the testing of HIV and syphilis for pregnant women during antenatal care.
- Provide STI services and integrate such services in all types of care services including primary, HIV, reproductive health, family planning, antenatal and postnatal care services.
- Deliver human papilloma virus (HPV) vaccines through the National Immunisation Programme.

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

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

Domestic violence

According to the latest family and population survey conducted in Jordan in 2018, 21% of ever-married women aged 15–49 years have experienced physical violence since the age of 15, and 2% of them have experienced physical violence during pregnancy (Jordan Department of Statistics, 2019). To note that some particular populations within Jordan may face even worse conditions, one study estimated the overall prevalence of violence perpetrated against pregnant women in a bedouin community at 40.6% (Okour, 2011).

24% of ever-married women who have experienced spousal physical or sexual violence reported injuries. What is alarming is that only 1 in 5 women (19%) who

have experienced any physical or spousal sexual violence have sought help to stop the violence, while two-thirds have never sought help or told anyone about the violence. Among women who have experienced physical or sexual violence and sought help, the most common source for help was their own family (77%). It is quite uncommon for women who have experienced physical or sexual violence to seek help from service providers such as doctors/medical personnel, lawyers and the police. Also, 3% or less of women suffering such violence have ever sought help from any of these sources (Jordan Department of Statistics, 2019).

Minimum age of marriage

Currently, the Personal Status Law No. 15 of 2019 specifies in paragraph A of article 10 that the age of marriage is 18 solar years. However, in paragraph B of the above-mentioned article allows exceptions for those who have reached 16 solar years. Previously, the age of marriage was 15 lunar years in the 1976 law, and the temporary law of 2010 set the age of marriage at 18 with an exception being allowed for those who reached 15 years of age. The amendments of 2019 were undertaken due to a public interest in the issue. The application of the exception in paragraph B was further restricted in scope as it requires the approval of the Chief of Justice for the marriage to proceed. The approval of the Chief of Justice requires the application for marriage to go through multiple stages as well as satisfy multiple criteria, such as requiring that the girl does not drop out of school to proceed in the marriage. The criteria are regularly subject to amendment and the high number of cases where the marriage is approved by the Chief Justice Department continues fuelling the debate about the necessity to cancel the exception entirely or to alternatively further restrict its application to specific cases.

It should be noted that basic education for the age group 6–16 years is compulsory and free in public schools in accordance with article 10 of the Education Law No. 3 of 1994 and its amendments.

Femicide and so-called “honour crimes”

Recent preliminary findings of the Jordanian National Commission for Women suggest that there were 20 femicide crimes in 2020 and 19 crimes in 2019. The study reflected that 77% of the perpetrators were family members. The results showed that 39.1% of the perpetrators were the victim's brother, 20.2% a group of her family members, 17.5% the victim's father, 13.5% the victim's husband, 5.4% the victim's uncle, 2.7% the victim's half-brother and 1.3% the victim's cousin (Jordanian National Commission for Women, 2021a; JNCW, 2021b).

The study also found that 8.1% of the victims were minors, while 20.5% of them were in the age group of 19 to 30 years old, and 9.4% were between the ages of 31 to 40. However, the age of the victim was not mentioned in 62.1% of the total cases (Jordanian National Commission for Women, 2021a; JNCW, 2021b).

As for the motives/reasons for murder, 20.2% of the crimes were because of family or marital disputes followed by 18.9% that were because of absence from home. 9.4% of the crimes were caused by financial issues and 4% were caused by using Facebook or the phone (Jordanian National Commission for Women, 2021a; JNCW, 2021b).

There are no clear statistics on 'honour killings' as such, but estimates from the early 2000s indicate that Jordan may have had some of the highest rates of honour killings in the world per capita (Faqr, 2001).

Female genital mutilation

When it comes to female genital mutilation (FGM), the National Centre for Human Rights has not documented any such cases since its establishment in 2003 although Jordan has no specific legal prohibition of FGM. Anecdotal evidence and media reports suggest that the practice of FGM in Jordan is very low and highly localised.

Underlying factors

Indicators across the board show that several barriers impede the proper prevention, mitigation and management of GBV in Jordan. A recent study examined the socio-ecological environment surrounding GBV in an attempt to understand related underlying factors and key determinants. The results of this study indicate that norms, attitudes and policies that support practices related to SGBV and child marriage are deeply entrenched within families and communities. These are reinforced by the restrictive gender norms that limit freedoms and opportunities available to girls and are well embedded in the legal frameworks of both governmental and religious institutions leading the way to these practices to continue (Gausman et al, 2019).

