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The Knowledge Platform on
Sexual and Reproductive Health
and Reproductive Rights

POLICY BRIEF

EMPOWERING WOMEN AND GIRLS AND GENDER EQUALITY BY ENSURING THE PROVISION OF SEXUAL AND REPRODUCTIVE HEALTH AND REPRODUCTIVE RIGHTS

2020

المملكة الأردنية الهاشمية
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Executive Summary

This policy brief addressed the linksbetween gender equality and empowerment of women and girls and sexual and reproductive health and reproductive rights, to identify gaps and propose the necessary recommendations for policies, programs, and studies to improve the outcomes of sexual and reproductive health, reproductive rights, women's empowerment, and gender equality.

The analysis in this brief revealed many links between gender equality, empowerment of women, and sexual and reproductive health before marriage. The brief identified several familial processes and decisions before marriage that undermine the opportunities for improving sexual and reproductive health and empowerment and for breaking the cycle of poverty.

This brief also revealed many links between empowerment and reproductive health and rights after marriage, indicating the relationship between empowerment and marital sexual violence; the family and reproductive processes that undermine empowerment and reproductive health; legislation that supportsfamily processes and decisions, andundermines empowerment and reproductive healthas represented in early retirement, lump-sum retirement pension allowances, maternity insurance, and maternity leave; relationships between empowerment indicators and reproductive rights and practices; the gap in reproductive preferences between spouses; rapid transition to motherhood; infertility, reproductive rights, and domestic violence; resorting to cesarean deliveries; underutilization of available reproductive health services such as the premarital medical exam; early detection of breast cancer; missed opportunities to obtain Family planning information and services; not seeking institutional aid after exposure to family violence and postpartum care.

The brief concluded with recommendations divided into three categories, as follows:
The first policy: rationalizing family processes and decisions through the preparation and implementation of a participatory national program directed at the family to support the enabling environment that makes sexual and reproductive health rights and gender equality a tangible reality, in partnership with relevant national institutions; as the analysis in this brief revealed many irrational family processes and decisions that undermine the empowerment of girls and women and familial sexual and reproductive health, given the fact that the family is the primary and most important social institution that bears the responsibility of addressing and fixing these issues.

The second policy: mainstreaming the perspective of the relationship between gender equality and empowerment of women and girls and sexual and reproductive health

in the national strategies, plans, and programs, to enhance the recognition of these relationships and their importance in accelerating the pace of sustainable development and poverty alleviation, achieving population goals and improving the quality of human life.

The third policy: reforming policies and amending the relevant legislation after implementing a set of studies proposed by the policy brief to guide the reform process. The first sub-policy within this framework is to change the maternity leave and insurance policy in a direction that enhances the health of mother and newborn and enables her in public life, i.e., not to stimulate mothers to have closely spaced childbearing. The second sub-policy is to reduce the lost opportunities to break the cycle of poverty arising from the gaps between gender equality and women's empowerment and sexual and reproductive health through the institutionalization of a program that guarantees counseling and related services when women are present for any reason in health and community facilities such as health, social centers and hospitals.

Introduction

In the past three decades, the importance of promoting women's empowerment, gender equality, and human rights has been emphasized in sexual and reproductive health programs and policies in many international and regional agreements. The centrality of addressing the interdependence between empowerment, gender equality, human rights, and sexual and reproductive health was recognized in the program of action of the International Conference on Population and Development in Cairo 1994, the Beijing Conference Declaration and Platform for Action, the Nairobi ICPD 25 + commitments, and the 2030 Sustainable Development Goals (SDGs).

Investing in promoting sexual and reproductive health contributes to empowering women and girls and achieving gender equality. It also contributes to supporting sustainable development efforts by raising the level of health and well-being, especially that women and girls who can make choices and control their reproductive lives are more able to obtain high-quality education, finding decent and rewarding work, and making free and informed decisions in all areas of life. Their families and societies are also better off financially, and their children, if they decide to have children, are healthier and better educated.

On the other hand, gender equality and the empowerment of women are among the essential social drivers for health in general and for sexual and reproductive health in particular, and investment in other aspects of human development such

as health, education, employment, fighting poverty, raising the standard of living and empowering woman and youth, positively effects of sexual and productive health.

While progress has been made in understanding how specific dimensions of gender inequality and human rights violations shape sexual and reproductive health outcomes and understand the health implications of investing in sexual and reproductive health, more attention is needed to explore the links between sexual and reproductive health and reproductive rights and sensitive aspects related to gender equality, in order to better understand the impact of these types of interventions on sexual and reproductive health outcomes, and to contribute to promoting the integration of effective interventions for empowerment, gender equality, and human rights approaches into sexual and reproductive health programs and policies, and to establish stronger links with networks and organizations working in the field of gender equality.

Within this context, the Higher Population Council and Share-Net Jordan prepared this policy brief, with funding from the international Share-Net Foundation, intending to uncover the relationships between sexual and reproductive health and reproductive rights on one hand, and women's empowerment and gender equality on the otherin the Jordanian society; identifying gaps in policies; reviewing national legislations, strategies and programs related to sexual and reproductive health; how to strengthen the links between sexual and reproductive health, reproductive rights, women's empowerment, and gender equality; and proposing the necessary recommendations for policies and programs to improve the outcomes of sexual and reproductive health and reproductive rights, women's empowerment and gender equality by filling these gaps.

A group of Jordanian experts participated in preparing this brief, supported by a committee of practitioners (Community of Practice) from national institutions in the public and private sectors, civil society institutions, in addition to the technicians of the Higher Population Council and Share-Net Jordan project, based on many national and international studies.

1. Definitions

1.1 Sexual and Reproductive Health

Reproductive health is a state of complete physical, mental, and social well-being in all matters related to the reproductive system, its functions and operations, and not just being free of disease or disability. Therefore, reproductive health means; the ability to enjoy a satisfying and safe sex life, ability to reproduce, and freedom to decide on reproduction timing and frequency. .....[1]

Considering the previous definition, reproductive rights include some human rights that are already recognized in national laws, international human rights documents, and other United Nations documents that show an international consensus. These rights are based on recognizing all spouses and individuals' fundamental right to decide for themselves freely and responsibly onthe number of their children, inter-birth interval, the timing of their birth, and that they have the information and means necessary for that, and the recognition their right to attain the highest possible sexual and reproductive health level. It also includes their right to make decisions related to reproduction without discrimination, coercion, or violence, as stated in human rights documents. In the exercise of this right by spouses and individuals, they should take into account their future livelihood needs and children's livelihood and their responsibilities towards society, and the promotion of the responsible exercise of these rights for all people should be the primary basis of the policies and programs supported by the government and society in the field of reproductive health.[2]

Violations of women's rights related to sexual and reproductive health are often deeply rooted in societal values of women's sexuality, and this context includes gender inequality as a determinant alone or in combination with other socio-economic inequalities, including unequal power dynamics in interpersonal relationships and other social and cultural norms and practices, and economic conditions. Women are often evaluated based on their reproductive capacity and early marriage and early pregnancy, or repeated pregnancies that occur at very close intervals, often occur due to the efforts made to conceive males because of son's preference. Often, women are also subject to blame for infertility, suffer from ostracism, and are subject to various violations of human rights as a result.[3]

1.2 Gender equality and women empowerment

Gender equality and women's empowerment are two terms, one of which is achieved by realizing the other, as gender equality is defined as "equal rights, responsibilities, and opportunities between women and men, girls and boys,"[4] it is a human right. Empowerment of women is defined as "women and girls gaining power and control over their lives, and this involves increasing awareness, building self-confidence, expanding options, increasing access to and control over resources, and changing structures that reinforce and perpetuate discrimination and gender inequality."[5] It can be said that,empowerment is the strengthening of women and girls' power in the economic, social, and political fields, and it can be achieved by creating more opportunities for women and girls to possess more assets and capabilities. According to the United Nations Economic and Social Commission for Western Asia (ESCWA), empowerment is one of the necessary factors to promote equality between both sexes, focusing on identifying and reforming the imbalance in the balance of power relations between women and men.[6]

Without gender equality and women's empowerment, the highest possible level of sexual and reproductive health cannot be achieved, and there is a recognition of this at the level of international policies. One hundred seventy-nine governments have ratified these rights through the Program of Action issued by the International Conference on Population and Development of 1994, which stipulated that individuals' rights and dignity - including equal rights for women and girls and universal access to sexual and reproductive health and rights - are essential to achieving sustainable development.

