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WHAT'S MISSING? A HUMAN RIGHTS APPROACH TO REPRODUCTIVE HEALTH POLICIES IN JORDAN

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TC660H
Plan II Honors Program
The University of Texas at Austin

May 10, 2018

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ABSTRACT

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This aim of this thesis is to evaluate the extent to which Jordan's National Reproductive Health/Family Planning Strategy 2013-2017 (NFPS) incorporates the reproductive rights principles established in the 1994 International Conference on Population and Development (ICPD).

I trace the global history of family planning programs to identify the two main models: the population control framework and reproductive rights framework. Next, I examine the context and development of Jordan's NFPS, before analyzing it through the lens of the reproductive rights-based framework. I conduct an in-depth analysis of Jordan's NFPS using the principles laid out in the ICPD, and a qualitative literature review to assess the impact of Jordan's NFPS and related policies on women's reproductive health and reproductive rights. Specifically, I evaluate whether or not the NFPS met the ICPD standards of high-quality, accessible, available and acceptable reproductive health services and whether it increases the ability of Jordanians to make full, free and informed decisions. My key finding is that the Jordan government has pursued a single-minded goal of fertility limitation, without paying sufficient attention to the rights of family planning clients, who are in this case, its citizens. This narrow focus has led to potentially coercive policies and an ineffective family planning program that fails to meet the rights principles internationally agreed upon in the ICPD. I conclude by formulating recommendations and an action plan to promote the realization of women's reproductive rights within the Jordanian culture and policy environment.

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Acknowledgments

I would like to offer my most sincere appreciation to Professors Abigail Aiken and Hina Azam for taking the time to be my first and second readers and bringing their patience, knowledge and insight to my work. My first exposure to reproductive rights and policy was in Professor Aiken's course. By the end of the semester, I developed a deep interest in the topic and sought to continue learning more throughout my senior year through my thesis research. As my advisor, she encouraged me to combine my interests in the Middle East with reproductive rights studies, and has guided me through the entire process, from identifying the research question to thinking analytically about how to improve Jordan's National Family Planning Strategy. Her recommendations have sent me on multiple journeys through fascinating books and concepts I would not have considered without her expertise. Additionally, her relationship made the thesis process much more fulfilling, for I would look forward to presenting meaningful information during our meetings, and always left motivated to learn more.

Doctor Azam's expertise on Islamic feminism challenged me to understand and incorporate the culture and religion in Jordan throughout my framework. She helped me separate the Western framework from the true wants and needs of women in the East and seek to define my conception of Islamic feminism. I deeply appreciate that she was willing to dive into the thesis with me, even though the topic was not exclusively related to her field and though she knew she would spend the fall semester conducting her own research.

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Chapter 1: Introductory Discussion and Framework

Section 1. Introduction

Governments around the world have used national family planning programs since the middle of the 20th century. As the international consensus on the purpose and content of the programs evolved along with corresponding economic and social conditions, two main frameworks emerged: a population control approach and a reproductive rights approach.[1]

The former approach materialized following the end of the Cold War when developed countries pursued the goal of reduced population growth for economic ends. This narrow focus led to insufficient attention to the rights of citizens, to coercive policies, and to ineffective family planning programs. Then, in the 1990's, a reproductive rights approach emerged and shifted the focus of family planning policies away from reaching specific demographic targets to focus instead on the needs, aspirations and rights of individual women and men.[12]

In 2013, the Hashemite Kingdom of Jordan found itself host to one of the fastest growing populations in the world and to an influx of refugees fleeing the turmoil in Syria.[3] In response, the **Higher Population Council**, the Jordanian government's reproductive health agency, with support from the **USAID-funded Health Policy Project**[4] and the input of stakeholders, instituted the **National Reproductive Health/Family Planning Strategy 2013-2017 (NFPS)**.

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[1] Lane, Sandra D. "From Population Control to Reproductive Health: An Emerging Policy Agenda." *Social Science & Medicine*, vol. 39, no. 9, 1994, pp. 1303-1314

[2] Reichenbach, Laura (Ed.) and Mindy Jane Roseman (Ed.). *Reproductive Health and Human Rights. The Way Forward*. Philadelphia: University of Pennsylvania Press, 2011. Web.