Another study conducted by the UNICEF in 2014 on early marriage also found that most people believed there were certain compelling circumstances under which early marriage is acceptable though many believed that early marriage is not generally advisable. Among Jordanians interviewed in the study, an overwhelming majority reported that the major contributing factor to early marriage was the

fact that it was a socially accepted tradition and that it was believed to ensure protection for girls.

The Family and Population Survey of 2018 reports that 46% of ever-married women and 69% of all men aged 15–49 agree that the beating of one's wife is justified under at least one of the specified circumstances. Among women, attitudes justifying the beating of wives generally decline with increasing education and household wealth (Jordan Department of Statistics, 2019).

Discriminatory laws also appear to codify the continued practice of honour crimes and child marriages. This is done by allowing for loopholes that enable families to marry girls below the age of 18 based on religious or social grounds, by maintaining legal justifications for honour killings and by continuing the practices that introduce gender bias in official statistics so that instances of honour killings are not reliably recorded (Gausman et al, 2020).

It is also important to note that within this context, Jordan ratified the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) in 1992 but held reservations to article 9(2) which states equal rights with regards to the nationality of children, article 16(1)(c) which states equal rights and responsibilities during marriage and at its dissolution, article 16(1)(d) which states equal rights and responsibilities as parents and article 16(1)(g) which states equal personal rights including the right to choose a family name, a profession and an occupation. The expressed reservations to these articles do not support the proper prevention of and protection from GBV.

In terms of services offered to GBV survivors, it should be noted that in spite of the progress made in recent years, there is still a lack of 'safe spaces' especially in highly populated areas. A need for more capacity building of frontline workers is also highlighted. The most substantial challenging issue remains to be legal assistance and security services. These are still considered to be one of the greatest sensitive areas of service provision as the majority of survivors decline referrals. Survivors, in fact, have expressed fears of retaliation in case of seeking police assistance as well as fears of stigma due to the lack of confidentiality and of a survivor-centred approach among law enforcement actors (victim blaming, perpetrators asked to sign pledges instead of serving jail terms, etc.). Furthermore, the legal system does not encourage survivors to come forward as specific types of SGBV are not being criminalised (such as marital rape) or due to related inflicted punishments being too lenient (GBV IMS Task Force, 2019).

In summary, preventing, mitigating and managing GBV is a complex challenge for any country especially for Jordan where norms, attitudes and policies constitute major barriers. Several problem areas are identified. These include the gender roles

perpetuated in families and communities, the attitudes of both men and women towards violence against women, the lack of awareness on and access to the services offered, the poor quality of case management at multiple levels and the barriers in the legal and policy environments.

Also, there is currently limited research and understanding of the gaps in the existing service delivery infrastructure available to support survivors of GBV as well as of the barriers faced by the survivors in accessing those services.

D.2.2. Policy guidelines associated with theme 2

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

- Adopt a broad definition of sexual violence to include non-consensual sex.
- Review and amend regulatory frameworks providing protection to sexual violence perpetrators in general and to rape and honour crimes perpetrators in particular.
- Strengthen Law No. 15 for 2017 that protects women and girls from domestic violence by clarifying the definition of domestic violence crimes.
- Ensure that community-based protection systems are effective for protecting women and girls from GBV including early and forced marriage, rape, intimate partner violence (IPV), honour crimes and domestic violence. Emphasis shall be made on outreach to remote and rural areas.
- Eliminate child marriages and specify that the legal minimum age for marriage should be 18 years for both men and women with proper limitations of validated exceptions made.

b. collaboration and coordination

- Strengthen collaboration and coordination among the health, social and legal sectors for early reporting and treatment and 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.

2. Awareness and social and behavioural change

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

3. Evidence-based and documented data and information

- Support ongoing research on the causes and possible preventions of SGBV for decision-making as well as on the gaps associated with SGBV services and the utilisation of these services.
- 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.

Policy strategic objective 2: to improve the quality of GBV-related services

Policy statements

To increase the capacity of SRHRR health care providers to support the management of GBV cases and provide quality services, key actors shall commit to the following:

1. Quality of GBV services

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

Second priority area of intervention

Policy strategic objective 1: to improve the accessibility and utilisation of GBV services

Policy statements

To achieve a comprehensive access to and utilisation of GBV-related services, key actors shall commit to the following:

1. Enabling environment

a. Regulatory framework

- Strengthen the policies and strategies which facilitate the availability and accessibility of comprehensive services for survivors of GBV/SGBV including the collection of medico-legal evidence, PEP and emergency contraception, and ensure the implementation of these policies and strategies.
- Develop policies and strategies which ensure that the most-excluded women and girls — including those from indigenous communities, persons living with disabilities, those from the LGBTQI+ community (lesbian, gay, bisexual, transgender, queer or questioning and intersex), displaced persons, migrants, refugees and others — have equal access to GBV prevention and response.
- Support and strengthen the development of an infrastructure where survivors can seek help and protection.

