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| HEALTH SERVICES QUALITY ACCELERATOR ACTIVITYGENDER EQUITY AND SOCIAL INCLUSION ANALYSISOctober 2021 |

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# ACRONYMS AND ABBREVIATIONS

|  |  |
| --- | --- |
| **ANC** | Antenatal Care |
| **CHC**  | Community Health Committee |
| **COC**  | Combined Oral Contraceptives |
| **DHS**  | Demographic and Health Survey |
| **FP**  | Family planning |
| **GBV** | Gender-Based Violence |
| **GESI** | Gender Equity and Social Inclusion |
| **HSQA** | Health Services Quality Accelerator  |
| **IUD** | Intrauterine Device |
| **JCAP**  | Jordan Communication, Advocacy, and Policy Activity |
| **M&E**  | Monitoring and Evaluation |
| **MCH**  | Maternal and Child Health |
| **MOH**  | Ministry of Health |
| **NEET** | Not in Education or Employment  |
| **NGO** | Non-Governmental Organization |
| **PNC**  | Postnatal Care |
| **PWD**  | People with Disabilities |
| **RMNCH** | Reproductive, Maternal, Newborn, and Child Health  |
| **UNCHR** | United Nations Refugee Agency |

# INTRODUCTION

The goal of the USAID Health Services Quality Accelerator (HSQA) Activity is to accelerate and sustain improvements in equitable reproductive, maternal, newborn, and child health (RMNCH) outcomes, moving Jordan towards self-reliance and sustainability. The activity has an emphasis on equity: that everyone has a fair opportunity to reach his or her full health potential. This focuses attention on marginalized populations who are continually underserved by their health system and experience disproportionately poor health outcomes.[[1]](#footnote-1)

HSQA’s gender equality and social inclusion (GESI) approach focuses on the gaps encountered by some population groups in access to, uptake of, and receiving quality RMNCH services. It encompasses gender as well as a broader range of social and structural determinants that reduce the equity for specific population groups in Jordan. Some of the marginalized groups who have been identified as having lower RMNCH service utilization and poorer health outcomes include women, youth particularly girls, people with disabilities (PWD), refugees, and people with less education or lower incomes. Those who experience multiple intersecting inequalities are the most marginalized.

The Year one GESI Work Plan :

* Support HCAC to include youth-friendly services among the accreditation standards.
* Work in leveraging existing training materials and create new specialized GESI materials to shift provider norms related to youth SRH, GBV (Gender-Based Violence), PWD accessible services and gender by incorporating content on leaderships, management, and respectful care into pre-and in-service training and continuous professional development (CPD).
* Identify GESI stakeholders in the health sector and begin engaging them in dialogue about how the Activity can contribute to GESI specifically in the health sector in relation to RMNCH service delivery. This included government, academic, professional association, NGOs and INGOs
* Provide technical support to make health facilities more inclusive of men and accessible for PWD, GBV survivors/victims and other marginalized groups.
* Provide capacity development for MOH and other partners to mainstream GESI principles in the services.
* Participate in revision for related legislations and policies from gender and inclusion perspective if needed/ requested by MOH or other partners.
* If needed, participate in developing reports on RMNCH related human rights treaties and mechanisms such as CEDAW, CRC, CRPD, UPR.
* Engage local government and elected officials to improve the accessibility infrastructure and safe transportation to the health services.

# GENERAL OVERVIEW ABOUT RMNCH IN JORDAN

Jordan worked to improve the quality of RMNCH services by developing some strategies and adopting good practices in the last decades. However, research and studies show that there are numerous challenges that face the achievement of RMNCH targets in Jordan, including limited integration of RMNCH programs in primary healthcare programs at health centers and obstetrics/ gynecology services in hospitals. Other challenges include the shortage of programs that evaluate the level of RMNCH services in both public and private sectors, the compliance of service providers with approved protocols, beneficiaries’ satisfaction with the client care provided by the staff, and the proper protocols, weak RMNCH services provided to Syrian refugees in camps or host communities in addition to the financial, social, cultural barriers preventing Syrian refugees from accessing services.[[2]](#footnote-2)

Second, missing some services such as sexual health, sexually transmitted diseases, adolescent and youth health affect the availability and quality of RMNCH comprehensive services, excluding groups of people. Also, lack of accessible and comprehensive package of essential RMNCH services for some groups such as youth, PWD, GBV survivors/ victims and lack of specialized and integrated services (medical, psycho-social, and family) to ensure accessibility for all groups, including minorities who are at risk of exclusion and discrimination.[[3]](#footnote-3)

Other key challenges are the lack of specialized RMNCH training programs for service providers; and weak and discriminatory legislation and regulations to support rights based RMNCH service delivery. Lack of coordination among donors who fund RMNCH and FP programs, inadequate capacity developing courses, and adolescent health education programs targeting youth and RMNCH, lack of awareness programs about FP and reproductive health aimed at engaged couples.[[4]](#footnote-4)

# LEGISLATIVE REViSION OF RMNCH RIGHTS

Jordan is committed to the following legal instruments to provide RMNCH services:

* ***At the global and regional level:***
1. Sustainable Development Goals.
2. The International Covenant on Economic, Social and Cultural Rights
3. Convention on the Elimination of All Forms of Discrimination against Women
4. Convention on the Rights of the Child
5. Convention on the Rights of Persons with Disabilities.
6. Decisions of the International Conference on Population and Development, and all successive reviews including the Post-2014 Conference on Population and Development[[5]](#footnote-5)
7. Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations[[6]](#footnote-6)
8. The national commitments at the Nairobi Summit (25), Jordan continues to provide quality information, advice and FP services based on the human rights approach, especially in remote areas and to vulnerable groups, and to provide FP through the MOH and distribute to all concerned stakeholders, where Jordan aspires to raise the rate of using modern FP methods from 37.4% in 2018 to 43.3% in 2025.  Jordan continues to work to reduce sexual and gender-based violence by implementing legislation to protect against violence, reduce child marriage; implementing strategies, programs, social, psychological and health services and implementing the National Action Plan to limit the marriage of individuals under the age 18 in Jordan 2018-2022 [[7]](#footnote-7).
9. The global Strategy for Women's, Children’s, and Adolescent Health (2016-2030).[[8]](#footnote-8)
10. Multi-sectoral Arab Strategy for Maternal, Child, and Adolescent Health 2019-2030.[[9]](#footnote-9)
11. A Framework for Sexual and Reproductive Health Integration in Primary Health Care of the Arab States[[10]](#footnote-10).

Jordan also is committed to national policies and legislations, including:

* National Reproductive and Sexual Health Strategy 2020-2030.[[11]](#footnote-11)
* The Jordanian Response Plan for the Syrian Crisis 2020-2022.[[12]](#footnote-12)
* MOH strategic plan 2018-2022.[[13]](#footnote-13)
* Costed Implementation Plan for FP 2020-2024.[[14]](#footnote-14)
* The National Strategy for Health Sector in Jordan 2016- 2020.[[15]](#footnote-15)

On the other hand, the Jordanian constitution is the backbone of all legislations. At the beginning of 2022, parliamentarians approved adding “Jordanian women” to the title of the second chapter of the Constitution to become the “Rights and Duties of Jordanian Men and Women.” Besides amending paragraph 5 of the same article of the Constitution aiming at enhancing legal protection for persons with disabilities and increase their political participation. These amendments are supposed to improve equality between men and women, especially in accessing respectful services. Jordan enacted several legislations addressing the RMNCH rights and services. This section will present most of these legislations on a thematic level.

**Awareness for youth:** Article 6 in Education law indicated that “the Ministry of Education must provide guidance and preventive health care in public schools and supervise its availability in the proper level in the private schools”. However, the reality confirms a lack of educational programs that cover adolescent health in school curricula and the schools do not provide sufficient health information for youth.

**Maternity and childcare:** In 2016, the Jordanian government issued the monitoring bylaw of women's death during pregnancy, childbirth, and puerperium No. 10 of 2016. The bylaw stipulated the establishment of a national registry in the MOH for maternal deaths so that every death that occurred during pregnancy, childbirth, and the puerperium would be recorded. Article 6 in this bylaw stipulated that the Minister of Health forms a national committee to study cases of deaths arising from pregnancy, childbirth, and the puerperium, the causes and places of death, and submits recommendations to the Minister of Health to reduce women's deaths.