[3] Murshidi, M. M., Hijjawi, M. Q. B., Jeriesat, S., & Eltom, A. (2013). Syrian refugees and jordan's health sector. *The Lancet, 382*(9888), 206. doi:http://dx.doi.org.ezproxy.lib.utexas.edu/10.1016/S0140-6736(13)61506-8

[4] The Health Policy Project is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement

The NFPS assesses the reproductive health challenges facing Jordan, and sets out the government's goals for policies, interventions and the five-year national-level outcomes it expects its health providers to achieve in the area of reproductive health throughout the country.[5] The NFPS is broken into the problem areas of policy, access, and beliefs and behaviors.

The objective of this thesis is to evaluate the NFPS. My aim is twofold: 1) to explore the extent to which reproductive rights have been incorporated into the country's reproductive health policy; 2) to determine gaps in the implementation of this policy and to make policy proposals to fill these gaps. I argue that the Jordanian government developed its NFPS using a population-control framework that failed to uphold the rights and well-being of its people.

[5] "Jordan National Reproductive Health/Family Planning NFPS: At a Glance." Health Policy Project, Higher Population Council and Health Policy Project, 24 Sept. 2013, www.healthpolicyproject.com/index.cfm?id=publications&get=pubID&pubId=239.

Section 2: Theoretical Framework

In my argument, I will trace the global history of family planning programs in order to fully compare and contrast the population control and reproductive rights approaches. I will focus specifically on the **1994 International Conference for Population and Development (ICPD)** in Cairo, Egypt as the basis for understanding the rights-based framework. Then, I will trace the context and development of Jordan's **National Reproductive Health/Family Planning Strategy (NFPS)**. This process lays the foundation for me to fully analyze Jordan's NFPS and determine the extent to which it implements a rights-based approach based upon the internationally agreed-upon rights principles in the ICPD. Finally, I will propose recommendations plan based on my findings in order to promote the realization of women's reproductive rights within the Jordanian culture and policy environment.

The analysis will be performed through the following steps:

1. Explore the Jordanian government's human rights commitments.
2. Identify the laws and policy that affects women's health and rights.
3. Examine the implementation of these policy and laws and identify gaps.
4. Assess the impact of the laws, policies, and their associated programs on women's reproductive health and reproductive rights.
5. Formulate recommendations and an action plan based on the findings in order to promote the realization of women's reproductive rights within the Jordanian culture and policy environment.

Section 3. The History of Family Planning Programs:

This section will briefly explain the five phases in the development of population policies, from the founding of the United Nations to the present day. It examines the three major United Nations International Population Conferences and the roles of each conference in shaping the global policy environment. The phases can be divided into the following periods: 1) 1945-1970; 2) 1970-1980; 3) 1980-1990; 4) 1990-2000; and 5) the beginning of the 21st Century.

1945-1970

Around the time of the United Nations' establishment in 1945, the focus of the international community was not yet on population and development.[6] In 1954, the United Nations organized the first World Population Conference to allow information exchange on population variables, determinants and consequences. In contrast to later conferences, the Conference participants did not represent specific countries. Rather, the Conference consisted of demographers and population specialists, and it acted as a forum for the exchange of scientific information.[7] Demographic data and knowledge of population trends was lacking, and the relationship between population growth and economic development was not yet fully explored. The Conference helped establish the importance of demographic research for population policy, the need to study populations in their specific social and economic contexts, and the need to fill gaps in knowledge.[8]

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[6] United Nations, Population Division, Department of Economic and Social Affairs, *Fertility, Contraception and Population Policies (April 2003)*, available from http://www.un.org/esa/population/publications/contraception2003/Web-final-text.PDF

[7] Mirkin, Barry. "Evolution of National Population Policies since the United Nations 1954 World Population Conference." *Genus*, vol. 61, no. 3/4, 2005, pp. 297-328

[8] DeJong, Jocelyn. "The Role and Limitations of the Cairo International Conference on Population and Development." *Social Science & Medicine*, vol. 51, no. 6, 2000, pp. 941-953.