The Global Gender Gap Index is used to measure gender equality, and this composite index bears indications of equality and the empowerment of women in general. Table (1) shows that Jordan's gender gap index has not improved in the past decade and a half, as Jordan's overall rank on this index has declined from 93 to 138 out of 153 countries, and although Jordan is close to closing the gender gap in health and education, the gender gap in economic and political participation remains large.

Table (1) Global Gender Gap Index - Jordan 2006-2020

Indicator	Rank/Value 2006	Rank/Value 2020	Indicator	Rank/Value 2006	Rank/Value 2020
Economic participation and opportunities	105/0.442	145/0.408	Health and survival	62/0.975	103/0.971
Educational achievement	70/0.997	81/0.971	Political empowerment	100/0.048	113/0.121
Total	**93/0611**	**138/0.623**			

Source: World Economic Forum, Global Gender Gap Report 2020; ISBN-13: 978-2-940631-03-2.

The statistics of the second round of the Employment and Unemployment Survey for the year 2020 indicate that the economic participation rate of Jordanian females amounted to 14.1% compared to 53.8% for males, the unemployment rate reached 28.6% among females compared to 21.5% among males, and the percentage of employed women reached 19% of the total number of Jordanian workers.[7]

The Population and Family Health Survey 2017/18[8] indicates that 12% of Jordanian women of childbearing age who have ever been married own a house on their own or with others, compared to 27% for Jordanian men aged 15-49, and 8.3% of Jordanian women of childbearing age who have been ever married own land alone or with others, compared to 11.9% for Jordanian men. These low property ownership rates may be due to the low chances of women obtaining their legitimate rights to family inheritance or family purchases of real estate. Moreover, 14.6% of currently married Jordanian women

of age 15 -49 years who have financial gains during the seven days preceding the interview are the ones who decide on their own how to use their cash income. This percentage is 20.9%, 12.7%, and 8.3% if this income is higher than, less than, or equal to the husband's income, respectively.

Statistics obtained from administrative sources indicate large differences between women and men in the ownership of assets and wealth as represented in the ownership of land and apartments and the area size of each of them, in loans, in the value of deposits in banks, and in the value of securities, i.e., stocks.[9] Table (2) shows the most prominent of these indicators.

Table (2) Ownership of Resources, Real Estate and Financial Assets by Sex - Jordan 2019		
Components	(%) Female	(%) Male
Landowners	17.6	46.6
Land area	11.0	66.0
Apartments owners	24.5	57.6
Apartments area	23.3	69.0
Stockholders (stocks and bonds)	44.6	55.4
The total value of securities (stocks and bonds)	25.2	74.8
Bank deposits	37.2	62.8
The value of bank deposits	27.5	72.5
The total value of loans from commercial banks	18.1	81.9
Individual borrowers (microloans)	76.3	23.7
The total value of the small loan	58.8	41.2
Jordanian workers insured in Social Security	28.9	71.1
Source: http://jorinfo.dos.gov.jo/Databank/pxweb/ar/GenderStatistcs/GenderStatistcs__Gender-/ ndicators__Economy/Table44_Economy.px		

2. Sexual and reproductive health, gender equality and women's empowerment in the global agenda for sustainable development 2030

The 2030 Sustainable Development Goals recognize that sustainable development can only be achieved with gender equality, as it intersects with most of the sustainable development goals, including the health goal. Despite this, the fifth goal of the Global Agenda 2030 goals has been devoted to gender equality, and this goal involves a target related to universal access to sexual and reproductive health (5-6), in addition to the sexual and reproductive health goal 3-7 contained in the health goal.

The inter-linkages between sexual and reproductive health, equality, and empowerment with the rest of the sustainable development goals (SDGs) have been reflected in the SDGs'indicators. The second goal, which is to end hunger, provide food security and improved nutrition, and promote sustainable agriculture, emphasized on measuring the prevalence of anemia among women of childbearing age and according to the state of pregnancy; under the fourth goal, the rate of participation of young women in formal and

non-formal education and training; under the eighth goal, the proportion of women in informal employment in non-agricultural employment; under the tenth goal, the percentage of women who live below 50% of the national average income; the third goal, which is to ensure that everyone enjoys healthy lifestyles and well-being at all ages, has a large space for reproductive health indicators, which is the maternal mortality ratio, the proportion of births supervised by skilled health professionals, the mortality rate of children under the age of five, the neonatal mortality rate, the number of new HIV infections per thousand uninfected persons of the population by gender, the proportion of women of reproductive age (15-49 years) whose need for family planning was met by modern methods, the fertility rate of adolescent girls (10-14 years and 15-19 years) per 1,000 women in that age group; under the fifth goal related to achieving gender equality and empowering all women and girls, we find the percentage of cohabiting women and girls aged fifteen and over who have been subjected to physical, sexual or psychological violence from a current or previous partner during the previous twelve months, the percentage of women and girls aged fifteen and over who have experienced sexual violence from persons other than a partner during the previous twelve months, the percentage of women between the ages of 20-24 who married or had a partner before reaching the age of fifteen and before reaching the age of eighteen, the proportion of women between the ages of 15-49 years who make informed decisions about sexual relations, contraceptive use and reproductive health care, the number of countries that have laws and regulations to ensure that women and men of 15 years of age and over have full and equal access to sexual and reproductive health care, information and education; under the eleventh goal, the percentage of victims of physical or sexual harassment and where it occurred during the previous twelve months; under the sixteenth goal related to peace, justice and international institutions, the percentage of those who were subjected to physical, psychological and sexual violence during the previous twelve months, and the percentage of young women between the ages of 18 and 29 years who were subjected to sexual violence before the age of eighteen.[10]

3. Links between gender equality, empowerment, and SRH before marriage.

3.1 Responding to the challenge of the needs of the high proportion of adolescents and single youth

The percentage of the population of adolescence and youth 10-24 constituted (30.5%) of Jordan's total population in 2019 (which numbered 3.216 million; of whom 1.51 million were girls). The percentage of those aged 10-19 years is (20.5%) and at the age of 15-24 years is 19.9%.[11] The percentage of ever married women at ages 15-19 and 20-24 years is 8% and 35%, respectively, and the percentage of ever married men at ages 15-19 and 20-24 years is 0.4%, 4.4%. Thus,[12] the largest proportion of young people 15-24 years old have never been married and this large number of young people who have different needs and services from their married counterparts need to be taken into consideration. In fact, 81%

of young people indicate that they have an urgent need for awareness programs in the field of sexual and reproductive health, and 43% of them faced challenges in obtaining information related to their sexual and reproductive health for reasons, the most prominent of which is the refusal and reluctance of parents to their children obtaining information about sexual and reproductive health, including 26% of the female sample and 11% of the male sample.[13] Young people criticize teaching reproductive health topics in the school curricula and complain about their teachers' insufficient response to their embarrassing questions about it. Despite keenness to know all the issues related to their sexual and reproductive life, adolescents, of both genders, are hesitant to talk to their parents about the changes that they are going through that accompany the stage of puberty and maturity, and so do parents. Many teachers skip these topics because they are either hesitant about them or don't feel comfortable when addressed in the biology curriculum.[14]

