Raising awareness and overcoming challenges to achieving comprehensive Sexual and Reproductive Health in Jordan

NWO-WOTRO SRH Programme Policy Brief for Higher Population Council and Share Net Jordan

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Executive Summary

Jordan has greatly progressed in improved sexual and reproductive health (SRH) provision within its health system and has signed up to international commitments on SRH. But there is more work to do, especially when it comes to achieving comprehensive SRH. Looking at the type of information and involvement of youth and vulnerable populations such as refugees is particularly important. This policy brief summarises specific research findings and policy recommendations around barriers to accessing SRH services for various sectors of the population.

This policy brief has been co-developed by the Higher Population Council (HPC) and Share Net Jordan (SNJ) in collaboration with four SRH research projects on Jordan. The research was supported by NWO-WOTRO Science for Global Development to conduct research specifically on SRH and reproductive rights of women, young people and vulnerable populations. Youth, health care providers, and Ministry officials were involved in dialogue with the researchers to debate the findings and recommendations.
The recommendations are:

- Involving populations such as youth including young males and refugees in defining the services they need
- Use innovative and participatory methods to encourage this dialogue, such as interactive theatre and peer group education
- Work with health care providers to address their perceived biases to SRH and expand the general access, coverage, as well as quality of their services. Appropriate legislation should protect this access for all people.
- Engage relevant and broad-based Ministries to ensure this is widespread across public, private and NGO sectors

HPC and SNJ hope that this collaboration supports the Jordanian population, including health care providers, to ensure the best optimum sexual and reproductive health outcomes possible.

Introduction

Globally every country faces barriers in providing comprehensive sexual and reproductive health (SRH). Despite the fundamental aspect of sexual and reproductive health (SRH), this has been often been considered as a taboo or sensitive topic.

The International Conference on Population and Development (ICPD) in Cairo in 1994 was a pivotal milestone which emphasised the fundamental need for women to have more decision-making power over sexuality and reproduction and introduced the concepts of SRH. 179 governments, including Jordan, endorsed the Programme of Action of the ICPD and agreed that matters of demographics, economic and social development, and reproductive rights are inextricably linked and mutually reinforcing. The 2030 Agenda for Sustainable Development (i.e. Sustainable Development Goals), adopted by all United Nations Member States in 2015, calls for comprehensive access to SRH (Targets 3.7 and 5.6). Jordan also recently participated and signed up to ICPD+25. Jordan published its own National Reproductive Health/Family Planning Strategy for 2013-2017 and is currently developing its updated SRH Strategy for the year 2020-2024, as well as having other related strategies, such as the Ministry of Health Family Planning Strategy for the year 2020-2024.

Access involves both ensuring user-friendly service provision, and that people are aware of, accept, and use these services. Given the sensitivity of SRH, different and innovative types of service provision are needed for each population group. It is necessary to involve each population group in defining the best service for them, and implicitly, the barriers to their use. A ‘one size fits all’ approach in SRH is unlikely to be effective.

Background

SRH in Jordan

Jordan has widely available public primary health care, but multiple social barriers exist for individuals who are not currently married to access SRH information and care and there are limitations in the service and care provided. Groups that face such barriers include young women and men who are not married, women not currently or never married (widows, divorced), and men.

Although adolescents and youth (age 10-24 years) in Jordan constitute 30.5 percent of the total population, many face considerable challenges in addressing their SRH needs. SRH has been a neglected and taboo subject worldwide until its importance has emerged clearly in recent years. Young people Jordan are exposed to rigid social expectations and gender roles, which influence SRH outcomes. In a HPC study from 2020, 81 percent of

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young people surveyed expressed an urgent need for SRH awareness programs, 72 percent would like to participate in such programs, and 43 percent said they faced challenges to in accessing reliable SRH information (HPC, 2020). Globally there has been limited research so far on adolescent SRH from an inclusive perspective, especially in the Middle East, including Jordan.

Jordan’s Total Fertility Rate (TFR) has dropped in recent decades – from 7.1 children per woman in the mid-1970s to a low of 3.3 in 2012 and then to 2.7 in 2017-2018 according to the most recent Demographic Health Survey (DHS). This is because of consistently high educational achievement rates for both women and men, as well as tendencies for Jordanian women to marry relatively later in life than women from other countries in the region (Krafft & Sieverding 2018).