During this time, governments, including the administration of President Dwight D. Eisenhower (1953-1961), believed it was inappropriate to intervene in fertility and family planning. This sentiment changed during the 1960s, when international awareness focused on the rapid growth of the world's population. The global community was focused on development and considered rapid population growth and the correspondingly high consumption of resources to be a dangerous impediment to this objective.[6] [8]

Policymakers developed the sentiment that the widespread adoption of population control measures, specifically among poorer populations, could jumpstart progress. In fact, the 1962 United Nations Resolution: "Population Growth and Economic Development," highlighted the fact that the poorest people in the least developed countries had the highest fertility rates.[9] In other words, this period saw the global rise of the population control approach to reproductive policy. The population control approach rested on the belief that high birth rates and disproportionately young populations hampered the ability of developing countries to raise their national per capita income and improve living standards, or to modernize.[6] The movement to control fertility also became official United States policy in relation to the developing world.

In other words, this period saw the global rise of the population control approach to reproductive policy.

In 1965, population experts at the **Second World Population Conference** paid special attention to the relationship between population control and economic development.[10] At this point, a number of developing countries like India, Pakistan and Egypt had established family

[9] The Secretary-General (1964) General Assembly Resolution on Population Growth and Economic Development. In: Mudd S. (eds) The Population Crisis and the Use of World Resources. World Academy of Art and Science, vol 2. Springer, Dordrecht

[10] Thomas, C. J. *World Population Conference, 1965. Volume II: Fertility, Family Planning Mortality.* vol. 131, Royal Statistical Society, 1968.

planning programs to respond to rapid population growth. In the same year, President Lyndon B. Johnson's State of the Union message called for funding to "seek new ways to use our knowledge to help deal with the explosion in world population and the growing scarcity in world resources."[11] A key source of American foreign aid, USAID, began funding and coordinating population control activities in developing countries.[6]

In the same time period, but in stark contrast, the right of parents to control the number of children was established as a basic human right. The 1968 **International Conference on Human Rights**, held in Tehran, proclaimed that, "the protection of the family and of the child remains the concern of the international community. Parents have a basic human right to determine freely and responsibly the number and spacing of their children." Also against this context was progress in the development of new methods of contraception, including the oral contraceptive pill and the intrauterine device (IUD). [6]

1970-1990

This period saw self-interested developed countries become increasingly involved in the policies of developing countries. The Cold War and the Vietnam War played roles in sparking this sentiment in the US. Following each conflict, the US had fears about high birth rates furthering the spread of communism or of dissatisfied populations.[12] In 1974, Henry Kissinger, Secretary of State and Director of the National Security Council, issued a memorandum calling for support of population control in politically-strategic countries (Bangladesh, Brazil, Colombia,

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[11] "PROGRAMING: LBJ State of Union Address in Color." *Broadcasting (Archive: 1957-1993)*, vol. 70, no. 2, 1966, pp. 58.

[12] Horn, Denise M. "Locating Security in the Womb: US Foreign Policy, Population Control and International Family Planning Programs." *International Feminist Journal of Politics*, vol. 15, no. 2, 2013, pp. 195-212.

Egypt, Ethiopia, India, Indonesia, Mexico, Nigeria, Pakistan, the Philippines, Thailand and Turkey).[6] Many in developing countries nervously viewed these efforts as potential forms of genocide. [13]

As the decade continued, specialized agencies of the United Nations came to widely view rapid population growth as a major obstacle to development. The United Nations hoped to encourage countries to develop strategies in accordance with a global population NFPS that would slow down population growth.[6] The Secretariat published a review of policies that could affect fertility - including abortion and sterilization.

Many in developing countries nervously viewed these efforts as potential forms of genocide.

A major international NFPS emerged in the 1974 **World Population Plan of Action**, which had the main objective of increasing development. It recommended all countries respect and ensure the "rights of persons to determine in a free, informed, and responsible manner the number and spacing of their children…," but its text focused less on population policies, and more on social and economic policy.[8] It solidified the moderation of population growth as a legitimate governmental concern and stimulated widespread international population assistance in developing countries.[6]

During this period, the tide slowly began to shift among feminist scholars who were aware of the potential abuses associated with international population programs and began to reject this framework. A growing body of literature addressed the ethical implications of family planning.[14]

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[13] Guttmacher, A. P. "Progress and failure in population control." *The Journal of reproductive medicine* 8.4 (1972): 159.