3.2 Early marriage undermines reproductive health as well as empowerment

Several countries have put in place strategies to eliminate early marriage under the age of 18 years. However, some parents intend to forcibly marry their daughters, believing that marrying a girl guarantees her future and eases the burden of caring for her, unaware of the health and psychological risks of this harmful practice.[15]

When girls marry at a young age, they are more exposed than others to violence from an intimate partner and sexual abuse compared to those who marry at an older age, and that underage marriage makes girls more vulnerable to severe health risks of early pregnancy and childbirth, as complications of pregnancy and childbirth are the leading cause of death among girls in the age group 15-19 years. Simultaneously, girls who marry later and delay pregnancy beyond their teens have a greater chance of enjoying more excellent health, obtaining a higher education, and building a better life for themselves and their families. According to the United Nations, complications from pregnancy and childbirth are the leading causes of death among girls aged 15-19 in developing countries out of the 16 million adolescent girls who give birth each year.[16]

Underage marriage exposes the mother to giving birth to babies whose size is very small or below average or weighing less than 2.5 kg,[17] and in Jordan, the percentage of such births among mothers under the age of twenty (21%) is slightly higher than it is among older mothers,[18] and these births are more likely to die. Recent statistics in 2019 showed that 68% of newborn deaths were of low-weight babies.[19]Underage marriage may not raise childbearing levels due to the relatively low fecundity to conceive unless this marriage is widespread and causes a rise in the percentage of married women who become vulnerable to pregnancy and childbearing.[20]

A study in 2019 examined the causes of early marriage and concluded from an analysis of patterns based on population and family health surveys that those who marry under the age of eighteen are more likely to be harmed due to violence by the husband. The secondary analysis of the population and family health surveys showed that high educational attainment

is strongly linked to the lower levels of child marriage for all those who married under the age of eighteen and fifteen. According to the qualitative aspect of the study, it was found that poverty, norms, traditions, and family disintegration were the main motives for child marriage, and the study examined each of these motives with the participants in order to find the more profound reasons leading to each of these motives. The study found nine second-degree motives and 27 third-degree motives.[21]

The study of underage marriage in Jordan in 2017 showed that the percentage of married females under the age of 18 years whose educational level is basic and less amounted to 86.7%, and the percentage of those whose husbands had a basic educational level or less is 46.5%. In addition, the husbands of married women under the age of 18 years are mostly in non-employment status. The overall continued character is that there is no economic activity for married females under 18, as their marriage has no ambition or desire to work. According to the 2015 census data, females who are neither working nor looking for work account for more than 98%. The husbands of underage married women are mostly in unstable employment status. More than half of Jordanian underage married women have their husbands not working or working irregularly.[22]

Female marriage under the age of 18 is still practiced in Jordan accounting for 15% of first-time marriages in the last five years (see Table 3) and is expected to decline in the coming years due to the expected effect of the new legislative restrictions that regulate underage marriage.

Table (3) Adolescent marriage among those who married for the first time in Jordan 2015-2019

Marriage Type	2015	2016	2017	2018	2019	Total
First time marriages	67,743	67,613	62,861	56,334	53,453	**308,004**
Marriages at age 15-17 years	10,866	10,907	10,434	7,776	7,225[a]	**46,013**
[23] %	16.0	15.3	15.6	13.8	13.5	**14.9**

a. 295 of the grooms were underage.

The percentage of early married females among those who married for the first time in 2019 by governorate[24]

Amman	Balqa	Zarqa	Madaba	Irbid	Mafraq	Jerash	Ajloun	Karak	Tafila	Ma'an	Aqaba
10.1	13.3	20.6	12.7	15.2	21.7	11.8	8.0	7.5	3.5	12.6	14.7

Source: Sharia courts in Jordan for the five years 2015-2019

3.3 Use of premarital medical examination and sexual and reproductive health

Before marriage, the medical examination is the starting point in avoiding the occurrence of reproductive anomalies and hereditary blood diseases, but about half of the ever-married husbands and wives(52% for husbands and 53.2% for wives) sought to obtain this examination. Surprisingly, the proportion of newly married men young men and women below the age

of twenty who sought this examination were also low (42% -43%)[25], although this examination has become mandatory by law since 2004. Studies have shown that awareness of medical examination and its role in reproductive health is higher among university girls than less educated girls. Furthermore, the scientific research that has dealt with consanguineous marriage indicated that the incidence of diseases and disabilities among children of close relatives is evident due to the lack of a medical examination at the time of marriage. The premarital exam can help prevent hereditary blood diseases and other genetic birth defects associated with kinship marriages and avoid problems, not only at the health level but also extends to other levels related to economic, social, and psychological difficulties.[26]

3.4 Consanguineous marriage and reproductive health

There is a relationship between several hereditary diseases and disabilities, especially hereditary blood diseases (Mediterranean anemia and sickle cell anemia) and consanguineous marriage, which is more common in Jordan among the lower segments than among the wealthiest segments (32% versus 21%)[27], and surprisingly, it is more common among married women in the age group 15-29 years than among subsequent age groups.

3.5 The possibility of pregnancy before wedding is not ruled out

Every year 18-24 girls killed by their families in the name of honor, and the number of these crimes reached 21 in 2019; and it is disturbing that there is strong support for these crimes in the social culture, according to one of the surveys, which found that half of the boys and one-fifth of girls justify the killing of girls if they inflict shame to their families, and those who reject these crimes are often described as spreading "outrageous."[28]

Since most newly engaged and married couples enter into relationships without adequate information and services available beforehand, the possibility of unwanted or pre-wedding pregnancies remains possible. Since a large proportion of marriage contracts end before the actual wedding, a dispute between the two families may erupt which entails an additional cost on the two families' income because of the refusal to complete the wedding. Statistics show that a high percentage of divorce cases occur before wedding. Thus, the possibility of pregnancy during the engagement period and before the wedding ceremony is existed due to cohabitation among engaged couples. The percentage of dissolved marriage contracts before wedding reached 38% of the total divorce cases for the 2015-2019 period and reached 35% in 2019, in addition 65% of the divorce cases of Jordanian women in 2019 were from same-year marriage contracts and before wedding.[29] Sexual assault examinations occupy an important place in the National Forensic Medical Center clinics work, and in 2019 they reached 808 examinations.[30]

4.The links between gender equality, empowerment and SRH after marriage.

4.1 Empowerment and marital sexual violence

The familial abuses committed against girls and women are evidence of weak empowerment. Women in the poorest segments are more accepting of wife's abuse by her husband than the richest segment (60% compared to 31%) and are less able to refuse marital intercourse if they do not want it (60% versus 75%). Moreover, they are less able to ask the husband to use condom than women in the wealthiest segments (62% versus 76%), and less to have a bank account (5% versus 47%). Women in the poorest segments, in general, are more vulnerable to the control and psychological, physical, and sexual violence by their spouses. Moreover, the percentage of low-weight births among mothers of the lowest segment (19%) is higher than the national rate.[31] The rate of polygamy is low in Jordan because the divorce of previous wife's usually precedes it, but it is more common among the lower segments than among the richest (6.5% versus 3.3%).[32]

4.2 Reproductive and family processes undermine both empowerment and reproductive health

It is not the public policies that always stand behind poverty and the weak empowering women. Programs managers are usually busy measuring poverty rates and providing aid to the poor, but do not give enough attention to the causes that lead to poverty, which are mostly family and reproductive processes that start with: the bride and groom often and originally come from large and poor families; marrying off minors, shortening the length of their education and depriving them from paid work; the early succession and frequency of childbearing and the increase in family expenditures in relation to their income accordingly; the family decision for the early withdrawal of working mother from the labor market; divorce, widowhood, and polygamy; depriving women of their legitimate inheritance rights of their parents, husbands, children and siblings assets, in favor of men, known as the phenomenon of "feminization of poverty", the recent problem of female debtors is a testament to all this.