As for childcare and the provision of breastfeeding, the Public Health Law[[16]](#footnote-16) stated in Article 4 that the MOH should coordinate with the relevant authorities to encourage and promote breastfeeding for children. The MOH has the right to ban any visual, audio, or read advertising and any means of displaying notes, instructions, identification cards, display sheets, pictures, films, or goods to advertise alternatives to breastfeeding. The same article emphasized the need to take care of the health of women and children by providing the necessary services for them, including taking care of the pregnant woman during pregnancy, during childbirth, and during the puerperium, monitoring the growth of the child, and providing vaccinations, following the reproductive health and FP requirements, besides the obligation to conduct the necessary medical examination for those wishing to marry. It is not permissible to perform the marriage contract before conducting this examination. In addition, Article 29 of this law obligated parents to visit any public health centers or authorized vaccination centers or doctors to vaccinate the child with the vaccines listed within the National Immunization Program, free of charge.

The Jordanian Personal Status Law No. (15) of 2019[[17]](#footnote-17) in the article (166) obligated the mother to breastfeed her child if his/her father has no money to pay for another woman to breastfeed the child, if the mother refuses, the father should pay for another woman to breastfeed the baby as stipulated in Article (167) of the same law.

In the same context, the Labor Law[[18]](#footnote-18) granted women workers in the private sector seventy days of paid maternity leave. While the civil service bylaw[[19]](#footnote-19), gave women employees in the public sector ninety days of maternity leave aimed at preserving the health of the mother and the infant and improving breastfeeding opportunities. The feeding hour for working women aims to enhance breastfeeding for children under one year, but there is no evidence that breastfeeding will occur. So, some recommendations ask to change this hour to be "hour of care" instead of breastfeeding hour and allow the working father to have this hour to take care of his children during the first year of their lives.

According to official figures, approximately 48% of the total workers in Jordan are not registered in the national social security system, The percentage of women participating in social security is 28.5%[[20]](#footnote-20). Most of the working women are concentrated in agriculture, secretarial and beauty salons. This situation forbade them from benefiting from maternity leave and other social protection rights, including health insurance[[21]](#footnote-21).

**Early Marriage:** Article (10) of the Jordanian Personal Status Law No. (15) of 2019[[22]](#footnote-22) requires both males and females to complete eighteen years of age to be eligible for marriage eligibility. But the same law gave the power to judge in exceptional cases, to approve the marriage of a person who has reached the age of sixteen years. As detailed later, this provision justifies early marriage and a flagrant violation of children's rights, which causes them many health, psychological and social risks.

**Abortion:** In terms of protecting the life of the fetus, Jordanian legislation rejected and criminalized abortion, as Articles 321 to 325 of the Jordanian Penal Code[[23]](#footnote-23) stipulate penalties for abortion, whether with the pregnant woman's consent or without her consent. However, Penal Code increases the penalty in three cases; in cases of her refusing the abortion, in case of causing her death because of this abortion, and in case the person who performed the abortion is a doctor, surgeon, pharmacist, or midwife. While Article 324 reduces the penalty for what has been called honor crimes.

**Women in Prisons**: The Jordanian Execution Law No. 25 of 2007[[24]](#footnote-24), in Article No. (23-a-5), prohibits the imprisonment of a woman in-debt if she is pregnant, and this provision remains active until three months after giving birth. The newborn's mother will not be imprisoned until her child completed two years of age. Besides that, the Correction and Rehabilitation Centers Law No. 9 of 2004[[25]](#footnote-25) in Article 15 stipulates that the pregnant woman in prison must be treated appropriately according to the doctor's directions and according to instructions issued by the Minister for this purpose, and if the inmate gives birth inside the prison, this will not be recorded in the birth certificate. Instead, it's sufficient to register the governorate in which the center is located, and the inmate may keep her newborn until it has completed three years of age and then hand him/her over to his/her relatives.

**Reproductive and sexual health rights for persons with disabilities:** Article (23) of the Rights of Persons with Disabilities act number 20 to 2017[[26]](#footnote-26) stipulates that the MOH, the General Food and Drug Administration, and the relevant authorities, in coordination with the Higher Council for the Rights of Persons with Disabilities, provide reasonable accommodations that are needed to ensure that women with disabilities can fully benefit from reproductive health programs and services.

In terms of ​​the right to body integrity, it was noted that hysterectomy and sterilization for persons with intellectual and psychosocial disabilities have become a genuine concern to human rights and persons with disabilities activists. These actions are justified by those who commit them as medically needed, while non-medical specialists cannot argue their validity and credibility. No legislation explicitly criminalizes or punishes these crimes. While recommendation No. 53 of the Universal Periodic Review in the seventeenth session confirmed that article (335) of the Penal Code[[27]](#footnote-27) could be invoked to punish performing hysterectomy for women with disabilities or other forms of forced sterilization. The Law of the Rights of Persons with Disabilities also considered in Article No. 30 that a hysterectomy is violence against women with disabilities unless it is for medical reasons that affect their health and life. In addition, the General Iftaa' department prohibited in 2014 the removal of uterus for girls with disabilities, except in cases of illness that can't be treated without this operation[[28]](#footnote-28).

**Reproductive health rights for children of Jordanian mothers**: In 2014, the Jordanian government declared that the non-citizen children of Jordanian mothers would enjoy some rights, including health care, after activating a special identification card. However, according to a study prepared by Human Rights Watch in 2018[[29]](#footnote-29), Jordanian mothers of non-citizen children did not report an improvement other than the MOH’s instructions to oblige public hospitals to treat their children like other Jordanian citizens. Some of the non-citizen children of Jordanian mothers reported paying higher fees in public hospitals, despite showing identification cards that prove their status. Many of them cannot get identification cards because of procedural difficulties, which do not entitle them to the benefits promised by the governmental declaration.

# THE UNDERLYING DETERMINANTS OF INEQUALITY IN HEALTH

Health inequities arise from the societal conditions in which people are born, grow, live, work and age, referred to as the social and structural determinants of health. These factors are largely beyond the individual’s control yet influence their opportunities in life. Because of existing power structures, social and structural determinants are not neutral, but serve to either advance or hinder various population groups’ access to quality health services. Specific population groups are marginalized or excluded from the decision-making at the family, community, or national levels. Figure 1: describe the conceptual framework of the underlying determinants of health.

In many societies, these groups include women, the young and the old, PWD, racial and ethnic minorities, refugees, and those with lower income and/or education or living in rural areas. Those groups might face double discrimination, e.g., women with disabilities in rural areas face discrimination more than women with disability in cities, who already face more discrimination than women without disabilities in the exact location.

Structural determinants are the policies and systems at the institutional level, such as the organization of the health system. Social determinants are the norms negotiated at the community level and in families, with decisions about expected roles and behaviors. The social and structural determinants are dynamic and mutually reinforcing, as higher-level decisions and actions are made by people rooted in (unequal) community norms, and policies and services serve to maintain the existing power structures. The individual-level includes various factors such as behavior, and biological factors play roles in health outcomes. For example, if an individual quits smoking, his or her risk of developing heart disease is significantly reduced. Many public health and health care interventions focus on changing individual behaviors, such as substance abuse, diet, and physical activity. Positive changes in individual behavior can reduce the rates of chronic disease in this country. On the other hand, some biological and genetic factors such as age and sex affect specific populations more than others. For example, older adults are biologically prone to be in poorer health than adolescents because of the physical and cognitive effects of aging[[30]](#footnote-30). The individual’s opportunities in life are influenced by the structural and social determinants, whether the individual chooses to support or challenge them. All three levels contribute to the individual’s access to, and uptake of RMNCH services and the quality of care they receive.

Figure 1. Conceptual framework of the underlying determinants of health[[31]](#footnote-31):



# LITERATURE REVIEW: BARRIERS TO EQUITABLE ACCESS TO QUALITY RMNCH SERVICES

Unfortunately, there is no comprehensive assessment of health inequalities in Jordan. The documentation of national-level programs, initiatives, and services is poor, besides weak research and studies related to reproductive health, especially regarding reproductive health for young people, adolescents, persons with disabilities, and the elderly[[32]](#footnote-32). Existing literature documents look at many of the inequities in access to quality RMNCH services. Some of the key factors that disadvantage specific population groups include gender (in different ways for women and men), age (in different ways for the young and the old), living with disabilities, refugee status, informal workers who not protected by social protection instruments, low income and education, and residency in a remote area. This section summarizes the current state of knowledge by describing these determinants and their impact on RMNCH.