The rate of decline in TFR, however, slowed over the past 15 years prior to the 2017 Population and Family Health Survey. Reasons given for this plateau include: the influx of Syrian and Iraqi refugees; as a hedge against divorce; cultural wishes for a larger family including male preference. Moreover, familial pressure from husbands and in-laws strongly discourages use of modern contraception methods (Krafft & Sieverding 2018).

There is also a rising prevalence of early marriage in Jordan, following a decade of decline (UNICEF and HPC 2019). According to the most recent DHS in 2017-2018, 7.5% of Jordanian women and 37% of Syrian women age 20-24 were married before age 18 in Jordan, with the overall rate at 10.7% according to the 2019 Supreme Judge Department report. Children who marry are at an increased risk of experiencing violence within those relationships as compared to adults and poorer (UNICEF and HPC 2019, Jordan DHS 2017-2018). The main drivers of early marriage include poverty, traditional attitudes and customs, religion, and displacement. With increasing political instability in Syria, early marriage rates among the Syrian refugee population are increasing. Some families marry off their daughters to protect them from sexual violence.

The Covid-19 pandemic has brought increased barriers for SRH in Jordan, as well as potential opportunities. A rapid assessment (UNFPA, 2020) found that in general accessing SRH services has been more difficult post the pandemic, with lack of information about how to access services including virtual consults. However, the assessment suggested that virtual services were more accessible to adolescent girls, with 48% of those surveyed accessing a service, than other age groups.

Approach and NWO-WOTRO SRH Research Programme

This policy brief was developed through multiple stages. Firstly, it considered the evidence available on SRH in Jordan, including the national SRH strategy, Study to Assess the Current Status of Reproductive Rights of Adolescents and Youth in Jordan, and related initiatives (Higher Population Council (HPC)’s publications).

Secondly, it drew on the latest SRH research in Jordan, in particular the four SRH research projects of NWO-WOTRO Science for Global Development conducted in Jordan between 2017-2020, which was part of a three country research programme collaborated with HPC. HPC, together with Share-Net International, had produced the “Jordan Agenda Setting for Sexual and Reproductive Health and Rights Knowledge Platform” in 2015 which served to inform the call for research proposals. Its purpose was to ensure that the selected research projects were most relevant to SRH practice and policy in Jordan. The four projects are summarised in the table below and all their publications to date can be accessed through the hyperlink:
Table 1: Project number, short title and link to project website

<table>
<thead>
<tr>
<th>Short title</th>
<th>Project Title</th>
</tr>
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<tbody>
<tr>
<td>Contraceptive counselling</td>
<td>Examining Reproductive Health Services of Women, Female Youth, and Female Refugees in Northern Jordan with a Behavioral Economics Lens</td>
</tr>
<tr>
<td>Early marriage</td>
<td>Syrian Refugee Youth in Jordan: Early Marriages in Perspective</td>
</tr>
<tr>
<td>Interactive theatre</td>
<td>Sexual and Reproductive Health and Rights of Women and Young People in Jordan: A Mixed Methods study using Interactive Theatre</td>
</tr>
<tr>
<td>Jordanian and Syrian youth</td>
<td>Understanding and meeting the sexual and reproductive health needs of Jordanian and Syrian youth</td>
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Thirdly, a series of meetings was held at the final stages of the research projects in 2020 with key policy makers and population stakeholders in Jordan to engage their views regarding recommendations in this brief. This included representatives of various Ministries, service providers, NGOs working in this area, and young people. The detailed discussions from the stakeholder consultation meetings are available in the report. This process of developing this policy brief is in keeping with key recommendations to start a systematic and inclusive dialogue on SRH in Jordan that is informed by rigorous evidence. It follows on from other policy briefs produced by HPC and SNJ on related topics.

Barriers and Challenges for SRH – key groups in Jordan

For SRH to advance in Jordan, we need a public health approach that looks at the whole population, and their health needs, not only those who are using services. We need to acknowledge the strong social and cultural norms that create barriers to obtain specific and timely SRH information and services.

Currently in Jordan, as displayed below, we do not know how many people are actually excluded from SRH services, with services overwhelmingly focussed on married women, who also often seek care outside the public sector according to findings from the Interactive Theatre project. There is limited data and awareness about excluded groups, and also about SRH care outside of modern family planning and maternal health services.
Excluded groups include adolescents and youth, refugees, men, the most economically marginalised, and those facing increased stigma (e.g., divorcees, widows). In order to fully understand the needs of each group, they must be consulted. There are also important populations that support these vulnerable groups, such as service providers and parents that are important to reach.