An analytical study in 2013[33] entitled Determinants of Women's Work in the Labor Market and their Impact on Fertility indicates that those who were outside the labor force were mostly females who were less fortunate in education, most of whom were of rural origins. They were more committed to inherited values, whose marriage patterns were characterized by being kinship patterns, were married at early ages, and experienced a death of their children. The results also highlighted the important effect of woman's work status and the important impact of variables such as the wife's education level, wife's current place of residence on her fertility level. The study also showed that variables such as the wife's current age, age at first marriage, use of family planning methods, and the incidence of child deaths have important and decisive effects on Jordanian women's fertility level.

4.3 The relationship between wife empowerment and reproductive practices and rights

Studies show that decision-making related to pregnancy is a complex process, and it often includes the woman herself, her partner, significant others, her family, and members of society. It is often observed that the male partner plays a major role in these decisions.[34-35] The results of another study indicated that, in general, when women are empowered, they enjoy better sexual and reproductive health outcomes, including reduced fertility, longer birth intervals, and lower levels of unintended pregnancy. All three are often achieved through increased use of contraception.[36]

Progress towards achieving gender equality requires complementary and transformative measures to promote women's rights and empowerment by addressing structural inequalities embedded in social structures, including addressing gender gaps, unequal policies and discrimination, which have reinforced the disadvantage of women and girls over time and affected their full participation in development. Humanitarian crises can be devastating to women and girls in particular because they increase their vulnerability to sexual violence. As long as women, girls, and other marginalized groups are exposed to harmful practices such as child marriage, they will never exercise their sexual and reproductive health and rights. Eliminating these harmful practices provides women, girls, and other marginalized groups with the ability to control their bodies and the freedom to make decisions about their rights, sexual and reproductive health and lives, and this component is linked to demanding legislation to end harmful practices, and then to ensure the enactment of legislation by providing access to legal support and compensation for their violated rights.

Women's sexual and reproductive health is linked to multiple human rights, including the right to life, the right to be free from torture, the right to health, the right to privacy, the right to education, and the prohibition of discrimination. Both the Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women have indicated that a woman's right to health includes her sexual and reproductive health. This means that states have obligations to respect, protect, and fulfill women's sexual and reproductive health rights. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health affirms that women have the right to access services, goods and facilities related to reproductive health care characterized by the following: (a) availability in sufficient numbers; (b) physical and economic access to them; (c) access to them without discrimination; and (d) quality.[37]

In Jordan, there is a variation in fertility indicators according to wealth index, as Table (4) shows apparent differences in nine indicators of actual and desired childbearing between mothers in the poorest and wealthiest family segments.

Table (4) Economic Empowerment and Reproduction									
Wealth Level	Began childbearing at age 15-19 (%) years	Total Fertility Rate (births per woman)	Desired fertility (births per woman)	Average ideal number of children	Completed fertility rate (births per woman)	Unmet need for family planning (%)	Desire to stop childbearing (%)	Average birth interval (month)	Pregnant women %
Lowest quintile	13.0	3.9	3.0	3.9	4.3	16.8	48.7	30.7	8.6
Highest quintile	0.6	1.4	1.2	3.6	3.6	14.8	52.8	42.4	3.9
Source: Department of Statistics and ICF. 2019. Population and Family Health Survey 2017-2018. Main report, Amman, Jordan and Rockville, Maryland, USA; Link: https://dhsprogram.com/pubs/pdf/FR346/FR346.pdf									

A small percentage (12%) of married Jordanian women who do not currently use a family planning method believe that the wife is the one who decides to use the method.[38] However, a high percentage of those who have ever married (86%) believe that there is justification for the wife's refusal of marital intercourse if she knows that her husband has a relationship with another woman; (this percentage drops to 79% among Syrian women) or asking him to use a condom if she knows that he has a sexual disease (82%) and this percentage drops to 76% among Syrian women. Moreover, 69% of currently married Jordanian women reported that they could refuse marital intercourse if they did not want to, compared to 56% among Syrian women, and 73% of them reported that they could ask the husband to use a condom before marital intercourse, compared to 57% among Syrian women.[39]

There appears to be a relationship between the degree of women's empowerment and the opportunity to exercise their reproductive rights. Two indicators were employed to measure the degree of women's empowerment: the first is the number of reasons for which the woman believes that her husband has the right to beat her, as the greater the number of reasons that justify this from her point of view, this indicates her low empowerment and status and vice versa;the second indicator is the number of family decisions in which the wives participate. The smaller the number of family decisions in which they participate, this indicates a low level of empowerment and status, and vice versa.

The results (Table 5) indicate a relationship between the first indicator and the ability of women to exercise their reproductive rights. According to this indicator, the greater the degree of empowerment, the greater the percentage of those who participate in making all family decisions, and the greater the percentage of women who use traditional and modern family planning methods among them. Consequently, the percentage of their unmet need for these methods is less and the lower is their average ideal number of children.

There is also a clear relationship between the second empowerment indicator and the exercise of reproductive rights. The greater the number of family decisions that women participate in, the greater the percentage of those who use family planning methods among them, and thus

the overall percentage of their unmet need for these methods is less, and the lower is their average ideal number of children.[40] Corresponding statistics from the 2012 Population and Family Health Survey indicate similar relationships.

Table (5) Empowerment and reproductive practices among married women in 2017/2018 and 2012 JPFHS

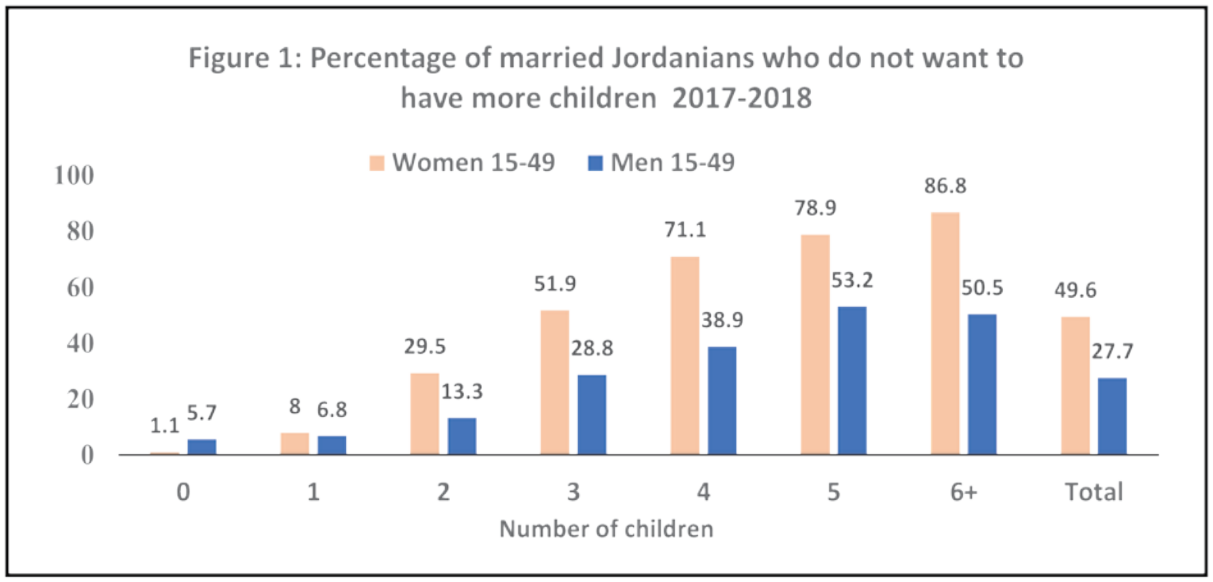
Reproductive practices 2017/2018					
Empowerment indicators	Participate in making all decisions (%)	Using a family planning method(%)	Use a modern family planning method (%)	Have an unmet need for family planning (%)	Average ideal number of children
(1) Number of reasons that justify wife beating					
0	83.2	52.2	37.7	13.8	3.7
2-1	74.6	52.4	37.5	14.9	3.9
4-3	67.8	51.1	37.0	12.3	4.1
7-5	56.2	42.1	33.5	19.7	4.0
(2) Family decisions in which the wife participates	Not applicable				
0		36.9	25.4	18.4	4.0
2-1		49.1	34.0	16.2	3.7
3		53.3	38.9	13.6	3.9
Reproductive practices in 2012 JPFHS					
Empowerment indicators	Participate in making all decisions(%)	Using a family planning method(%)	Use a modern family planning method(%)	Have an unmet need for family planning(%)	Average ideal number of children
(1) Number of reasons that justify wife beating					
0	72.0	62.4	41.8	10.6	3.9
2-1	64.2	60.5	42.7	12.6	3.9
4-3	60.0	62.5	42.7	11.4	4.0
7-5	56.5	57.3	41.1	11.9	4.2
(2) Number of family decisions that the wife participates in	Not applicable				
0		46.2	32.0	16.1	4.1
2-1		59.1	41.4	11.6	3.9
3		62.8	43.1	11.6	4.0