[14] Grimes, Seamus. "From Population Control to 'Reproductive Rights': Ideological Influences in Population Policy." *Third World Quarterly*, vol. 19, no. 3, 1998, pp. 375-393.

In 1979, the United Nations General Assembly adopted the "**Convention on the Elimination of all Forms of Discrimination Against Women**" (CEDAW) treaty that served as an international bill of rights for women. Though it was adopted, its principles were not fully integrated into family planning programs throughout the next decade. In 1984, at the **International Conference on Population** in Mexico City, the concepts from the World Population Conference were upheld, but family planning programs and modern contraception were also recognized as the rights of all couples and individuals.[8] Countries, like Guyana, Uruguay, and the Central African Republic, that were previously conservative towards contraceptives moved towards supporting contraceptive use.[6]

Toward the end of the 1980's, the Ford Foundation[15], the International Women's Health Coalition, the Population Council[16] and the World Health Organization conceptualized a "reproductive health" approach to potentially replace population control as a less limited and more ethical approach. The authors argued this approach could "considerably strengthen the achievements of existing family planning and health programs, while helping women to attain health, dignity and basic rights."[17] As the idea developed, scholars debated what the reproductive rights approach should encompass.

1990-2000

As previously mentioned, the population movement led to important questions regarding the beneficiaries of population programs - were they women or nations? Early generations of

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[15] A globally oriented private foundation with the mission of advancing human welfare
[16] An international, nonprofit, non-governmental organization that conducts social science and public health research
[17] Germain, A., and J. Ordway. "Population Control and Women's Health: Balancing the Scales. 1989." *International Women's Health Coalition, New York, United States of America Google Scholar*.

feminists, notably Margaret Sanger and Emma Goldman, began to view access to contraception as a tool of empowerment, or a "weapon in the struggle [for poor women] against capitalist exploitation."[18] The 1991 article "Ethics and Family Planning" by Kerstin Hagenfeldt, Swedish professor of obstetrics and gynecology, is one example of the emerging literature on this topic. The article highlighted the ethical problems surrounding contraception during this period, including the lack of respect for the autonomy and dignity of the woman. Professor Hagenfeldt argued that the woman's personal choice must be respected, that the primary beneficiary of reproductive services must be the woman and not society, and that the moral principle of justice must encompass the extension of reproductive health services to all. Professor Hangenfeldt specifically cited CEDAW and called on the international community to actually uphold the agreement.[19]

The **Global Women's Health and Rights Movement** (GWHRM), which had first emerged in the 1970's, gained momentum in the early 1990's.[1] The movement challenged population control efforts and criticized existing international family planning programs. By the 1980s, it had become organized enough to develop coalitions with the human rights community and magnify its calls..[8] The activists became increasingly vocal about coercive population control programs in the developing world, and as a tactic, focused on openings in the international arena via United Nations conferences.[8] The conferences presented opportunities for women from the North and South to collaborate, exchange ideas and challenge the norms of population-control programs.[1]

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[18] Chesler, Ellen. *Woman of valor: Margaret Sanger and the birth control movement in America*. Simon and Schuster, 2007.
[19] Hagenfeldt, K. "Ethics and Family Planning." *Advances in Contraception : The Official Journal of the Society for the Advancement of Contraception*, vol. 7, no. 2-3, 1991, pp. 159-163.

The GWHRM accomplished the goal of shifting the discourse from population-control to reproductive rights in a series of international conferences in the 1990s, culminating in the first major global United Nations population conference taking place at the **International Conference on Population and Development** in Cairo, 1994 (ICPD). In preparation of the ICPD, over 100 women's organizations drafted the Women's Declaration on Population Policies, which outlined ethical principles and conditions that would allow women to control their reproductive health. This approach was ultimately adopted at the ICPD.