**Women and girls:** In Jordan, Women are held responsible for most reproductive health issues such as pregnancy, fertility problems, and sexually transmitted diseases. However, men play a core role in deciding if to have a child. According to DHS 2017-2018, almost half (42%) of women say they have problems in accessing health care.[[33]](#footnote-33) Social pressures discourage women from holding jobs outside of the home, reducing women’s bargaining power within the home, including decisions around FP (FP). In addition to the lack of detailed understanding of how to use the methods effectively, and doctor-patient communication is generally weak. The shortage of women doctors relative to demand and males dominating the medical professions may lead to some women using alternative, less effective methods. Women with less education and income, particularly those living in rural areas, face greater barriers to accessing high-quality RMNCH services than their urban, more educated counterparts.

**Adolescents and youth**: 34.6% of the population is under 15 years of age with limited access to youth-friendly health services. Many youths do not have enough information to make fully informed choices about using FP and choosing an effective method.[[34]](#footnote-34) Schools do not provide sufficient health information for youth. The information provided to engaged couples immediately informally (parents, peers) before marriage but still does not constitute comprehensive sexual education[[35]](#footnote-35). The absence of national programs on reproductive and sexual education also marginalizes youth and adolescents and puts them at higher risk of contracting HIV. Adolescent and youth health services in public health centers targeting young people are weak, and a comprehensive package of essential SRH services for this age group does not exist[[36]](#footnote-36), in addition to the absence of specialized SRH training programs for service providers[[37]](#footnote-37), and lack educational programs that cover adolescent health in school curricula. For the formal SRH education, for example at universities, begins only after age 18 due to cultural constraints.

For all the previous reasons, the preferred source for youth about RMNCH information is parents, peers, mass media, community events, and the internet, particularly for adolescents. The role of parents is perhaps not surprising due to the high value placed by youth on family relationships. However, given gender norms around protecting youth from exposure to inappropriate behaviors makes parents reluctant and ill-equipped to discuss sexual and reproductive health (SRH) with their children.

Some youth, especially females, might marry early. The percentage of early marriage has increased (10% of married women aged 15-18 years have married under 15). Early marriage causes subsequent health complications for females resulting from adolescent pregnancy and childbirth, resulting in death. Besides the social and psychological implications, including dropping out of school and higher rates of violence, increased burdens on women and girls, and hindered access to reproductive health services. According to Jordanian law, the minimum age of marriage is 18 years for both girls and boys, but they can marry as young as 15 years with approval from a Shari’a court, which is commonly provided. The rate of young women aged 15-17 who are married is estimated to be 13.2%.[[38]](#footnote-38) The rate has been found to be higher among refugees from Syria (25%), Palestine (17.6%), and Iraq (4%). Girls from poorer backgrounds and with lower levels of education are likely to be married earlier. Women aged 15-19 years are less likely to discuss FP with their husbands (70%) compared to women aged 20-24 years (50%). They are also less likely to discuss ways to prevent HIV/AIDS with their husbands (12%) than women between the ages of 20-24 years (25%). At the same time, young men (aged 12-18 years) are reluctant to go to the maternal and child health centers because they believe only women go there for services.[[39]](#footnote-39) Without information or services, married adolescent and young women are likely to quickly become pregnant. A JCAP study in 2015 found that 40% of married women between the ages of 15-19 were currently pregnant, compared to 25% of those aged 20-24 years. Pregnancies at an early age can lead to complications during pregnancy and childbirth, such as increased risk of stillbirth and newborn deaths.

Also, attitudes by RMNCH providers towards single or unmarried young people, particularly women are usually negative. SRH providers sometimes refuse to provide them with counselling and medical services or request the presence of the mother to examine a single young woman. Judgment is particularly harsh of adolescent and young women. Judgmental attitudes are reinforced by a policy that prohibits pregnant women from accessing reproductive health services without a marriage license. This makes it very challenging for unmarried women, as well as for married women who lack a license (e.g., Syrian adolescents married by religious authorities) to obtain services.

The Sexual and Reproductive Health and Rights among youth in Jordan/ landscape analysis[[40]](#footnote-40). The analysis point to challenges faced by youth while accessing RMNCH service, these challenges include the strain placed on the health system by the increasing demand. Misinformation and concerns over the possibility of negative side effects related to FP use. In addition to the social expectation that limit partner involvement in FP and reproductive health, and youth’s concerns over privacy and confidentiality in obtaining RMNCH services because strict social norms control adolescent sexual behavior. While “youth-friendly services” are theoretically available through women and child health centers as well as pilots of adolescent care services, in practice even married young people reluctantly visit reproductive health centers. Youth say 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. Sometimes requested services are denied due to age: youth are often advised not to use contraception because of fears over infertility, as girls are expected to become pregnant soon after marriage. COCs were more readily provided by female providers. Compounded by the poor quality of care extended to the general population, such as long wait times, poorly staffed clinics, and bad communication skills, adolescents and youth are reluctant to access care.

Young Syrian refugees face additional hurdles to accessing RMNCH services. A major obstacle for youth between ages of 12-24 years living in urban areas is the requirement to have an ID card. Cost is another hurdle, as for most services Syrians pay the same rates as uninsured Jordanians. In refugee camps, while age-disaggregated data is not available, less than half of pregnant women in Syrian refugee households (47.9%) had access to prenatal healthcare in 2017 and only 51.9% of Syrian refugee households with lactating women had access to postnatal healthcare.[[41]](#footnote-41)

**Persons with disabilities PWDs:** The 2015 Census found that 11.2% of the population had a disability. Research has found that the figure doubles (23%) among refugees. Disabilities present physical, intellectual, and social barriers to accessing care, particularly among disabled women although there is an absence of granular level data, such as the form of disability by gender and governorate and the impact this has on accessing health services. PWD have the same RMNCH needs as other people, and perhaps more, given their social isolation and vulnerability to exploitation, discrimination, and abuse. In particular, women with disabilities have little opportunity to leave their homes and become socially isolated. Both women and men with disabilities are at elevated risk of violence, particularly refugee women, and children who are three to four times more likely to be abused than children without disabilities.[[42]](#footnote-42)

*“These [health] centres are relatively acceptable, but they do not rise to the level of expectation, especially not to the Internet and computer world generation; the youth know a lot of information, but we need more services for youth and seminars and information to parents and some of the girls.”*

*15-year-old female (Khalaf et al., 2009)*

Given their social isolation, many PWD have magnified barriers to RMNCH information, either on staying healthy or the services available. PWD have high unmet need for health services, for example, UNHCR data found that 37% of Syrian refugees with disabilities had not received surgical treatment, rehabilitation, or psychological support of assistive devices.[[43]](#footnote-43) The first challenge in accessing care is the lack of accessible public transportation. PWD using public transportation also risk harassment and discrimination. Harassment of women on public transportation has already been noted. It is also experienced by Syrian refugees with disabilities.[[44]](#footnote-44) Oher main barriers that PWDs face in accessing reproductive health services, especially regarding the lack of accessibility and reasonable accommodations in facilities for wheelchair users. There is also lack of accessible information because of missing sign language, large print and Braille…etc. also, the medical and nursing staff is not qualified to provide services to PWDs or to communicate with them[[45]](#footnote-45).

The 2017 Law of the rights of persons with Disability requires that all health facilities become accessible to PWD within 5 years. Failure to comply could result in a loss of license. All medical, technical and administrative staff working in hospitals are also required to receive training for effective communication with persons with disabilities (including seeking their informed consent for medical procedures and supplying leaflets in Braille), as well as methods for detecting and handling physical and mental abuse.113

**Syrian refugees:** RMNCH services that are provided to Syrian refugees are weak[[46]](#footnote-46), Syrian women receive less antenatal care (ANC) and postnatal care (PNC) than Jordanian women, are less likely to deliver in a health care facility or use modern contraceptive methods, and fewer refugee children are fully vaccinated. Refugees are at higher risk of discrimination at the health facility. Focus group discussion participants in a USAID gender analysis reported that women from non-Jordanian origins or carrying other nationalities are often ranked lower Jordanian women. As a result, verbal or other abuse of these women is considered more acceptable.92 Young refugee women also struggle to find youth-friendly services like their Jordanian counterparts. Refugee women attending NGO clinics report being displeased with the quality of care, citing providers who are too busy, the limited number of clinics, and the lack of female doctors.[[47]](#footnote-47)

The health system is straining to meet the large demand for RMNCH services within the complex environment of refugees living across camps and host communities. RMNCH services are provided to refugees for free through the public health system and NGOs, as well as for a fee from the private sector. Health system partners are cognizant of challenges such as availability and cost and working together to piece together a feasible response that leverages resources from all partners, without unduly burdening the public health system.