Third priority area of intervention

Policy strategic objective 1: to ensure the provision of GBV services

Policy statements

To ensure a proper provision of GBV essential services, key actors shall commit to the following:

1. Supply of GBV services

- Review the modalities of key-actor programming to provide services for GBV survivors and those at high risk ensuring that the do-no-harm principle is respected and that a survivor-centred approach in service delivery is applied.
- Consider adapting standard UNFPA interventions, such as women's and girls' safe spaces (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 the ones 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 and response and GBV referral systems are functioning according to the national and regional guidelines.
- Prioritize reinforcing the response capability of national hotlines.
- Increase remote access to mental health and psychosocial support (MHPSS) and safety planning opportunities through trained service providers.
- Ensure an effective access to justice, legal aid and remedies for GBV survivors, including compensation and rehabilitation.
- Ensure the availability of GBV clinical management tools such as forensic kits, sutural kits for cervical and vaginal tears, post-rape treatment kits and dignity kits.
- Ensure that GBV referral pathways and information are updated and disseminated regularly to all GBV actors to facilitate access to GBV services.

D.3. Theme 3: autonomous decision-making and bodily integrity concerning marginalised and disadvantaged groups (with a focus on adolescents)

D.3.1. Theme overview

With the adoption of the 2030 Agenda, UN member states pledged to ensure that “no one will be left behind” and to “endeavor to reach the furthest behind first”. Thus, all of the SDGs, including those related to sexual and reproductive health and wellbeing, are aimed at reaching marginalised populations (UN General Assembly, 2015).

Some population groups often experience poorer sexual and reproductive health outcomes including adolescent girls, indigenous peoples, migrants, sex workers, persons with disabilities and people of diverse sexual orientations and gender identities (UN, 2006).

Preserving autonomy is a central component of the right to life, the right to privacy and liberty and the right of the individual to make informed decisions about their own body, among others (UN, 2006).

Adolescents face numerous barriers in exercising their sexual and reproductive autonomy. In the area of marriage and access to sexual and reproductive health services, for example, adolescents face numerous obstacles including the stigmatisation of adolescent sexuality. This is compounded with the existence of laws and policies that discriminate on the basis of age or that mandate parental/guardian consent or authorisation for reproductive health services.

The resulting lack of autonomy hinders the access to confidential health care and comprehensive sexuality education as well as the access to contraceptive measures. It also subjects them to harmful practices such as early and forced marriage or female genital mutilation (CEDAW, 2009).

Autonomous decision-making and bodily integrity of adolescents in Jordan: indicators, problem areas and underlying factors

Adolescents in Jordan constitute 21.5% of the population (Jordan Department of Statistics, 2019). The most recent Jordan Population and Family Health Survey reports that a majority of them face an array of threats to their bodily integrity, some of which are age related. More than three-quarters of children aged 10-14 years have reported experiencing violent discipline at home in the past month, with more than half experiencing physical punishment and more than a tenth experiencing severe physical punishment (Jordan Department of Statistics, 2019).

Research has also found that violent discipline at school is endemic, with Syrian refugees regularly bearing the brunt (UNICEF, 2017a; Krafft et al., 2018). Risks that adolescents face are, however, deeply gendered — while boys are more at risk than girls of physical violence especially from teachers and peers, girls are at risk of child marriage and sexual and gender-based violence (Abu Hamad et al., 2017; UNICEF, 2017a; IRC, 2015; USAID, 2015).

Many adolescents in Jordan also face considerable challenges in addressing their SRH needs (Khalaf et al., 2010; Johns Hopkins, 2001), including those related to the prevention of unintended pregnancies and STIs (Higher Population Council and Health Policy Project, 2013; Johns Hopkins, 2001), those related to early marriage (UNICEF 2014; Kradshah, 2012) and those related to sexual coercion and violence (Okour and Badarneh, 2011).

In fact, because marriage and sexual activity are tightly linked in Jordan, and because taboos about discussing sexual topics are quite strong (Al Omari et al., 2016; Anwar, 2016; Sanjakdar, 2009; DeJong and El-Khoury, 2006), relatively few unmarried adolescents appear to have accurate information about pregnancy or contraception (Jones et al., 2019).