10,750 people, delegations from 179 countries, seven observers, and many heads of state attended the Cairo conference. The Conference produced the **Programme of Action,** known as the most comprehensive document on sexual and reproductive rights. The Programme broke ground, moving away from the population-control framework, and instead, placing people's rights at the heart of development. The Conference integrated family planning and women's health services, explicitly promoted the rights of women, and affirmed sexual and reproductive health as a fundamental human right.

Furthermore, the Cairo conference introduced the important concepts of the empowerment of women and gender equality. It was pivotal in recognizing that empowering women and girls is key to ensuring the wellbeing of individuals, families, nations and the world, and in using strikingly open language in denouncing social ills against women such as rape, incest and sexual harassment. For the first time, an international document used the words "sexual" and "sexuality", mentioned men's fertility, and introduced the concepts of safe motherhood and unsafe abortion.[6] The ICPD departed from the population movement's use of demographic targets with family planning as the means to achieve them. Instead, it recognized

women's reproductive and sexual rights *independent* of their role as mothers. And it called on governments to do the same.

Among tens of instructions, the Programme urged governments to make reproductive health services available to all women of reproductive age, to assess unmet need for good quality family-planning services, to take steps to meet this need, and to expand maternal and child health services in primary health care. Following the Conference, many governments began to review their population policies. Some countries in Africa and Western Asia removed legal barriers to the use of contraception.[1]

Due to the extensive and varied process that created the ICPD and the ground it shattered in the areas of reproductive rights and family planning, this thesis will use the principles in the ICPD Programme of Action to guide its discussion and understanding of a rights-based framework in the analysis and recommendations that follow this section.

The Beginning of the 21st Century:

Progress has been achieved in many countries in terms of implementing the principles of the ICPD Programme of Action. However, many births are still unwanted or mistimed, and modern family planning methods remain unavailable to many couples worldwide.[20] There also remains a threat of sexually transmitted infections including HIV/AIDs and information on these topics is still restricted from adolescents, despite their biological vulnerabilities to the diseases.[13] Countries in Africa, Asia, the Middle East and the Pacific have specifically hosted regional

[20] Haslegrave, Marianne. "Implementing the ICPD Programme of Action: what a difference a decade makes." *Reproductive Health Matters* 12.23 (2004): 12-18

conferences to incorporate reproductive health principles and/or family planning strategies in their respective countries. [21]

[21] Examples: Asia Pacific Conference of Reproductive and Sexual Health and Rights; **Africa Conference** on Sexual Health and Rights; Eleventh International Conference of the International Coordinating Committee (ICC) of National Institutions for the Promotion and Protection of Human Rights in Amman, Jordan

Section 4. Reproductive Health Context in Jordan and Brief Introduction to its NFPS:

The Hashemite Kingdom of Jordan borders Saudi Arabia, Israel, Syria, Iraq and Palestine. It became an independent state in 1946 after gaining sovereignty from Turkey and it is a constitutional monarchy ruled by King Abdullah II. Muslims form the majority of the population with 95% following Sunni Islam, and minorities following Shia Islam, and the Druze and Christian religions. Jordan is a lower middle-income country with a relatively modern health system and a population of nearly 10 million people.[22] Amman is the country's capital city and political center, and will accordingly be referenced throughout.

It is important to consider what we know about the current state of reproductive health in Jordan. The country has relatively strong health indicators. For instance, in 2012, health indicators showed a steep rise in life expectancy coupled with a decline in the infant mortality rate from 1990 statistics.[23] Health insurance coverage also expanded to include the elderly and children below 6 years of age.