**Men:** an enormous challenge affecting men's reproductive and sexual health engagement is the shortage of male-friendly reproductive and sexual health services. The provided services are still widely viewed as a 'women's issue'. There is no privacy to encourage men to attend and meaningfully take part in the care of their partner. Adding to that, the lack of adequate resources, infrastructure, and space. Integrating men into maternity and child-care services becomes a challenge in these circumstances. Short-staffed and overworked health workers find it challenging to incorporate strategies for encouraging male participation.

Jordan's National, Reproductive and Sexual Health Strategy 2020-2030, mentioned under the society pillar to enhance the participation of men, boys, and young men in SRH interventions to increase the effectiveness of programs. To achieve this result, men will be targeted by specific educational and guided FP messages and tools in addition to engaging men, boys, and young men in SRH behavioral change programs[[48]](#footnote-48).

The evidence shows the positive association between male involvement and SRH outcomes and impacts, especially those related to the utilization of services, preparation for childbirth, and nutrition[[49]](#footnote-49). In this regard, the best practices recommend that it's essential to use a gender lens when planning and programming men's engagement in SRH, including FP—which means engaging men as clients of SRH services, as supportive partners (to their wives). As agents of change in terms of SRH services, the health systems strengthening efforts need to streamline critical concepts such as male involvement as they work towards developing the building blocks of the health system such as human resources, infrastructure and financing, health services, health management information systems, technology, and governance. In terms of health care financing, the reliance on external aid would need to be minimized to ensure more sustainable ways of driving the agenda. Also, there is a need to sustain the positive perceptions and deepen the engagement into more holistic involvement of men. Besides developing resources and skills, standardize practice, share ideas, and engage the community and cultural leaders for a system-level approach to enable change[[50]](#footnote-50). The table (1) shows some important figures according to the findings of the Population and Family Health Survey 2017-2018[[51]](#footnote-51), and the review of SRH issues and priority research[[52]](#footnote-52) in Jordan.

Table 1: The state of sexual and reproductive health in Jordan in numbers

|  |  |  |
| --- | --- | --- |
| **Theme** | **Figure/ percentage**  | **Comments** |
| childbirths occur within less than 18 months after the previous childbirth | 16% | High  |
| unplanned or unintended pregnancies | 14% | Low compared to previous surveys |
| use of modern FP methods | 37% | Decreased from 40% in the last survey |
| modern FP methods varies according to the governorates | e.g. 25% in Ma'an compared to 43% in Jerash |  |
| modern FP methods varies according to the level of well-being | 35% for women in the lowest welfare quintile compared to 39% in the higher quintile |  |
| Modern FP methods varies according to the nationality  | 32% for Syrian women, compared to 38% for Jordanian women |  |
| Unmet need for FP methods | (14%) in 2017-2018 | Declined from 27% in 1990 to 12% in 2012 |
| Unmet need for FP methods | 19% for Syrian women, compared to 14% for Jordanian women |  |
| Cessation of FP methods | 30% | Because of: inadequacy of the method (12%) or failure of the method (11%), and the desire for a more effective method (9%) |
| Women who do not currently use contraception and have not discussed FP with health service providers | 79% | High  |
| married women (ages 15 to 49 years) who make informed decisions about sexual relations, the use of contraception and reproductive health care | 58.2% | Decreased compared to previous surveys |
| Cesarean deliveries | 26% | Large proportion of planned operations are not medically required. |
| women face at least one obstacle and challenge in accessing healthcare | 42% | Physical barriers, distance, not knowing where to go, and the service provider is male. |
| Female physicians, are mostly employed by the private sector in urban areas | 72% in 2011 |  |
| Midwives are concentrated in the central governorates: Irbid Amman, and Balqa.18 | 52%  |  |
| Poor women are more likely to use traditional methods compared to the wealthiest cohort.[[53]](#footnote-53) | (13%) compared to (11.6%) |  |
| Poorest married women who experience at least one problem compared to in the highest wealth quintile | 61.2% compared to 23.2% |  |
| The primary reasons that decrease accessing health care for women are.[[54]](#footnote-54) | getting money for treatment (40.6%), followed by lack of transport (37.8%), distance (36.8%), not wanting to go alone (36.3%). |  |
| Women in the lowest wealth quintile access FP services from private health providers, mostly from pharmacies | 49% | Getting only pills and condoms, and more effective contraceptive methods (IUD, implants, female sterilization).[[55]](#footnote-55) |
| Mothers from the lowest quintile receive less counselling on newborn danger signs and on breastfeeding during postnatal care, compared to the wealthier mothers. [[56]](#footnote-56) | 50% compared to 85%. |  |
| All ever-married women aged 15-24 years had heard of HIV/AIDS | 98% |  |
| all ever-married women aged 15-24 years who knew where to get an HIV test | 15.5% |  |
| All ever-married women aged 15-24 years had comprehensive knowledge about HIV/AIDS | less than 10%  |  |
| child marriage among Jordanians tended to increase in 2012-2015 | from 9.7% to 11.6% |  |
| child marriage among Syrian tended to increase in 2012-2015 | From 35.3% to 43.8% |  |
| Total fertility rate among Jordanian women | to 2.7 children per woman of reproductive age |  |
| Total fertility rate among Syrian women in Jordan | 4.7 children per woman of reproductive age | High  |
| Under-five mortality rate | Syrian children (25 per 1000) compared to Jordanian children (16 per 1000 |  |

# CROSS CUTTING ISSUES AFFECT ACCESSING RMNCH SERVICES/RIGHTS

**Transportation and public spaces:** While more than 90% of Jordanians – poor as well as the wealthy – live within 4 kilometers of a primary health care center,19 transport is less reliable for women and men in remote and rural areas. The use of public transport can also be a negative experience for women, discouraging its use. Recent studies show that many women in Jordan have experienced sexual harassment on public transport.20 Traveling alone is particularly risky for women.

**Perceptions and stereotypes:** Men may exclude themselves from some RMNCH services and rights such as FP because they consider these services are a woman’s responsibility and decline to accompany them to the health facility. As a result, women may decide not to seek care. Besides that, men also feel they are unwelcome in FP clinics because of how they're labeled and that most health providers and beneficiaries are female, in addition the physical space is not inviting for men to join their wives.

**Economic status and low income:** Access to services is also limited by lack of income and geographic availability of facilities. For example, during COVID-19, female-headed households (58%), Syrians (27%), camps population (31%) and smaller- size households (33%) have experienced the highest disruptions in access to routine vaccination. The primary reasons for the lack of access were reported to be: clinic closure (50%), travel restriction (26%), and fear of COVID-19.21 This gap highlights that women, particularly those who experience intersecting social inequalities, are the hardest hit when health services are restricted.

**Woman’s marital status:** The most marginalized of women also include women who do not have a man’s support (husband, father, or brother, also defined as ‘sanad’). This includes women who are widowed or divorced, women whose husbands are living elsewhere, and women whose husbands or male guardians have deserted them. Without the man, they have no authority over family assets, are legal minors under the Personal Status Law, and at the mercy of distant male relatives who deny them basic freedoms. They are vulnerable to increased harassment and exploitation, including during their transport to the health facility as well as while receiving care, as they may be denied reproductive health services that are offered mainly to married mothers.22

**Gender based violence:** Health facilities are also ill-equipped to support women experiencing GBV. Approximately one in four women have experienced some form of violence from someone within their home (including fathers, husbands, and brothers).24 Health facilities are required by law to report women GBV survivors, which may lead to the woman being returned to her home or incarcerated for her protection. Few support services exist. Women with disabilities or homeless women are often referred to Ministry of Social Development rehabilitation programs, prison, or mental health hospitals.25 As a result, women experiencing violence may hide their experience, with devastating consequences for their health and the health of their children.