Below we discuss the research findings for each of the sub-group that need to receive SRH information.

**Adolescents and Youth**

Young people in Jordan face considerable challenges in addressing SRH needs and require reproductive health-related support, information, and services (Interactive theatre & Jordanian and Syrian youth projects, HPC 2017). Despite the significant demand, very few young people access health services in general due to a range of barriers found within the health system and their communities (Interactive theatre & Jordanian and Syrian youth projects). The Jordanian and Syrian youth project engaged 271 young men and women in a participatory, structured brainstorming process called concept mapping to understand how they envision their SRH needs. They also conducted 32 focus groups with 180 young men and women to discuss issues related to obtaining SRH information and services. Young people lack knowledge on SRH, what it involves and where to seek care. This is compounded by a culture of shame that further hinders them from seeking care. Communication challenges between health care providers and patients were also reported (Interactive theatre & Jordanian and Syrian youth projects). The relatively conservative social and cultural norms found throughout Jordan can help keep youth protected in some ways, while conversely, they may create barriers to youth being able to obtain specific and timely SRH information and services (Jordanian and Syrian youth project).
Young males

The Interactive theatre project revealed that in general, men of all ages had low level of knowledge about what sexual and reproductive health is. They also have misconceptions and believe that the field is limited to fertility and pregnancy, and therefore to women, and particularly to married women. Many are not very acquainted with relevant governmental healthcare services available in their area. They found that males of different ages had difficulty identifying the title of the health professional that they should approach for SRH issues. This was reported to cause delays in seeking care or lack of utilization for their health problems which include SRH and other conditions such as urinary tract infection.

“You are afraid to go to a doctor or talk to your mother or father about this topic, especially that reproductive health is related to sex and sex is a taboo”

Young man, aged 18-24 Irbid

Parents

The parent-child relationship is fundamental to shaping children’s trajectories through adolescence. Parent-child sexual communication (PCSC) is one of the most important ways in which parents influence their children’s SRH attitudes and behaviours by using it as a means to educate while also transmitting values, beliefs, information and expectations. The Jordanian and Syrian youth project conducted focus group discussions with 90 mothers and fathers of either Jordanian or Syrian origin who had children aged between 15-19 years old with findings that parents wish to discuss SRH issues with their children, but are ill equipped for such discussions, as discussing sex-related issue within families is often taboo. Youth in Jordan also indicated that they consider their parents to be a trusted source of SRH information (Jordanian and Syrian Youth Project).

“Most parents shy away from telling their sons or daughters what they have to teach them,”

Jordanian mother from Amman

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2 Interactive theatre project
3 Jordanian and Syrian youth project: Othman et al, 2020
“[Parents should] break the obstacle of shame [in order to] make youth feel like they are able to tell their parents anything that they face.”

Jordanian Father from Zarqa²

Married women of reproductive age

In general, married women have been regarded as the main target group for SRH and face less stigma in utilising health services for their SRH. There are, however, significant barriers still present. For instance, the Contraceptive counselling project found that counselling provided to these women in primary health care clinics is sub-optimal. Midwives and doctors report heavy workloads that prevent counselling of all women, as well as reluctance to counsel Modern Family Planning Methods for cultural reasons. Currently, midwives provide some form of standardized counselling for new mothers. The counselling session, however, is passive, short, lacks privacy, and might not address the mother’s full needs. Misinformation provided in counselling sessions has also been noted. There is clearly room for improvement. Through their behavioural intervention that included improved counselling and SMS reminder messages, the Contraceptive counselling project found that continuation of modern family planning methods at 9 months was 45.2%, compared to only 26.8% in those receiving current standard care.

Women not currently married

The study participants in the Interactive theatre project stated that there are negative stereotypes and perceptions related to divorced women. Although divorce was reported as being increasingly accepted by the Jordanian community, divorced women seem to still be stigmatized. Once divorced, women are asked to return to their parents’ houses where fear from people’s gossiping leads to restrictions of movement and people’s interference in their personal life. These challenges were not reported specifically in relation to SRH. Widowed women in Jordan also revealed an array of barriers to seeking care which were different from divorced women. For example, a few of them did not seek care due to lack of knowledge about the importance of receiving regular check-ups despite being a widow (interactive theatre project). There was also evidence of stigma around seeking care for regular reproductive health issues for other non-married women, including those who were single.