In fact, the National Youth Survey of 2015 indicated that 70.5% of the surveyed youth (15–24 years) did not hear about sexually transmitted diseases (STDs), while only 11.5% of them did not hear about HIV/AIDS (UNESCO, 2017). The National Youth Survey conducted in 2001, which included 2142 Jordanians aged 15–24 years, shows that 29% of women and 44% of men aged 15–24 years did not know the meaning of the term reproductive health, and health care providers and media were the preferred sources of family planning and SRH information (Johns Hopkins, 2001), whereas a qualitative study of 60 Jordanian adolescent men and women between the ages of 12 and 18 indicated that there is a significant demand for reproductive health information, counselling and accessible and youth-friendly services near where they live or study (Khalaf et al., 2010).

Adolescent females (10–19 years old) may be able to find adolescent-friendly care services as part of maternal and child health centres. As for young boys, a study in 2010 indicated that young boys aged 12–18 never tried to go near maternal and child health centres because only women go there (Khalaf et al., 2010).

Additionally, a few qualitative studies conducted among Jordanians and Syrians have documented that youth perceive available family planning services to be unpleasant, unprofessional and of poor quality. Youth cite concerns that providers do not take them seriously, treat them like children, do not know what information youth need and view youth's questions as inappropriate (Khalaf et al., 2010).

An evaluation of services offered at selected public and private clinics in Jordan

noted a lack of private rooms at the Ministry of Health's (MoH) clinics, which is a concern that has been echoed by youth. Another study found that providers often give incorrect information to youth regarding reproductive health, such as instructing them not to use contraception because of fears over the relationship between family planning and infertility. Because of these and other challenges, utilisation rates of public sector health services among adolescents are extremely low. The Jordanian MoH estimates a primary health care utilisation rate among adolescents at 1% or less (MoH Jordan, 2015).

If we are to examine the policy landscape addressing this population, and in spite of having an increasingly youthful society, we find that health strategies tend to address young people's health issues implicitly with no clear definition of youth and adolescents as segments with specific needs nor with any indicators specifically aimed to address youth and adolescent health issues or progress of interventions. The National Reproductive Health Strategy has indicated that young people account for a high proportion of the Jordanian population and are the centre of the developmental process. It confirms the value of engagement of young people in population issues as well as the value of promoting positive beliefs and concepts on reproductive behaviour among this target group. This will ultimately contribute to the achievement of the desired SRHRR goals. Accordingly, the strategy considers youth as key players in awareness, services and policies. Nonetheless, health indicators lack segregated data on youth-specific issues. There is also a lack of information on the measures taken by Jordan to improve adolescent health through sexual and reproductive health education or adolescent-friendly health services.

In summary, adolescents, who comprise a substantial part of the population, are still largely overlooked by the health and education sectors in Jordan especially in relation to building and strengthening their autonomous decision-making and bodily integrity with regards to their sexual and reproductive health and rights. To date, there are no clear measures taken to offer nationwide youth-friendly services where the right to privacy and confidentiality are preserved and where health care providers and peer educators are willing and able to provide youth-sensitive services and counselling. Another key gap is the absence of mechanisms and procedures to ensure the participation of adolescents in the formulation, implementation and monitoring of relevant sexual and reproductive health strategies and programmes.

D.3.2. Policy guidelines associated with theme 3

Priority area of intervention

Policy strategic objective 1: to promote essential prevention, protection and response for autonomous decision-making and bodily integrity concerning marginalised and disadvantaged groups (with a focus on adolescents)

Policy statements

To promote essential prevention, protection and response for autonomous decision-making and bodily integrity concerning marginalised and disadvantaged groups, key actors shall commit to the following:

1. Enabling environment

a. Regulatory framework

- Introduce a legal assumption of competence that an adolescent seeking preventive or time-sensitive SRHRR goods and services has the required capacity to access such goods or services without parental/guardian consent or authorisation.
- Support initiatives that engage youth in the development of national youth-related strategies.
- Ensure that adolescents are recognised by law as rights holders who have the capacity to gradually become full and responsible citizens when given proper guidance and direction.
- Ensure there is respect for adolescents' rights to privacy and confidentiality, including respect for receiving advice and counselling on SRHRR matters.
- Ensure that adolescents are not deprived of any SRHRR information or services due to service providers' objections.

2. Quality of services

- Increase the capacity of health care providers to provide information and services to adolescents according to guiding principles associated with privacy, confidentiality and respect among others noted in the regional report.

3. Supply of services

- Ensure that appropriate services are made available to adolescents independent of parental or guardian authorisation when this is in the best interest of the adolescent.
- Ensure the availability of youth-friendly and confidential reproductive health services including family planning for adolescents from different socio-economic backgrounds.

4. Social and behavioural change

- Provide adolescents and their families with information on the dangers of early marriage and early pregnancy, on evidence-based sexuality education and on ways to protect themselves from unwanted sex and/or unintended pregnancies and sexually transmitted infections.
- Increase the awareness of families about the rights of adolescents for autonomous decision-making and bodily integrity.

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