The Kingdom's total fertility rate (TFR), defined as the average number of children a woman would have assuming that current age-specific birth rates remain constant, has been high and stagnant for over a decade.[2425] This stagnation has raised questions because Jordan has implemented national family planning programs and, during the same period, USAID has

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[22] Irvine, Verity Elizabeth, et al. "Jordan." Encyclopædia Britannica, Encyclopædia Britannica, Inc., 13 Apr. 2018, www.britannica.com/place/Jordan.
[23] "Jordan." World Health Organization, World Health Organization, 28 Apr. 2018, www.who.int/countries/jor/en/.
[24] Spindler, Esther, et al. "Jordan's 2002 to 2012 Fertility Stall and Parallel USAID Investments in Family Planning: Lessons From an Assessment to Guide Future Programming." *Global Health: Science and Practice* 5.4 (2017): 617-629.
[25] Howse, Kenneth. "What is fertility stalling and why does it Matter?." *Population Horizons* 12.1 (2015): 13-23.

invested nearly $476 million of aid between 1997 and 2015.[2425] Moreover, while only 1 in 4 women worldwide typically tend to have a fourth child after three consecutive pregnancies, 1 in 2 Jordanian women who have had three births try to get pregnant again within 2 years.[26] Thus Jordan has both short birth intervals between births and a relatively high fertility rate.

While the TFR did drop from 6.6 in 1983 to 3.7 in 2002, it has hardly changed since then. Within this period, from 2002 to 2012, Jordan experienced an 87% increase in population.[24] Although it is common for countries to experience stalling in fertility rates after periods of rapid decline, Jordan's decade-long stall is one of the longest lasting periods of stagnation assessed worldwide, despite accompanying investments in family planning programs.[2427]

In addition to the stagnant TFR, the effectiveness of contraceptive methods used by married women in the country have decreased. Though Jordan's national contraceptive prevalence rate increased from 56% in 2002 to 61% in 2012, the increase was mostly due to increases in the use of less effective traditional contraceptive methods. For instance, the use of withdrawal, also known as the "pull-out" method, increased from 15.2% in 2007 to 18.9% in 2012.[24] Furthermore, the only two contraceptive methods for which usage increased over time have been condoms and withdrawal. The use of more effective modern methods, such as oral contraceptives and intrauterine devices, has remained almost constant since 2002. [24]

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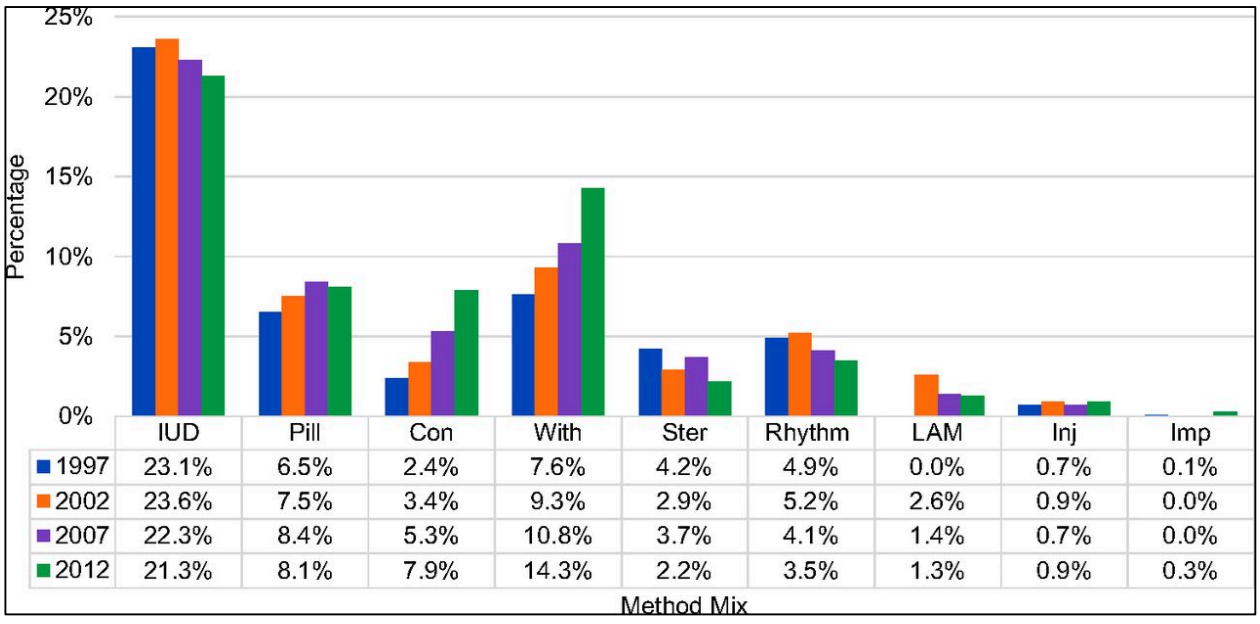
[26] Bardaweel, Sanaa K., Amal A. Akour, and Maria-Vanessa Z. Kilani. "Current knowledge, attitude, and patterns of oral contraceptives utilization among women in Jordan." *BMC women's health* 15.1 (2015): 117.