Source: Population and Family Health Survey 2017/2018 and 2012

4.4 There is a gap in reproductive desires between husband and wife[41]

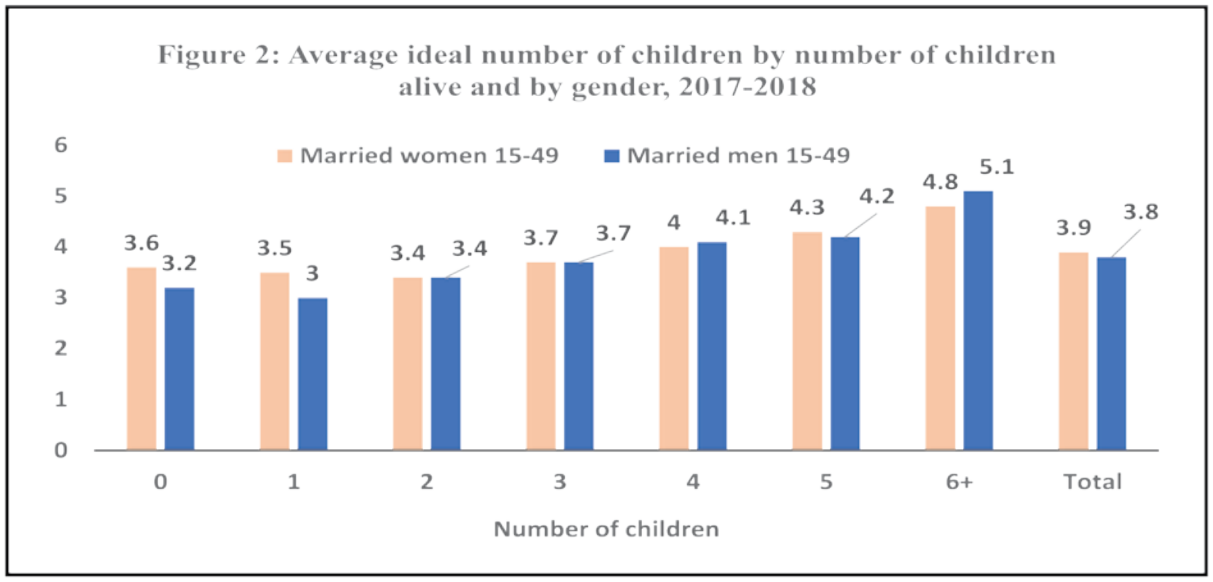
The knowledge of Jordanian married women and men about family planning methods is universaland identical. However, Jordanian men are less than Jordanian women in the degree of exposure to family planning information in all the audio, print, visual and electronic media, and men rarely accompany their wives to government clinics and NGOs maternal clinics. During pregnancy and the postpartum period, they are deprived of such information, and this may stand behind the significant differences between men and women in the desire to have more children, for example, 49% of currently married women do not want to have more children, while only 28% of currently married men do not want to have another child (Figure 1), and this difference is evident at the second child and increases after that to reach its maximum at the fourth child and beyond. While 87% of women who have six or more

children do not want to have more children, about half of all men with the same number of children do so. In general, half of Jordanian women do not want to have more children, while only 28% of Jordanian men want to do so. These gender differences need attention by the managers of reproductive health programs.



Source: Department of Statistics, Population and Family Health Survey 2017/18

Contrary to the previous results on the differences between women and men in thedesire to stop having children, the ideal number of children was higher among married women or equal to that of married men until the fifth child (Figure 2), but it becomes higher for men from the sixth child and beyond. In general, married men and women who have five or more children reported an ideal number of children less than the number they had, meaning that their actual childbearing exceeded the ideal numberthat they perceived, which may indicate a past unmet need for the use of contraception.



Source: Department of Statistics, Population and Family Health Survey 2017/18

Violence directed at the wife in all its forms is not among the areas of this policy brief, but it may be useful here as we address gender issues, including gender-based violence, to point

out that 69% of Jordanian men have agreed to at least one of the seven reasons that justify wife beating, while 45% of Jordanian women have agreed to this.

4.5 The rapid transition from wedding to motherhood is an indication of weak reproductive rights and empowerment

The newlyweds' transition to pregnancy and parenthood by having their first pregnancy a/o first birth has not received significant attention, although it is of great importance that arises from the many influences of the timing of first child on the life of couple. The spouses' haste to give birth to their first child shortly after wedding does not give the spouses sufficient time to understand, and test their marriage, and recover from the debts incurred by marriage, and it may also cause an early exit of the working wife from work, which negatively affects her empowerment and economic standing because she has not yet gathered many years in the labor market which might prevent her from deciding to leave work. The early exit of mother from work to take care of her first child and home results in decline in the family's income, which adds additional pressure on the husband's income caused initially by the arrival of first child.

Will couples in Jordan rush to the first pregnancy and give birth to their first child shorty after marriage? It is expected that husbands will accelerate the delivery of their first child. This event may be due to several reasons, including the absence of the principle of conscious and responsible planning for childbearing among newlyweds; their none use of contraceptives during the honey moon and first year of marriage; their exposure to pressure from their families and relatives who wish to see their grandchildren; the intent of the newlyweds to prove their fertility and avoid questions from family and friend; the family planning service providers ignore the needs of the newlyweds to postpone their first child because they believe that the use of FP methods for delaying the first pregnancy might affect their chances of conceiving later.

The results of the Population and Family Health Survey 2017/2018 showed that the percentage of spouses who gave birth to their first child within a year and a half and two years after the wedding amounted to 66.3%, 78.9%, respectively.[42] The direct reason behind the timing of first birth may be due to the low percentage of newlyweds who are in the age group of 15-19 years of age who use a modern method of family planning, as it reached only about 10% in the 2017/2018 survey.

4.6 Infertility, reproductive rights and partner violence

Infertility affects approximately 15% of women and 8% of men globally, with couples in the MENA region experiencing higher primary infertility rates (not having a live birth) compared to the global average, although secondary infertility rates (post live birth infertility) are similar

similar to the global average. In Jordan, approximately 3.5% and 13.5% of couples were defined as suffering fromprimary and secondary infertility, respectively.[43] According to the most recent Demographic and Health Survey among married individuals of reproductive age, 16% of women and 9% reported self-infertility.[44]

There are no statistics on the rates of infertility among husbands in Jordan. However, there are indirect indicators represented in the percentage of those who were previously married and reached the end of their reproductive life (45-49 years) and had never given birth, which amounted to 14.4%, while the same percentage among currently married women was 4.4%.[45] We do not know which of the spouses is responsible for this, but husband's sterility is often kept secret and attributed to the wife by the husband and his family, while speculation continues about the reasons for their delay in childbearing.