**Double discrimination and further excluding:** Barriers to both accessing RMNCH services and receiving quality care are compounded by other social determinants for some groups of women. Certain groups of women who are defined as lower status (migrant, uneducated, women with disability, divorced and poor women), are more vulnerable to exploitation, harassment, and GBV than the conventional Jordanian woman, including in traveling to and receiving quality RMNCH services. A study of women who gave birth in the last 1-3 months found that younger women, as well as women who lived in a village, were unemployed, and had inadequate family income experienced higher rates of neglect. Verbal abuse was directed more toward unemployed, young women living in urban areas who were undergoing their first birth experience.23

**Women's access to leadership positions in the health care sector**[[57]](#footnote-57): Women's effective participation in the decision-making process is influential in improving gender-responsive decisions at all levels and more inclusive and accessible quality services. Although women are more likely to work in the care sectors in Jordan, they are excluded from leadership positions and decision-making and managers (at a mere 1.2%)[[58]](#footnote-58), senior employees, including healthcare. Part of the reason behind that is the lack of confidence in the ability of women to assume these positions, besides the negative perception that they are less productive than men and that women in leadership positions cannot achieve economically reasonable results, in addition to retirement age for women is 55 while for men it is 60. Thus, many women stay at lower-level jobs without moving up to senior-level positions, eventually withdrawing from the labor market.

# IMPACT OF GENDER ROLES ON DEMAND FOR RMNCH SERVICES

Women and men are interacting and affected differently by RMNCH services. Their interest, accessibility to the services and information, ability, and power to make the decisions vary because of their gender roles and responsibilities, e.g. RMNCH services are used predominantly by women, due to their biological capacity for childbirth as well as their socially prescribed role as the caretaker for the family’s health. This division of labor has to some extent excluded men from utilizing health services, including RMNCH.

According to a 2016 qualitative gender study, Jordanian and Syrian married women wanted their husbands to accompany them to Family Planning FP centers, but the husbands rejected the idea based on the belief that FP was a women’s concern.9 At the same time, men have opinions about FP, often preferring traditional methods that they know about and which are considered safe, effective, available, free, and under their control.10 Interviews with key RMNCH stakeholders noted that: “men often know very little about sexual and reproductive health. They are a source of misinformation regarding FP methods.”[[59]](#footnote-59)

Studies have found mixed results about who ultimately makes the decision about using FP methods. The 2016 FP assessment by the Institute for Reproductive Health (IRH)[[60]](#footnote-60) highlighted how focus group discussions organized by the Jordan Communication, Advocacy, and Policy Activity (JCAP) said that the decision was made by the man, while a survey found that the husband or other family members rarely opposed the woman’s decision.[[61]](#footnote-61)

Men also have a strong influence on the choice of obstetrician for their wives, and they are particularly in favor of female doctors. This reflects the belief about women needing protection, for example, pregnant and postpartum women in three major hospitals described the involvement and influence of their husbands and fathers.[[62]](#footnote-62)

Decisions about FP are also influenced by the normative concept of Uzwa and son preference. Uzwa means the pride and power attained by having a large family with many male members. The preference for sons is aligned with the gender norms described in Table 1 and the challenges women can expect to face throughout their life. The ideal family size for Jordanians is four children, but families may continue child- bearing beyond that number to give birth to a boy.[[63]](#footnote-63) An earlier study found that with every additional male child, women were 30% more likely to use modern contraceptive methods, compared to only 11% with every additional female child.[[64]](#footnote-64)

While less research has been done on male involvement and decision-making in MCH, men’s support is vital. When husbands are not socially supportive to their wives or the couple relationship is tense, the mother may neglect caring for herself during pregnancy, or may neglect the newborn.[[65]](#footnote-65)

*“When I first got pregnant, my husband took me to a public hospital but told me that he didn’t want a male doctor seeing me. The doctor turned out to be a male, and so I didn’t let him check up on me or my baby. I ended up going to a private female obstetrician.”*

*“I sometimes go to a private female doctor because my husband refuses that I be seen by a male doctor, and there aren’t always female doctors available at the public hospital. In the private sector, you can choose which doctor you want. In my opinion, this is a very important issue in our society, especially given that my dad is also very religious and conservative.”*

# HSQA APPROACH IN INCREASING HEALTH EQUITY

The literature review highlights that Jordan has multiple groups experiencing varying degrees of marginalization and exclusion due to unequal social norms, biased legislations and regulations and structural determinants. Often the disadvantaging factors intersect in the lives of the most vulnerable. These social, legal and structural barriers hinder the uptake of health services and result in poorer health outcomes, particularly for RMNCH. The inequalities undermine progress toward better health and wellbeing, particularly in RMNCH.

Reducing the social, legislative, and structural determinants that create inequalities in health is a challenge that has yet to be resolved in any country in the world. Change in these determinants is influenced by wider changes in a community’s or country’s political, economic, environmental, and social context. Every change is negotiated between individuals, within families and communities, influenced by media and private and public company/organization marketing and services, and discussed by politicians, decision-makers and program managers. Some of the people involved will want the change, while others will not. Some have more power to influence the change, others have less. As a result, change is unpredictable and complex.

Jordan is experiencing a time of change, buffeted by migration, economic instability, COVID 19 pandemic and regional tension, while always balancing between the West and its peers in the Arab region. This can be considered a constraint and an opportunity. When cultural values are threatened, they are exaggerated, and punishments become more severe. Women want more freedom, but women breaking the norms are punished with harassment in public spaces, transport and at the workplace. At the same time, times of change provide the opportunity to increase persuasive dialogue on how increased equity, equality, accessibility, inclusion, and tolerance have the potential to stimulate and expand the economy, encourage innovation, and increase stability.

Building on this understanding of the complexity and unpredictability of equity in Jordan, the HSQA’s GESI approach is centered around four principles:

1. Actions to increase equity must be homegrown: Considering the necessity of local negotiation of social and gender norms, legislative instruments, and structural determinants complex interaction between social determinants, HSQA will identify and support local efforts to strengthen and mainstream GESI, rather than introducing new interventions or even new coordination platforms.
2. HSQA will support dialogue within the health sector on how GESI is defined in different countries and what inequality and exclusion mean in Jordan. The objective is to shift the narrative from GESI as a Western concept to a Jordanian concept of social equity and equality. As the current term for gender, is a source of confusion while distinguishing between gender and sex which might affects the practices and activities,[[66]](#footnote-66) to address this confusion capacity development about gender concepts and theories will be implemented and delivered for the MOH and other partners’ staff.
3. Marginalized groups must be engaged effectively and empowered in decision-making: Strengthening the voice of women, youth, and other marginalized groups at the planning and decision-making table not only ensures that any activities being considered are relevant and feasible, but also contributes to reducing the equity gaps by empowering them. This will involve ensuring meeting times are convenient, facilities are accessible to all, and activity managers are cognizant of their role ensuring everyone’s voices are heard and considered, including in health facility activities such as team-based problem solving. By engaging representatives in the decision-making process, this will improve the responsiveness or all GESI requirements.
4. The leading role of men must be recognized: HSQA will support men’s participation in any dialogue on social change as essential. This involves understanding why men have low uptake of health services and how this could be improved. It also involves identifying and supporting “positive deviants” or men who exhibit inclusive behavior to serve as GESI champions and raise taboo issues such as GBV and PWD and how to take them into consideration in RMNCH service delivery. Young men should be given opportunities to promote and advance youth-friendly services as well as other GESI priorities. Conversations must be cross-generational, bridging fathers, tribal leaders, and elders with adolescents and youth to find a mutually acceptable way forward. Religious leaders can be engaged in discussing the principle of equality among all humans as found in the Qur’an, and support to those who are disadvantaged situation.
5. Multi-level activities/ multi-tacks approaches are needed to ensure that social norms and structural determinants are mutually reinforcing: Social change toward increased equity involves both dialogue about social norms as well as legislative and institutional reforms, including in the health sector. While the tendency for national-level change related to GESI has been top-down donor pressure, institutional change can be facilitated by both bottom-up pressure, as well as better data on the actual situation in Jordan. While the relationship between government as CSOs is often contentious, we will engage both partners in consultative groups and taskforces. We will leverage champions and GESI CSOs to support the MOH and other health stakeholders to integrate GESI in their policies, strategies, plans, and programs. For instance, this may involve including GBV and PWD as training topics in RMNCH. We will also consider research projects to document the severity of gaps in health equity and their impact on national goals.