[27] Cetorelli V, Leone T. Is fertility stalling in Jordan? Demogr Res. 2012;26(13):293–318. doi:10.4054/DemRes.2012.26.13

Reliance on traditional methods in Jordan even exceeds the levels of use for the most widely used modern method in Jordan - intrauterine devices. To put this trend in context, 19% of women in Jordan are using traditional family planning methods compared to 2% in Egypt, 8% in Tunisia, 11% in Morocco, and 15% in Syria. More surprisingly, women with higher levels of education tend to use traditional methods at higher rates (20.8%) than women with basic levels of education (13.8%). [24]

A 2008 study found that 16.3% of Jordanian women have an unmet need for family planning, comprising 6.8% of women who wanted to limit births and 9.5% of women who wanted to space births. Unfortunately, the latest Jordan Population and Family Health Survey conducted by the Department of Health Services of USAID, which is the source of these data points, took place in 2012. The most recent survey dated in 2017 is still ongoing and has no data to report.



	IUD	Pill	Con	With	Ster	Rhythm	LAM	Inj	Imp
1997	23.1%	6.5%	2.4%	7.6%	4.2%	4.9%	0.0%	0.7%	0.1%
2002	23.6%	7.5%	3.4%	9.3%	2.9%	5.2%	2.6%	0.9%	0.0%
2007	22.3%	8.4%	5.3%	10.8%	3.7%	4.1%	1.4%	0.7%	0.0%
2012	21.3%	8.1%	7.9%	14.3%	2.2%	3.5%	1.3%	0.9%	0.3%

National Contraceptive Method Mix Among Contraceptive Users in Jordan by Year, 1997–2012 (Data from Jordan's Demographic and Health Surveys.)

The Kingdom has one of the fastest growing populations in the world. Jordan's population swelled from 586,000 people in 1952 to 10 million people at the end of 2017. It also has one of the biggest refugee populations in the world. Early on in the Syria war, the UN High Commissioner for Refugees said that between 1500 and 3500 Syrian refugees were arriving in Jordan each day.[3] This mass migration of refugees from the Syrian conflict, in combination with the previous migrations of Palestinian refugees, has built a refugee population of almost 2.5 million people.

The Jordanian government believes its high fertility and growth rates have challenged its social and economic progress due to limited resources, low economic growth, and environmental stress. If the current rate of annual growth continues, the Kingdom projects that its population will exceed 13 million people by 2042. The government believes this expanded population would strain Jordan's scarce health and education services infrastructure, and limited food , water ,environmental and energy resources.[28]

The government and the **Higher Population Council** (HPC) have been collaborating to address family planning, population and development issues in the Kingdom since 2002. Jordan underwent a First Phase **National Reproductive Health Action Plan** (RHAP) from 2003-2007 and a Second phase from 2008-2012. In 2010, the **USAID Health Policy Project** began supporting the HPC in its effort to research the availability of family planning and reproductive health **(FP/RH)** services in Jordan and people's attitudes towards them. The HPC then presented its research on the social and economic impacts of rapid population growth on Jordan's labor, education and health sectors. The HPC's efforts succeeded in gaining support from policy makers to prioritize reproductive health and population issues in Jordan. In 2012, the HPC, under

[28] Demographic Opportunity Policy Document, 2009, Jordan Higher Population Council.

the guidance of Princess Basma Bint Talal, used this research to begin developing the new national family planning and reproductive health (FP/RH) NFPS that is the focus of this thesis.[29] As mentioned, a group of local and international stakeholders, in coordination with the USAID Health Policy Project, crafted the five-year **National Strategy for Reproductive Health / Family Planning (NFPS)**, which was approved by the HPC in May of 2013 and sought to meet its goals in the areas of reproductive health and family planning policy, accessibility and public attitudes by the end of 2017.