“Not only divorced women, but even unmarried girls feel that it is taboo when they go to an obstetrician/gynaecologist (OB/GYN). I am a [single] girl and when I go to OB/GYN, I feel it is taboo. People look at you differently. They seem to question what brought you to an OB/GYN”

Single woman, aged 35+, Mafraq⁴

⁴ Interactive theatre project
Refugees

Jordan hosts the fourth highest number of refugees per capita in the world, which includes more than 745,000 registered with UNHCR from Syria, Iraq, Yemen, and other countries (69 refugees per 1000 country inhabitants).

Two projects particularly focused on refugees who originated from Syria (Jordanian and Syrian youth and Early marriage). There were more pronounced challenges for refugees in accessing health care in general, including SRH health services, compared to the Jordanians. A review on health challenges among Syrian refugees in Jordan found that financial barriers to accessing health care was reported with a prevalence of 66% for the Syrian refugees (Dator et al. 2018). Syrian refugees often lacked the identification cards required to access health services at Ministry of Health facilities. Recent changes in the policy on out-of-pocket payments for health services by refugees have led to confusion and reduced service utilization (Gausman et al 2020). Although family planning services are exempted from charge for uninsured Jordanians, the policy is inconsistently applied to Syrian refugees.

Syrian youth tend to have similar SRH issues compared to Jordanian youth. However, Syrian girls are likely to be more concerned about early marriage compared to Jordanian youth and the intersection between reproductive health, mental health and gender-based violence. They felt that there was a deep connection between early marriage and mental health. Trauma from the war in Syria and the difficult daily living situations faced by many Syrian refugees has likely had profound psychological consequences. The Syrian women in this study emphasised the interrelationship between “psychological stressors,” the war, restrictive social norms and early marriage, thus highlighting the need to address the unique concerns of this population through integrated programming approaches, addressing all youth health needs (Jordanian and Syrian youth and Early marriage).

According to the latest DHS 2017-2018, the rate of early child marriage (i.e. marriage before age 18) is still relatively high among women in Jordan, but much higher among Syrian women, with 37 percent of Syrian women age 20-24 married before the age of 18, compared to 7.5 percent of Jordanians. The median age at first marriage was 19.6 years among Syrian women, as compared with 22.9 and 23.0 years, respectively, among Jordanian women and women of other nationalities.

There is a wider social and economic context that places young Syrian refugee girls/women at risk of early marriage. The refugees face hardship in their lives, and while struggling to protect their family and to thrive, the parents often face a difficult dilemma whether to marry off their young daughter to protect her from the risk of sexual violence and gain some economic stability. While early marriage is regarded as providing protection for the girl, the existing evidence actually shows that women who marry before age 18 are much more likely to experience violence from her husband than those who marry after age 18 (Kidman 2017). The girls who experience early marriage also have more limited economic opportunities due to loss of schooling and can get trapped in a vicious cycle of poverty. Among the Syrian refugees in Jordan, the percentage of early marriage in 2011 was 12 percent, which was close to the percentage of early marriage in Jordan before the civil war (UNICEF 2014). In 2015, early marriage at the national level reached 13.4 percent, while its was 34.6 percent among the Syrians (HPC 2017).

“When there is awareness within society, fears will decrease…”

Syrian girl 5

5 Jordanian and Syrian youth project: Gausman et al., 2019
Service Providers

Although often framed as part of the solution, research findings suggest that service providers also face barriers and challenges in the provision of SRH care. As mentioned above with regards to contraception counselling, doctors and midwives face heavy workloads, but they also hold and face cultural barriers that preclude the full provision of SRH care. For example, a study that included urban Syrian refugees between 12 and 24 years found that poor treatment by health care workers was one of the biggest disincentives to seeking reproductive health services (HPC 2016).

The Jordanian and Syrian youth project looked specifically at provider attitudes towards youth-friendly SRH services. They found that youth-friendly attitudes were more dominant in Amman and among physicians compared to nurses and midwives. Those with training on SRH had more friendly attitudes towards youth than those who did not. Norms and personal beliefs heavily influence providers’ attitudes towards youth-friendly SRH services. Providers are conflicted between supporting confidentiality for young people and their sense of obligation to inform parents.