There are qualitative and quantitative studies linking infertility to increased intimate partner violence and other domestic violence forms in Jordan.[46] Evidence from the region indicates that the vast majority of women who seek fertility services have experienced domestic violence (e.g., Turkey 72%;[47] Iran 68% -90%).[48] There is conclusive evidence that infertility and its submission to fertility services are mentally, physically, and financially exhausting for both men and women.[49] It is important to mention that the cost of infertility treatment for both primary and secondary parts is high in Jordan. The public sector does not cover all items of this cost, which means that couples' rights remain without adequate response.

4.7 The rate of cesarean delivery is high

The percentage of cesarean deliveries among Jordanian women is 27%, rising to 32% among those in the age of 35+, and 27% among the richest segment compared with 24% among the poorest segment.[50] The percentage of cesarean deliveries in 2019 in the Ministry of Health was 30.74%,[51] which is twice the maximum recommended by the World Health Organization. Cesarean deliveries did not save the life of 62 mothers from death,[52] as 63% of their deaths were those who gave birth by cesarean section (42% emergency and 21% elective C-S) and the rest percentages were 16.1% or vaginal delivery, 12.9% died while pregnant, and 8.1% died after a miscarriage.[53]

4.8 The use of some reproductive health services is low; why?

Despite the expansion and improvement of government health services in Jordan, there are still social and operational obstacles to ensuring sustainable access to several services in the field of reproductive health. Furthermore, the poorest segments have more problems than the wealthiest segments in access to health care in general (61% have at least one obstacle compared to 23%, respectively).[54] Survey results show that 39% of Jordanian women of childbearing age who have ever been married mentioned at least one reason that impedes their access to health care when they need it and the most important reasons behind that were the need

to use a means of transportation; the unwillingness to go alone; the distance to the health facility; having cash money; and lack of female service provider.[55] The absence of health insurance cannot be excluded as a hindrance to obtaining health care, as the data indicates that 63% of outpatient patients and 69% of those admitted to hospitals have health insurance.[56]

Education, distance from the healthcare facility, availability and cost of public transportation, family income, knowledge about maternal care, and service provider fees have had a major impact on the utilization of prenatal care services in China.[57] A study inIndia concluded that family's economic situation is a strong determinant of the use of antenatal care services and found that wealthy women are two and a half times more likely to visit doctors during pregnancy than the poor.[58] In Pakistan, wife's education, husband's education, and the use of the media have very large effects on utilizing maternal health care services.[59] Wealth has also emerged as a strong indicator in Indonesia where a study found that the lack of education and income leads to a decrease in the use of health care services after childbirth.[60] In Egypt a study concluded that the education of women and the support of the husband and marriage at an older age had a positive impact on the use of maternal care facilities.[61]

The preference of women for a female service provider may limit their access to care in the facilities available to them but lack female health cadres. The Ministry of Health reports indicate that the percentage of IUDs installed by midwives is 68.7% and by doctors, 31.3%, and in some areas the percentage was 100 % by midwives.[62] Also, the absence of coverage with health insurance may impede access to health care or delay obtaining it, as the percentage of health center visitors who do not subscribe to health insurance is 22.8% (9.9% are not able), and the percentage of outpatients who do not participate in health insurance is 39.5% (25.1% are unable).[63]

Despite the high percentage of women who receive care from trained health workers during pregnancy visits and at childbirth, there are certain services, despite their availability, their use is still low in Jordan and below the hoped-for level, namely the pre-marital medical examination, as we explained earlier; early detection of breast cancer, cervical cancer and osteoporosis; low direct exposure to information about contraceptives; lost opportunities to obtain FP information and services; and seeking institutional help when exposed to marital violence.

4.8.1 Early detection of breast cancer is low; why?

The percentage of Jordanian women of childbearing age who underwent a self-examination or by a specialist to detect breast cancer during the past year, according to the reports of the Ministry of Health, is low (22%) even among those in the last years of their reproductive life. Breast cancer is the most common type of cancer among Jordanian women.[64] Jordanian women attributed the two most important reasons for their low pursuit of a mammography examination to the fact that there is no need for this (51%) and to the absence of disease

and symptoms (38%). Less than a quarter (24%) of Jordanian women of childbearing age who had ever been married had previously undergone an examination. Pap smear test is low, and the use of cervical cancer vaccine is not offered in Jordan. Also, 28% of Jordanian women are protected from tetanus after their last birth.[65]

4.8.2 Missed opportunities for receiving family planning information and service; why?[66]

There are also many missed opportunities for mothers to obtain information and services related to reproductive and sexual health when they visit health facilities and hospitals during pregnancy, during childbirth, before leaving the birth facility, during the postpartum period, and during visits to have their children vaccinated. However, 77% of Jordanian women who have ever been married and are still of childbearing age and are not using family planning methods did not receive family planning counseling from a health worker or in a health facility during the past year. Although all births in Jordan take place in a hospital, mothers' opportunity to obtain counseling on using a family planning method to avoid having a close pregnancy is lost by their discharge from hospital without exposure to this information.

4.8.3 Seeking institutional help after experiencing violence is low, why?

Although a quarter of Jordanian women aged 15-49 years who had previously been married disclosed that they had previously experienced psychological, physical, or sexual violence from their current or previous husbands or other sources, and a quarter of them had an injury; as a result, 35% of them sought help to stop this They used to seek help from their original families or the families of their husbands, and in very few cases they resorted to a friend or neighbor or to obtain institutional help from health workers, the police, a lawyer, or a social work organization.[67] There are several reasons for the so-called "culture of silence" or lack of knowledge and confidence in the services provided by official institutions in charge of these cases.

During the year 2018, the Family Protection Department dealt with 11923 cases and cases. About half of them (47.3%) were cases and not cases that were referred to the Social Service Office, and 16.9% were referred to the administrative rulers, while the percentage of sexual assault cases that were dealt with and referred to the competent judicial authorities was 13.5% of the total number of various complaints received. While the percentage of cases of physical assault was 22.3% of the total complaints and cases received by the administration.[68]

4.8.4 Pregnancy loss

The outputs of any pregnancy are classified into four outcomes: the termination of pregnancy with live birth, fetus's death (miscarriage), still birth i.e., completed 28 weeks of pregnancy, or the termination of pregnancy through induced abortion. These four outcomes are related to reproduction, i.e., the number of live births a mother gives birth to during her marital life. Therefore, the Population and Family Health Survey for the year 2017/2018 included ten questions directed to women who had ever been married to find out in detail the outcomes

of their past pregnancies. These questions began by asking the lady whether there had been any pregnancies during her previous reproductive life and up to the interview time that did not end with live birth but ended with miscarriage, induced abortion, or stillbirth.

The results (Table 6) revealed that about a quarter of women (25.3%) had previously had three such events in the past four decades, that is, in the years between 1975-2018, but 40.8% (1319/3236) had such events in the five years preceding the survey. During the years 2012-2017, 60% of these five-year incidents occurred in the last three years. As for the timing of pregnancy loss according to pregnancy duration, the results indicate that pregnancy loss in the last five years occurred between the second to ninth month of pregnancy, but the majority (77.3%) occurred in the first trimester of pregnancy.