# HSQA NEXT STEPS DURING YEAR I

Given the GESI principles above, HSQA’s Activity’s aim is not to necessarily integrating GESI into all activities, but to engage and empower Jordanian stakeholders to implement GESI activities that they prioritize for the local context, specifically in relation to RMNCH service delivery. This will involve a shared process of dialogue and prioritization, monitoring and scale-up.

The HSQA will work in the first year to support MOH and other counterparts initiate mainstreaming gender equality and social inclusion and human rights-based approach across all RMNCH services at strategy and implementation levels to improve the equitable and respectful RMNCH services for all, including the disadvantaged groups. By addressing the rooted individual, societal and structural causes of exclusion. This support will improve RMNCH services by determining the proper inclusion approaches/methodologies for each group starting with responsive baseline assessment, planning, and implementing the activities, monitoring, and evaluation until the sustainability after closing the project. MOH will be ensure "to not leave one behind" and "do no harm" as part of equitable RMNCH services. So, the HSQA’s GESI approach will ensure that the needs and priorities of these disadvantaged groups are integrated across all activities. All opportunities will also be taken to empower these groups by engaging non-governmental organizations (NGO) that represent their interests in appropriate national, governorate, and health facility committees. The direct contribution of disadvantaged groups into planning, improvement, and monitoring activities will help ensure that they are relevant and impactful. The following steps will be taken as part of GESI mainstreaming in RMNCH for the first year.

#####  Stakeholder Mapping

During the first quarter of the year, HSQA will identify GESI stakeholders in the health sector and begin engaging them in dialogue about how the Activity can contribute to GESI specifically in the health sector in relation to RMNCH service delivery. Discussion will center on who is currently being left out of RMNCH service delivery and clarifying the barriers they face, also the discussion will brainstorm to find sustainable good practices to engage all to enjoy these services on equal basis.[[67]](#footnote-67)

Pending a more comprehensive list of stakeholders, key partners at the national level will include, for example:

* Government: the ministries of Youth, Social Development, and Health (specifically the Woman and Child Health Directorate and the Institutional Development and Quality Assurance Directorate), Higher Council for the Rights of Persons with Disabilities, the Inter-ministerial Committee for Women’s Affairs.
* Academia: The Center for Women’s Studies at the University of Jordan.
* Professional associations: Jordanian Nurses and Midwives Council, Physicians and other Health Providers Associations.
* Non-profit organizations: the Jordanian National Commission for Women, Jordanian Women’s Union, the General Federation of Jordanian Women, Institute for Family Health. and the Higher Population Council
* INGOs and partners: FHI360, OXFAM, HIVOS, CARE international, mercy corps.

Similar discussions about local GESI priorities will be discussed as part of Activity planning at the governorate and health facility levels where HSQA is working.

##### Develop GESI Mainstreaming Approaches and Interventions

To mainstream GESI within the activities, HSQA will collaborate with other MOH and other stakeholders to develop the approaches through the following steps:

1. Set GESI priorities related to RMNCH services.
2. Define the type/s of gender mainstreaming needed to support the structures and processes of RMNCH services.
3. Define the equality objectives that should be reached during and after mainstreaming GESI in RMNCH.
4. Set the technical steps and procedures to mainstream gender for each GESI intervention.
5. Communicate gender mainstreaming both internally and with stakeholders.
6. Adopt gender mainstreaming methods and tools.
7. Strengthen the commitment of HSQA’s staff and stakeholders.
8. Incorporate gender and inclusion-related information and data into the MEAL system internally and with stakeholders.
9. Provide mentor coaching to guarantee GESI mainstream and sustain the adoption and impact.

##### Plan and Implement GESI Responsive Activities

Based on prior discussions, some potential activities that may be prioritized for HSQA support are included below. They require more consideration, exploration, and elaboration to determine if they are relevant and a priority for Jordanian GESI stakeholders, and how they could be implemented leveraging existing partners and programs. Some of the activities proposed by GESI stakeholders will require seed funding for further development and testing. Under guidance from the RMNCH leadership group, HSQA will provide Innovation Grants for testing and evaluation of these interventions and models.

**Equity in access to information and services**

HSQA will aid public and private health programs to increase access to all through providing equitable health services at existing heath facilities and service delivery points, with a particular focus on delivering RMNCH information and services to groups that are being left behind. This will entail consideration of issues such as how to:

* Maintain continuity of care for nomadic and mobile groups and ensure a continuum of RMNCH services beginning with primary health care, particularly in rural areas with more challenging transport.
* Adopt "to not leave one behind" and "do no harm" principles as part of equitable RMNCH services.
* Make health facilities more inclusive of men, including those accompanying their wives, daughters, or mothers. For example, waiting rooms could contain more information specific to male (health) issues and staff can encourage men to talk about their role in FP and childcare.
* Ensure that health facilities are accessible for PWD, including positive perceptions and behaviors in addition to technological and physical accessibility such as wide doorways and adjustable examination tables for women with disabilities (also required by new disability law). In collaboration with the Higher Council for the Rights of Persons with Disability, HSQA will provide technical support and capacity development to MOH and other stakeholders to adopt the accessibility and reasonable accommodations since it is obligatory by disability rights law 20/2017.
* Ensure that health facilities are youth friendly, starting by adopting this approach from the Jordan’s National Reproductive and Sexual Health strategy 2020-2030.
* Extend RMNCH information and services to isolated and marginalized groups such as girls with disabilities or Turkmen adolescent girls and boys through NGO outreach workers, community health committees (CHC), pharmacies, the internet, or novel new approaches.
* Capacity development for MOH and other partners to mainstream GESI principles in the services.
* Participate in revision for related legislations and policies from gender and inclusion perspective if needed/ requested by MOH or other partners.
* Participate in developing reports on RMNCH related human rights treaties and mechanisms such as CEDAW, CRC, CRPD, UPR.
* Engage local government and elected officials to improve the accessibility infrastructure and safe transportation to the health services.

**Equity in quality of RMNCH care**

HSQA will support public and private health programs to ensure that all patients and caregivers are treated equally and with respect, have their questions answered, and fully understand the options they have to ensure their wellbeing. Medical ethics apply equally regardless of whether the patient has a disability, living with HIV, a farmer or refugee…etc. The theme of patient-centered, high-quality care will be reinforced across all HSQA-supported activities, from updates to pre-service training and team-based coaching to supportive supervision and reinforced accountability and sustainability mechanisms. Activities may involve, for example:

* Engaging youth representatives in supporting the Higher Population Council to update the National Standards for Youth-friendly Reproductive Health Services 2017, align them with the accreditation system.
* Engage representatives from other marginalized groups such as PWD, adolescent and young women and men, in the design of patient-centered approaches, particularly through health-facility-affiliated CHCs.
* Dedicate specific innovation grants for GESI, including for GESI-related research. For example, grants may fund research to inform policies and legislation related to the needs of marginalized groups, document quality barriers for advocacy and training purposes, or assess the requirements to engage all staff in the services improving process.
* Leveraging existing training mechanisms to shift provider norms related to youth SRH, drawing on provider social norms research, and incorporating content on respectful care into pre- and in-service training and continuous professional development.
* Holding providers accountable to standards on respectful RMNCH care and youth-friendly services through measurement, supervision, and incentives.
* Strengthening referral linkages with non-health services to facilitate patient access to a wider range of services. For example, a memorandum of understanding between the MOH and the Family Protection Directorate can strengthen efforts to address family violence.

##### Develop a Monitoring and Evaluation Strategy:

Depending on the objectives and indicators that are selected, the HSQA MEL team will work with relevant counterparts to determine data collection mechanisms. The HSQA MEL strategy leverages existing data collections systems such as the MOH Performance Management Information System, Reproductive Health Information System, and Jordan Maternal Mortality Surveillance and Response System as much as possible, while supporting partners to revise indicators as needed – for example to better capture GESI data – and to improve the data quality.

HSQA will also support partners such as NGOs and CSOs to strengthen systems to collect and report qualitative GESI information which provides greater insight into the changes taking place and can be a useful advocacy tool to spur further improvements.