Providers identified several important barriers they face and their suggestions on how to improve their capacity (Jordanian and Syrian youth). Barriers include:

- Moral and religious barriers: Providers may not feel comfortable offering services to youth. At the same time, they are concerned about community and parental opposition.
- Lack of knowledge and specialisation: Providers are embarrassed to address certain topics with youth and providers lack confidence in how to deal with youth appropriately.
- Provider attitudes: Providers recognise that they can be judgmental and may intimidate clients
- Lack of confidentiality: Youth do not trust that providers from within their community will keep their visit confidential, and not inform their parents.
- Poor knowledge of national guidelines: Many providers – especially midwives- thought that providing SRH service to unmarried youth was illegal.
- Service providers at the forefront need regular updating on issues at hand. Counselling and information giving needs to become more interactive. Enhancing methods of counselling may overcome cultural barriers to SRH care.

Other Groups

There are other groups that also deserve attention and for whom research is sparse. Recently there has been concerted effort to look at the SRH of persons with disabilities, with a position paper published in 2018 (Share Net Jordan/ HPC, 2018), but more research and interventions are needed. Other groups include, the poor, rural and isolated groups and the elderly.
Policy Recommendations

Enhancing awareness of SRH issues and moving from a culture of shame to one of optimal health and well-being needs to be done in a manner appropriate to the cultural, religious and social norms in Jordan. Women (whether currently married or not), men and young people all have SRH needs and at the minimum require preventive health services and information. They need to be encouraged to seek regular check-ups and should not face barriers to accessing available services. This policy brief draws on studies done in Jordan to provide recommendations that best suit the Jordanian context.

Involve populations such as youth including young males and refugees in defining the services they need

Use mobile technology to increase awareness and connection with health services. Consider using the ubiquity of smart phones to promote health-related behavioral change, such as receiving health messages through the mobile phone and offering interactive features such as asking health professional for advice. This adaptation becomes even more important post COVID-19.

Create an interactive digital platform in Arabic – such as an SRH information portal. Data from this can help identify areas of interest in the population and focus awareness raising activities.

Ensure populations have confidential access to reliable and evidence-based information sources, which may include MOH endorsed website

Create a National Guideline with regards to SRH that is created through a learning in practice mechanism. This guideline should be developed through involvement of target groups and interactive methods (as below), and discuss comprehensive SRH awareness and provision for the populations mentioned, adolescents and youth, young males, unmarried females, refugees, those with disabilities, rural groups and others. The area of SRH skills and rights should be framed as an element of required life skills.

Introduce sexual education into schools, using innovative and participatory methods, which includes key stakeholders such as teachers and parents. Sensitise policy makers, community and religious leaders, and other key stakeholders of the value of providing SRH information and services to youth though formal programming. The insights gained through the evaluation of provision of this education, should then be fed back to strengthen delivery of youth SRH services (requiring cross Ministry collaboration as in point 4).

Advantages: Adolescents, youth and other vulnerable populations know best what challenges they face and what they need regarding SRH information and services. Their involvement is essential to improving their access.

Challenges: Adolescents, Youth and other vulnerable populations need a safe and secure space to openly discuss what they need. There is limited acceptability of visiting health services by the wider community, or for women’s visits to the services without a companion. There are also challenges with attitudes of healthcare providers. In the Interactive theatre project community members suggested that if a woman or young person has a companion, it would overcome some of the barriers to accessing care. The ‘culture of shame’ is a major barrier for implementation of youth friendly services in Jordan.

Potential Implementers: Youth groups, health service providers, Ministry of Health, Ministry of Education, refugees, community and religious leaders, schools, NGOs
Use innovative and participatory methods to encourage this dialogue

Consider the use of interactive theatre, which deconstructs the social stigma on the issues so that they can be discussed openly (Interactive theatre).

Introduce multi-component interventions, such as peer group education and counselling, and parent education on SRH.

Ensure the interventions are interactive, and focus on dialogue and discussion of one’s own experience, knowledge and strategies (Early marriage).

Pay special attention to include marginalized and neglected groups, such as individuals with disabilities, rural and isolated groups, the elderly and those in poverty.

**Advantages:** Art and theatre stimulate debate and brings out social norms/perceptions – “Making the invisible more apparent”. Through theatre, the audience is emotionally engaged, and the messages go to the heart of values underpinning SRH. Interactive group meetings are also in themselves an intervention as well as a strategy to design initiatives that address the needs of various groups. They may offer more adequate support in concrete circumstances. Such an approach that has a larger focus on listening may be more rewarding than activities that focus on the transmission of information to the participants. Using Innovative and participatory methods also assure locally appealing solutions.