Table (6) Pregnancy outcomes for women of childbearing age who have ever been married 2017-2018

Pregnancy outcomes	Have previously lost a pregnancy by miscarriage / abortion / stillbirth	Have never lost a pregnancy (their pregnancies ended with a live birth)	**Total**
Number	3236	9528	**12764**
Percentage (%)	25.3	74.7	**100.0**
The number of women who have never missed and who have previously lost a pregnancy in the five years preceding the survey			
Number Percentage (%)	1319 (10.3)	11445 (89.7)	**12764** **100.0**
Pregnancy loss in the last five years			
Abortion	Stillbirth	Miscarriage	**Total**
191 **%** 5	48 0.4%	1080 8.5%	**1319** **10.3%**
Source: Unpublished results from the Population and Family Health Survey 2017/2018			

4.8.5 The nutritional status of women

Obesity is higher among women at the end of their reproductive life 40-49 years (45%) than among women 15-19 years who are at the beginning of their reproductive life (6%). Obesity among the poorest segment is (26%) and the richest segment is (15%). As a result of the short period of exclusive breastfeeding (less than a month) and the low percentage of resorting to LAM through breastfeeding, half of newly delivered mothers are exposed to a new pregnancy within three months after childbirth. The Jordan Population and Family Health Survey 2017/2018 revealed that 43 percent of women and one third of children in the Kingdom suffer from anemia. Anemia is more common among women than children, as 43% of those between the ages of 15 and 49 have anemia. It has been observed that anemia is relatively high among women at all educational levels and family well-being. According to the governorate, the rate of anemia among women ranges from 35% in Madaba Governorate to 49% in Ma'an Governorate.

4.8.6 Knowledge and attitudes towards sexually transmitted diseases

Jordan is one of the countries with a low HIV prevalence rate. The number of registered HIV and AIDS cases in 2019 is (103). However, only 9% of men and women 15-49 years old have comprehensive knowledge of ways to avoid infection with HIV, and 90% of Jordanian women and 87% of Jordanian men ages 15-49 years have discriminatory attitudes against people living with this virus.[69]

5. Legislation strengthens family processes and decisions that undermine empowerment and reproductive health

5.1 Early retirement and lump sum compensation in the social security law cuts short women economically active life[70]

Although the law requires old-age retirement at 60 years for males and 55 years for females, subscribers to social security scheme can retire earlier than these ages; for example, the average age of early retirees during the years 2016-2018 was fifty years, and the percentage of early retirees out of the total cumulative number of retirees was 48% in 2018.Early retirement accounted for the largest percentage (63%) of those who retired that year, and during the period 2014-2018[71] the cumulative number of retirees who chose to receive lump sum compensation payment instead of continuous retirement salary was 158,744.[72]

Since 57% of Jordanian retirees receive an early retirement pension, this will deprive them of access to decision-making positions and opportunity to increase their pension salaries. In addition to this, the one-installment payment instead of a continuous monthly salary allowance eliminates social protection for Jordanian women and exposes them to the risk of losing decent life in the future. Women accounted for 79.1% of those entitled to a single installment of social security compensation in 2017 alone. No information is available about what women did with the lump sum compensation payment they received from the Social Security Fund, but we do not rule out that it was spent in ways that do not provide them with future protection.

According to the legislation, the widowed wife inherits her husband's retirement, but the divorced wife does not have such right. Instead, it is given to the second wife, who is often much younger than her husband with whom she usually did not live for many years compared to the divorced wife. Nevertheless, divorced and widowed woman inherit her parents' retirement pension upon their death as well as the retirement pension of their sons and siblings if they die during her life.

5.2 Maternity insurance encourages reproduction and exempts the employer from its obligations under the Labor Law.

The Social Security Law allocated in Chapter Five a maternity insurance in Articles No. 42-47,

and it may have been aimed at encouraging female workers to stay in the labor market for an extended period, which will positively affect the size, income, and situation of their families, in addition to enhancing the revenues of the Social Security Fund when they stay for more years at work. According to these articles, this insurance is funded from the establishment's contributions at the rate of three-quarters of one percent of the insured's wages.

According to this law, the insured woman is paid during maternity leave for the period specified in the applicable labor law, an allowance equivalent to her wage at the start of this leave, provided that she is covered by the provisions of this insurance during the last six months before her entitlement to the leave. The maternity leave allowance is stopped if the insured engages in a job during this leave. Article 56 - Paragraph (A) of the law stipulates that it is not permissible to combine the maternity leave allowance and the unemployment allowance, but the higher allowance is paid.

It is worth noting, according to this law, that the maternity leave granted to the insured is an actual service for its inclusion in the provisions of this law, as the insurance premium of old age, disability, death, and unemployment is deducted from the allowance, in addition to what the establishment pays for all these insurances. We cannot know the justifications for the introduction of maternity insurance, because the Labor Law guarantees the working mother a maternity leave with full pay. Had the legislator realized that the employers do not apply the labor law and abuse the period of leave and do not pay the wage in full during the leave, and if this is the case, then the legislator may have contradicted the labor law or offer a way out for employers.

The cumulative number of working mothers who benefited from maternity insurance until the end of 2018 (51,000; 10,169 of them in 2018 alone). The amounts paid to them were 55 million dinars,[73] with an average of 1078 dinars per woman, and 85% were in the 25-35 age group.[74] In addition to the maternity leave stipulated in the Labor Law and Civil Service By-law, the Social Security Law gives the mother a salary of two and third month (more than a thousand dinars on average) during this leave. All these advantages may carry within them an incentive for women to repeat childbearing with short spacing, and it is not necessarily an incentive to stay for longer years at work because it is not sure that a working mother will remain in the labor market after her family is complete or after her ability to conceive and give birth in her forties is reduced. Since early retirement is granted, the opportunity to leave work coincides with the end women reproductive life.

5.3 Misuse of maternity leave and conflict between the Civil Service By-law[75] and the Labor Law[76]

The by-law specified the period of maternity leave for married women working in the public sector to ninety days, under the section of maternity leave, paternity leave and breastfeeding

hours, within Article (105-a to c), which states that a pregnant employee is entitled to maternity leave of continuous ninety days before and after childbirth with a full salary. The father is also entitled to full-pay parental leave for two days. After the end of her maternity leave, the by-law also grants the employee for nine months, one hour of breastfeeding per day without affecting her annual leave, salary, and bonuses.

Although Jordanians are equal in rights according to the constitution, Articles 70-72 of Labor Law No. (8) of 1996 grants a working mother in the private sector the right to get maternity leave with full pay before and after childbirth for a total period of ten weeks, provided that the period is not less six weeks after childbirth, and she is prohibited to be employed before the expiration of this period. She also has the right for one year from the date of birth for a period to breastfeed her newborn, but not to exceed one hour per day. The law also stipulates that an employer who employs at least twenty female workers must prepare a suitable place in the custody of a qualified nanny to take care of the workers' children who are under the age of four years, provided that their number is not less than ten children.

The Labor Law grants a working wife a shorter maternity leave than that provided in the aforementioned civil service by-law, and an information is circulating about non-compliance to this leave by employers in the private sector. According to the labor law, the maternity leave period violates the international conventions on women's rights, stipulating that a working mother shall be granted a paid maternity leave of no less than 12 weeks (84 days)[77]. Maternity leave has been extended to give the mother sufficient time to take care of herself and her newborn and to maintain their health, and this, of course, only comes with a long spacing between pregnancies and newborns, and therefore it is necessary to assess the extent to which this goal has been achieved after prolonging the maternity leave by conducting studies according to what the recommendations indicated at the end this brief.

6. Recommendations

In light of the links and interrelationships between gender equality, the empowerment of women and girls and sexual and reproductive health and rights, and the gaps that exist in these links, which were revealed by the in-depth analysis in the policy brief, we propose the following policies, programs and studies that will contribute to improving the outcomes of sexual and reproductive health, reproductive rights, gender equality, and the empowerment of women and girls.

1. Rationalizing family processes and decisions through a national program directed at the family to support an enabling environment that makes sexual and reproductive health rights and gender equality a tangible reality.
2. Mainstreaming the relationship between gender equality and women and girls' empowerment and sexual and reproductive health in national strategies, plans, and programs.

3. Reforming policies and amending relevant existing legislation, after implementing the proposed policy-oriented studies to guide the reform process and based on institutional administrative data sources.