1. USAID (2018) Equity in health [Global Health News website] [https://www.usaid.gov/global-health/global-health-newsletter/](https://www.usaid.gov/global-health/global-health-newsletter/equity-in-health) [equity-in-health](https://www.usaid.gov/global-health/global-health-newsletter/equity-in-health) [↑](#footnote-ref-1)
2. Sexual and Reproductive Health Issues and Priority Research based on the Results of the Population and Family Health Survey (2017-2018), HPC [↑](#footnote-ref-2)
3. Sexual and Reproductive Health Issues and Priority Research based on the Results of the Population and Family Health Survey (2017-2018), HPC [↑](#footnote-ref-3)
4. Sexual and Reproductive Health Issues and Priority Research based on the Results of the Population and Family Health Survey (2017-2018), HPC [↑](#footnote-ref-4)
5. https://www.unfpa.org/sites/default/files/pub-pdf/ICPD\_UNGASS\_REPORT\_for\_website.pdf [↑](#footnote-ref-5)
6. https://www.unhcr.org/4e8d6b3b14.pdf [↑](#footnote-ref-6)
7. https://www.hpc.org.jo/en/content/jordan-participates-nairobi-summit-population-and-development-25 [↑](#footnote-ref-7)
8. https://www.who.int/life-course/partners/global-strategy/globalstrategyreport2016-2030-lowres.pdf [↑](#footnote-ref-8)
9. https://algeria.unfpa.org/sites/default/files/pub-pdf/english\_rmncah\_strategy\_final\_for\_web15-6-2020\_0.pdf [↑](#footnote-ref-9)
10. https://arabstates.unfpa.org/sites/default/files/pub-pdf/srh\_integration\_framework.pdf [↑](#footnote-ref-10)
11. [JORDAN'S NATIONAL STRATEGY.pdf (hpc.org.jo)](https://www.hpc.org.jo/sites/default/files/JORDAN%27S%20NATIONAL%20STRATEGY.pdf) [↑](#footnote-ref-11)
12. http://www.jrp.gov.jo/Files/JRP%202020-2022%20web.pdf [↑](#footnote-ref-12)
13. https://www.moh.gov.jo/ebv4.0/root\_storage/ar/eb\_list\_page/%D8%A7%D8%B3%D8%AA%D8%B1%D8%A7%D8%AA%D9%8A%D8%AC%D9%8A%D8%A9\_%D9%88%D8%B2%D8%A7%D8%B1%D8%A9\_%D8%A7%D9%84%D8%B5%D8%AD%D8%A9\_%D9%84%D9%84%D8%A7%D8%B9%D9%88%D8%A7%D9%85\_2018-2022.pdf [↑](#footnote-ref-13)
14. https://pdf.usaid.gov/pdf\_docs/PA00WB1W.pdf [↑](#footnote-ref-14)
15. https://extranet.who.int/countryplanningcycles/sites/default/files/planning\_cycle\_repository/jordan/national\_strategy\_for\_health\_sector\_2016-2020\_jordan.pdf [↑](#footnote-ref-15)
16. [قانون\_الصحة\_العامة\_وتعديلاته.pdf (moh.gov.jo)](https://www.moh.gov.jo/ebv4.0/root_storage/ar/eb_list_page/%D9%82%D8%A7%D9%86%D9%88%D9%86_%D8%A7%D9%84%D8%B5%D8%AD%D8%A9_%D8%A7%D9%84%D8%B9%D8%A7%D9%85%D8%A9_%D9%88%D8%AA%D8%B9%D8%AF%D9%8A%D9%84%D8%A7%D8%AA%D9%87.pdf) [↑](#footnote-ref-16)
17. https://www.aliftaa.jo/ShowContent.aspx?Id=205#.YeASpmhBzIU [↑](#footnote-ref-17)
18. http://www.mol.gov.jo/ebv4.0/root\_storage/ar/eb\_list\_page/%D9%82%D8%A7%D9%86%D9%88%D9%86\_%D8%A7%D9%84%D8%B9%D9%85%D9%84\_%D8%B1%D9%82%D9%85\_8\_%D9%84%D8%B3%D9%86%D8%A9\_1996\_%D9%88%D8%AA%D8%B9%D8%AF%D9%8A%D9%84%D8%A7%D8%AA%D9%87.pdf [↑](#footnote-ref-18)
19. http://www.csb.gov.jo/web/index.php?option=com\_k2&view=item&layout=item&id=28&Itemid=326&lang=ar [↑](#footnote-ref-19)
20. Phenix Center for Economic and Informatics Studies, "Policy Paper Toward Inclusion of All Workers in Jordan in the Social Security System," 2020, Jordan. [↑](#footnote-ref-20)
21. Phenix Center for Economic and Informatics Studies, "Policy Paper Toward Inclusion of All Workers in Jordan in the Social Security System," 2020, Jordan. [↑](#footnote-ref-21)
22. https://www.aliftaa.jo/ShowContent.aspx?Id=205#.YeASpmhBzIU [↑](#footnote-ref-22)
23. https://www.jba.org.jo/CMS/UploadedFiles/Document/2f2aa013-f5c6-45df-b478-6427fe39ceea.pdf [↑](#footnote-ref-23)
24. [2d319243-dc46-4967-8a43-307d73b50a9e.pdf (moj.gov.jo)](http://www.moj.gov.jo/EchoBusV3.0/SystemAssets/2d319243-dc46-4967-8a43-307d73b50a9e.pdf) [↑](#footnote-ref-24)
25. [قانون مراكز الإصلاح والتأهيل رقم 9 وتعديلاته لسنة 2004 (gc.jo)](http://www.gc.jo/documents/ce7c883b-a0ef-4560-97a9-3404d3f98c86.pdf) [↑](#footnote-ref-25)
26. http://hcd.gov.jo/ar/content/%D9%82%D8%A7%D9%86%D9%88%D9%86-%D8%AD%D9%82%D9%88%D9%82-%D8%A7%D9%84%D8%A3%D8%B4%D8%AE%D8%A7%D8%B5-%D8%B0%D9%88%D9%8A-%D8%A7%D9%84%D8%A5%D8%B9%D8%A7%D9%82%D8%A9 [↑](#footnote-ref-26)
27. https://www.jba.org.jo/CMS/UploadedFiles/Document/2f2aa013-f5c6-45df-b478-6427fe39ceea.pdf [↑](#footnote-ref-27)
28. <http://aliftaa.jo/Decision.aspx?DecisionId=243#.VuAaC3196M8> [↑](#footnote-ref-28)
29. [Treatment of Non-Citizen Children of Jordanian Mothers | HRW](https://www.hrw.org/report/2018/04/24/i-just-want-him-live-other-jordanians/treatment-non-citizen-children-jordanian) [↑](#footnote-ref-29)
30. <https://www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf>