**Challenges:** Most health education formats today impart information, rather than encourage interaction and dialogue needed to instigate behavioural change. There is also currently an unequal relationship between care providers (e.g. health providers) and care receivers (e.g. youth).

**Potential Implementers:** National Centre for Culture and Arts, youth groups, health care providers, NGOs

Work with health care providers to address their perceived biases to SRH and expand the general access, coverage, as well as quality of their services. Appropriate legislation should protect this access for all people.

Ensure continued training of health care providers in SRH with clear standards and compliance, include values training. Sensitise health professionals to barriers to accessing health services and the need to create demand for such services and data. Training can focus on more supportive attitudes towards comprehensive SRH provision for all, including youth, particularly unmarried youth and other vulnerable groups.

Enhance counselling quality by health care providers. Require publicly-funded clinics to update and revise, at a minimum, the counselling provided by nurses and midwives. This would include updating counselling guides to provide sufficient information for comprehensive SRH. Provide counselling in private.

A national program that develops specialised SRH trainers with a focus on youth can assist in working with healthcare workers over time to assist in developing their capabilities in practice, and linking SRH awareness with essential life skills helping to normalize the conversation. This would be more effective than one off workshops.
Emphasis needs to be made on health care providers’ own attitude to SRH, particularly in relation to unmarried youth, and consideration needs to be made about approaches of comprehensive SRH that are in line with cultural and religious sentiments. Training should be across multiple service providers, nurses, doctors, pharmacists and even pathology collectors. Residency programs, particularly of Family medicine and OB/GYN can incorporate up to date methods.

Develop an up to date document that outlines the legal framework with regards to SRH provision in Jordan, and identifies any gaps that require further legislation or clarification.

Enhance comprehensive primary health care services; provision of combined SRH and mental health services especially for married adolescents and Syrian refugees, to help youth cope with psychological stressors related to their SRH, including family and social pressure, street harassment, and gender based violence.

Explore different modalities for reaching these population groups (e.g. change in clinic hours or youth only hours) and their cost-effectiveness.

Explore possibility of outreach from health services to community centres, universities, and other venues where underserved populations are concentrated so that they can also be part of comprehensive primary health care services. Engage medical and nursing schools to deliver up to date training on SRH counselling and advice. Review the curricula of medical workers to create a supportive environment for providing medical advice to adolescents and unmarried people and to facilitate ways to provide this advice through specific protocols determined by the Ministry of Health.

**Advantages:** Jordan has a dedicated health care provider cadre of professionals. The modernisation of so much of the population, and the large number of young people who have increased access to information digitally, means that improved training including values clarification will support health care providers to address the needs of their population better and more sensitively.

**Challenges:** There are also plenty of private health care providers where regulation is not as straight-forward. There are already pressures of space and timing on health care providers that need to be considered. Health care providers may face resistance and push back from more conservative community elements.

**Potential Implementers:** Ministry of Health, Ministry of Education, Health Professionals Association, Health service provider schools and universities

Promote wide community dialogue with Ministries and providers under their remit. Draw on spaces already present in the population to open up discussions regarding SRH health.

Establish a national umbrella that can coordinate and follow overlapping lines of actions between the National Reproductive Health Strategy and the National Youth Strategy

Engage religious leaders in a discussion about SRH. Research indicates that almost all groups wish to discuss SRH topics, even with their children or a school setting if it is aligned with religious teachings. Producing guidance regarding SRH issues endorsed jointly by the Ministry of Health and Ministry of Awqaf and Islamic Affairs will be of assistance.
Advantages: Enhancing intersectoral collaboration will ensure common messaging and reinforces SRH awareness raising activities amongst populations. Common messaging from multiple sectors will assist in reducing taboos around SRH awareness.

Challenges: SRH is still seen as a responsibility of the health sector and encouraging full participation from other public sectors is a challenge. SRH awareness does not fall within the mandate of other Ministries, thus although sectors welcome technical support as appropriate, allocation of finances from their own budgets towards SRH related activities is a major obstacle. The private sector is focused on service delivery and is not incentivized to work on awareness raising activities.

Potential Implementers: Ministry of Health, Ministry of Education, Ministry of Awqaf and Islamic Affairs, policy makers, community and religious leaders, and other key stakeholders

References


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