The first policy: Rationalizing family processes and decisions through a national program directed at the family to support an enabling environment that makes sexual and reproductive health rights and gender equality a tangible reality.

Promoting women empowerment, gender equality, and sexual and reproductive health begins with the family, that is, placing the horse in front of the carriage and not vice versa, because the family is the basic and most important social institution that takes decisions closely related to the empowerment of its female members and their sexual and reproductive health. In this regard, there must be a national program directed to the Family, provided that it is a participatory program between the Ministry of Health, the Ministry of Social Development, the Ministry of Education, the Ministry of Culture, the Ministry of Youth, the National Council for Family Affairs, the Higher Population Council, the National Committee for Women's Affairs and other related parties, whether informational, service or international, in order to direct family processes and decisions towards enhancing empowerment, gender justice and sexual and reproductive health. The policy brief has identified a number of irrational family processes and decisions that undermine the empowerment of girls and women and the sexual and reproductive health of the family, and it is appropriate to mention them here to justify the existence of the proposed program:

- Girls' drop-off schooling.
- Marrying minors.
- Marriage between needy.
- Pressure from parents and grandparents on the newlyweds to have children soon after marriage.
- Multiple and convergent childbearing.
- Discrepancies in reproductive desires between spouses.
- Exclusive breastfeeding practices in the family do not conform to the recommended optimal practices.
- Consanguineous marriage.
- Decision to dissolve marriage contracts before wedding, despite possible premarital pregnancy and dispute between the families of the betrothed.
- Domestic violence, in its various forms, directed at the wife, daughter, divorced woman, and widow, including sexual violence, violence against infertile wives, and honor killings.
- A culture of silence that inhibits victims of gender-based violence from seeking help and institutional support.
- The family's underutilization of services available in the field of reproductive health, including premarital medical examination; advice to spouses regarding childbearing; early detection of breast and cervical cancer; girls and women victims of domestic violence seeking professional, institutional assistance from the Family Protection Department instead of family

mediation; the role of family protection committees in health centers services for menopausal symptoms and osteoporosis; and postpartum depression;

- Spouses' decision regarding the use of modern methods of contraception, which has witnessed a decline in recent years, according to household and administrative data.
- The scarcity of girls' entry into the labor market, as well as their decision to withdraw from it by early retirement or to receive one installment payment instead of the continuous retirement pension. This practice reduces the revenues of Social Security Fund and creates burdens for inspection and investigation of early retirees who may illegally work. In addition, one payment compensation may threat the social protection of women.
- The familial process of depriving females of their legitimate rights in the family inheritance from all sources, which led to a significant disparity between male and female in the ownership of resources represented in the size of homes and lands and the value of securities and bank deposits that each of them owns.
- Parents' inadequate responsibility of monitoring their sons and daughters' access to sexual content on websites, social networks, and cyberbullying.
- The unmet sexual and reproductive health needs of married and unmarried males and females as well as adolescents, widows and the elderly.

The second policy: Main streaming the perspective of the relationship between gender equality and the empowerment of women and girls and sexual and reproductive health in national strategies, plans and programs.

This policy aims to enhance the recognition of these relationships and their importance in the acceleration of sustainable development and poverty alleviation, achieving population goals and improving the quality of human life.Therefore, it is imperative to plan and budget for such mainstreaming and this requires:

- Preparing a guide that helps planners realize the importance of integration and its mechanisms in national plans and programs.
- Building the capacity of planners to integrate gender equality, empowerment of women and girls, and sexual and reproductive health into national and sectoral policies.
- Coordinate actions with relevant existing strategies and programs to ensure that they adopt this perspective.

The third policy: Reforming the following policies and amending the relevant existing legislation after implementing a set of proposed studies to guide the reform process based on institutional administrative data sources.

The first sub-policy: This policy (based on supporting scientific evidence) will seek to reform the maternity leave and insurance policy in a direction that enhances the health of mother and the newborn and enables her to participate in public life so that she is not motivated to have close childbearing that harms her health and the health of her child as well as not to

withdraw early from the labor market, as she is allowed by law to retire early and leave the workforce in conjunction with the end of her reproductive life.This policy reform requires the following:

- Working with the Social Security Corporation to make the necessary amendments to the Social Security Law in a way that enhances women's empowerment and reproductive health, with regard to early retirement, one-off payment, and maternity insurance, as well as to eliminates conflict with the Labor law and Civil Service By-law.
- Working with the Ministry of Labor, Civil Service Bureau and the Legislative Bureau to propose the necessary amendments to maternity leave legislation in the labor law and the civil service by-law.

Proposed studies to provide scientific evidence to support policy reform:

- Work with the Ministry of Education and the Ministry of Health to conduct a study on maternity leave based on the files at the Personnel Directorate in the two ministries to verify the assumption that the prolonged maternity leave had encouraged female teachers and nurses to repeat childbearing at close intervals and for teachers to time their births in order to link the maternity leave with the summer vacation.
- Conduct a survey to find out the positions and views of the general managers at the Ministry of Health and Education, Civil Service Bureau and other concerned ministries regarding the maternity leave and get their suggestions about it, such as legalizing it twice during the reproductive life of working mothers, in order to reduce the financial and administrative burden of providing surrogate teachers and nurses for mothers who are spending their maternity leave, and this will also reflect positively on the regularity and quality of education and health services;
- Conduct a study on a sample of married female employees working in the private sector to verify the practices of employers regarding maternity leave stipulated in the applicable labor law and their position on its duration.
- Conduct a study using the Social Security Corporation's database on (1) The motives for early withdrawal of female workers from the workforce and their exit from the social security umbrella by receiving the lump sum compensation instead of a continuous pension salary and its impact on the share of women in the workforce and the sustainability of empowerment; (2) The effect of inheriting the husband's retirement pension by his wife upon his death on the participation of married women in the workforce; (3) Evaluating the impact of maternity insurance not only on maintaining female workers at work but on the possibility of motivating them to give birth to benefit from the maternity leave allowance, even though the Labor Law stipulates that maternity leave is entirely paid by employers and not by the Social Security Fund.

The second sub-policy: Reducing the lost opportunities to break the cycle of poverty arising from the gaps between gender equality and women's empowerment and sexual and reproductive health by institutionalizing a program that guarantees counseling and relevant

service when women are present for any reason at health and community facilities such as health centers, hospitals, and social centers.

Proposed studies to provide supporting scientific evidence:

- Conducting a detailed analysis of the cases benefiting from the various aids provided by the National Aid Fund to women beneficiaries and women benefiting from the Covid-19 crisis assistance program, using administrative data to identify the familial and reproductive processes that generated their poverty and undermined their empowerment.
- Study the possibility of empowering the divorced wife and protecting her by enabling her to obtain a fair share in her husband's inheritance compared to the newest second wife.
- Reduce women missed opportunities to obtain information and services related to sexual and reproductive health and gender equality.
- Work with the gender unit in the Department of Lands and Survey to conduct a study on the property transfer and sales among family members before and after the death of the heir, in order to verify whether women have access to their legitimate rights to family inheritance.
- Conducting a participatory national dialogue to discuss public policies and family processes that have led to high rates of female unemployment.

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Share-Net
International
The Knowledge Platform on
Sexual and Reproductive Health & Rights

http://nl.share-netinternational.org
E-mail: info@share-net.nl
T: +31 20 5688512

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Jordan
The Knowledge Platform on
Sexual and Reproductive Health
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Amman - Madena Monawara Street
Faeg Haddaden Street, Building No. 13
Tel: 00962 6 5560741
Fax: 00962 6 5519210
P.O.Box 5118 Amman 11183 Jordan
www.hpc.org.jo

Facebook.com/hpcjo
Twitter@HPC_jordan
Youtube.com/hpcpromise
linkedin.com/in/hpcjo