<https://www.healthypeople.gov/2020/about/foundation-health-measures/Determinants-of-Health> [↑](#footnote-ref-30)
31. [The main determinants of health. Adapted from Dahlgren and Whitehead (1991) | Download Scientific Diagram (researchgate.net)](https://www.researchgate.net/figure/The-main-determinants-of-health-Adapted-from-Dahlgren-and-Whitehead-1991_fig4_327955458) [↑](#footnote-ref-31)
32. [https://www.worldbank.org/en/news/feature/2018/12/05/](https://www.worldbank.org/en/news/feature/2018/12/05/lessons-from-the-field-understanding-the-impact-of-social-norms-on-womens-employment-in-jordan) [lessons-from-the-field-understanding-the-impact-of-social-norms-on-womens-employment-in-jordan](https://www.worldbank.org/en/news/feature/2018/12/05/lessons-from-the-field-understanding-the-impact-of-social-norms-on-womens-employment-in-jordan) [↑](#footnote-ref-32)
33. DHS 2017-2018. The most frequently reported problems were having to take transport (25%), not wanting to go alone (24%), distance to a health facility and difficulty in getting money for treatment (both 22%). [↑](#footnote-ref-33)
34. MOH. FP Costed Implementation Plan 2020-2024. [↑](#footnote-ref-34)
35. Jordan’s national strategy reproductive and sexual health 2020-2030, [الإستراتيجية الوطنية للصحة الإنجابية والجنسية 2020-2030 النسخة النهائية (2).pdf (hpc.org.jo)](https://www.hpc.org.jo/sites/default/files/%D8%A7%D9%84%D8%A5%D8%B3%D8%AA%D8%B1%D8%A7%D8%AA%D9%8A%D8%AC%D9%8A%D8%A9%20%D8%A7%D9%84%D9%88%D8%B7%D9%86%D9%8A%D8%A9%20%D9%84%D9%84%D8%B5%D8%AD%D8%A9%20%D8%A7%D9%84%D8%A5%D9%86%D8%AC%D8%A7%D8%A8%D9%8A%D8%A9%20%D9%88%D8%A7%D9%84%D8%AC%D9%86%D8%B3%D9%8A%D8%A9%202020-2030%20%D8%A7%D9%84%D9%86%D8%B3%D8%AE%D8%A9%20%D8%A7%D9%84%D9%86%D9%87%D8%A7%D8%A6%D9%8A%D8%A9%20%282%29.pdf) [↑](#footnote-ref-35)
36. United Nations (2018).United Nations Youth Strategy: Youth 2030. https://www.un.org/youthenvoy/wp-content/uploads/2018/09/18-00080\_UN-YouthStrategy\_Web.pdf [↑](#footnote-ref-36)
37. Higher Population Council (2015). Jordan Agenda Setting for Sexual and Reproductive Health and Rights Knowledge Platform (Share-Net International). http://share-netinternational.org/wp-content/uploads/2017/02/Annex-9-Jordan-agenda-setting-and-mapping.pdf [↑](#footnote-ref-37)
38. OECD Development Centre (2018) Youth Well-being Policy Review of Jordan. Paris: OEDC [↑](#footnote-ref-38)
39. Same reference number 38 [↑](#footnote-ref-39)
40. https://cdn1.sph.harvard.edu/wp-content/uploads/sites/112/2020/03/Landscape-Analysis-FINAL-28-Feb-2020.pdf [↑](#footnote-ref-40)
41. https://reliefweb.int/sites/reliefweb.int/files/resources/2017%20CARE%20Jordan%20Syrian%20refugees%20FACT%20SHEET%20%28revised%2916062017.pdf [↑](#footnote-ref-41)
42. Center for Insights in Survey Research (2017) Survey of Jordanian Public Opinion, National Poll #15, May 22-25, 2017. [https://www.iri.](https://www.iri.org/sites/default/files/2017-7-12_jordan_poll_slides.pdf) [org/sites/default/files/2017-7-12\_jordan\_poll\_slides.pdf](https://www.iri.org/sites/default/files/2017-7-12_jordan_poll_slides.pdf) [↑](#footnote-ref-42)
43. Department of Statistics (DOS) and ICF (2019) Jordan Population and Family and Health Survey 2017-18. Amman and Rockville: DOS and ICF [↑](#footnote-ref-43)
44. International Fund for Agricultural Development (NA) Enabling the rural poor to overcome poverty in Jordan. Rome: IFAD [↑](#footnote-ref-44)
45. Position Paper on the Rights of Persons with Disabilities to Reproductive Health Services and Sex Education. https://www.share-net-jordan.org.jo/sites/default/files/Position%20Paper-SRHof%20Persons%20with%20DisabilitiesEng%20%28004%29\_1.pdf [↑](#footnote-ref-45)
46. Harvard School of Public Health (2019). Understanding and meeting the sexual and reproductive health [SRH] needs of Jordanian and Syrian youth. https://www.hsph.harvard.edu/women-and-health-initiative/projects/understanding-and-meeting-the-sexual-and-reproductive-health-needs-ofjordanian-and-syrian-youth [↑](#footnote-ref-46)
47. Gausman J, Othman A, Hamad I et al (2019) Sexual and Reproductive Health and Rights Among Youth in Jordan: A Landscape Analysis. Boston: Harvard T.H. Chan School of Public Health [↑](#footnote-ref-47)
48. Jordan’s national strategy reproductive and sexual health 2020-2030 [JORDAN'S NATIONAL STRATEGY.pdf (hpc.org.jo)](https://www.hpc.org.jo/sites/default/files/JORDAN%27S%20NATIONAL%20STRATEGY.pdf) [↑](#footnote-ref-48)
49. Tokhi M, Comrie-Thomson L, Davis J, Portela A, Chersich M, Luchters S. Involving men to improve maternal and newborn health: A systematic review of the effectiveness of interventions. PLoS ONE. 2018; 13(1): e0191620. https://doi.org/<https://doi.org/10.1371/journal.pone.0191620>. Available from: [Accessed 19th August 2018]. [↑](#footnote-ref-49)
50. https://www.engenderhealth.org/pubs/gender/gender-toolkit/toolkit.html [↑](#footnote-ref-50)
51. Population and Family Health Survey 2017-2018, Department of Statistics http://www.dos.gov.jo/dos\_home\_a/main/linked-html/DHS2017.pdf [↑](#footnote-ref-51)
52. Sexual and Reproductive Health Priorities and Studies based on the Results of the Population and Family Health Survey (2017-2018) [↑](#footnote-ref-52)
53. Bradley, Sarah E.K., and Benjamin Johns. 2019. Trends in Sources for FP in Egypt and Jordan. Presentation prepared for and presented at the Demographic and Epidemiological Patterns and Trends in the MENA Region meeting, June 2019. Sustaining Health Outcomes through the Private Sector Plus (SHOPS Plus) Project, Abt Associates Inc [↑](#footnote-ref-53)
54. Department of Statistics (DOS) and ICF (2019) Jordan Population and Family and Health Survey 2017-18. Amman and Rockville: DOS and ICF [↑](#footnote-ref-54)
55. Bradley, Sarah E.K., and Benjamin Johns. 2019. Trends in Sources for FP in Egypt and Jordan. Presentation prepared for and presented at the Demographic and Epidemiological Patterns and Trends in the MENA Region meeting, June 2019. Sustaining Health Outcomes through the Private Sector Plus (SHOPS Plus) Project, Abt Associates Inc [↑](#footnote-ref-55)
56. Department of Statistics (DOS) and ICF (2019) Jordan Population and Family and Health Survey 2017-18. Amman and Rockville: DOS and ICF. [↑](#footnote-ref-56)
57. Phenix Center for Economic and Informatics Studies, "Policy Paper Toward Inclusion of All Workers in Jordan in the Social Security System," 2020, Jordan. [↑](#footnote-ref-57)
58. Data provided by the Jordanian Department of Statistics. Available at: [http://dosweb.dos.gov.jo/](https://translate.google.com/translate?hl=en&prev=_t&sl=ar&tl=en&u=http://dosweb.dos.gov.jo/ar) [↑](#footnote-ref-58)
59. Hashemite Kingdom of Jordan (2019) National Social Protection Strategy 2019 – 2025 [↑](#footnote-ref-59)
60. Cited in: Institute for Reproductive Health (2016) Final Report: Jordan Family Planning Assessment. FACT Project. Washington DC: IRH [↑](#footnote-ref-60)
61. National Committee for Women (2018) Sexual Harassment in Jordan. Cited in: Management Systems International (2020) Final Report: USAID/Jordan Gender Analysis and Assessment. Amman: USAID [↑](#footnote-ref-61)
62. Gausman J et al (2019) How do Jordanian and Syrian youth living in Jordan envision their sexual and reproductive health needs? BMJ Open, 9:e027266 [↑](#footnote-ref-62)
63. UNICEF (2020) Socio-Economic Assessment of Children and Youth in the time of COVID-19. Amman: UNICEF. [https://www.unicef.](https://www.unicef.org/jordan/media/3041/file/Socio%20Economic%20Assessment.pdf) [org/jordan/media/3041/file/Socio%20Economic%20Assessment.pdf](https://www.unicef.org/jordan/media/3041/file/Socio%20Economic%20Assessment.pdf) [↑](#footnote-ref-63)
64. Management Systems International (2020) Final Report: USAID/Jordan Gender Analysis and Assessment. Amman: USAID [↑](#footnote-ref-64)
65. Alzyoud F et al (2018) Exposure to verbal abuse and neglect during childbirth among Jordanian women. Midwifery, 58:71-76 [↑](#footnote-ref-65)
66. Management Systems International (2020) Final Report: USAID/Jordan Gender Analysis and Assessment. Amman: USAID [↑](#footnote-ref-66)
67. Outside the scope of this Activity, but of possible interest to the GOJ are the WHO’s Innov8 and HEAL tools for analyzing and documenting health inequalities. More information at https://[www.who.int/publications/i/item/9789241511391 and](http://www.who.int/publications/i/item/9789241511391and) https://[www.who.int/data/gho/health-equity/assessment\_toolkit](http://www.who.int/data/gho/health-equity/assessment_toolkit) [↑](#footnote-ref-67)