[29] "A New Roadmap to Guide Family Planning in Jordan." Health Policy Project, USAID, 7 Aug. 2013, www.healthpolicyproject.com/index.cfm?ID=JordanFPSuccessStory.

Section 5. International Discussion of Human and Reproductive Rights:

Thus far, we have traced the transition from a population control to a reproductive rights approach that took hold in the Cairo ICPD. To reiterate, a rights-based approach moves away from a focus on reaching specific demographic targets to a focus on the needs, aspirations and rights of individual women and men. In the decades prior to Cairo, women were conceptualized and treated as targets important in the sense of macroeconomic changes. Population policy was concerned first and foremost with decreasing women's fertility rates, especially in developing countries. On the other hand, a rights-based approach entails making certain that family planning policies and programs embrace actions and values integral to human rights. It entails asking what human rights mean in relation to family planning, how to incorporate them into national family planning program, and why this is important.

A rights-based approach moves away from a focus on reaching specific demographic targets to a focus on the needs, aspirations and rights of individual women and men.

This section seeks to fully discuss the components of a rights-based approach using two main documents: **the Programme of Action** that emerged from the ICPD in Cairo and **UN General Comment 14**. The latter is the mostly widely used and comprehensive articulation of the human right to the highest standard of health, and was set out in the International Covenant on Economic, Social, and Cultural Rights (ICESCR) on August 11, 2000. Notably, the ICPD Programme of Action is referenced in Comment 14. A discussion based on both documents is necessary to form a deeper understanding of a reproductive-rights framework. This section is meant to serve as a point of reference as one reads through the next chapter of this thesis, which will analyze the extent to which Jordan implements these principles into its Family Planning NFPS.

The UN Comment established the **AAAQ criteria** for governments to make health care services, namely:

- Available
- Accessible
- Acceptable
- Of the highest possible quality

The criteria are now used in human rights instruments and authoritative interpretations, and are considered a tool to link principles and realities by articulating rights principles in practical and tangible guidance. In more depth, the criteria stand for the following:

Availability: This criterion refers to the presence of functioning public health and health care facilities, goods, and services, as well as a sufficient quantity of programs available within the country. Governments must routinely provide a wide choice of family planning methods and ensure proper removal services for implants and IUDs, supported by sufficient supplies, necessary equipment, and infrastructure.

Accessibility: This criterion has four components: nondiscrimination, physical accessibility, economic accessibility, and information accessibility. The latter includes to counseling and must include accurate, unbiased and comprehensive information. Governments must secure equitable service access for all, including disadvantaged, marginalized, discriminated against, and hard-to-reach populations, through various service models.

Acceptability: This criterion implies that all health facilities, goods, and services must be respectful of medical ethics including confidentiality, be sensitive to gender and life-cycle requirements, and be culturally appropriate.

Quality: This final criterion emphasizes that health facilities, services, and commodities must also be scientifically and medically appropriate and of good quality. This requires, among other things, skilled medical personnel and scientifically approved and unexpired drugs and equipment.

In the following discussion of the ICPD conception of reproductive-rights, these 4 criteria are readily apparent because they are so integral to reproductive health. The ICPD Programme of Action established an internationally agreed-upon comprehensive definition of reproductive rights and reproductive health including sexual health.[30] Section 7.2 of the Programme of Action defines reproductive health as a state of *complete* physical, mental and social well-being, rather than the mere absence of disease or infirmity regarding the reproductive system. According to the Programme, reproductive health asserts that individuals can have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Reproductive health asserts that individuals can have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Implicit is the rights of individuals to make full, free and informed choice - this requires information and access.

Implicit in this last condition, according to the Programme, is the rights of individuals to make full, free and informed decisions. Meaning, they must have access to factual, comprehensive information and to safe, effective, affordable and acceptable health care services and legal family planning methods of their choice. They must also be absolutely free from coercion. The provision of full, free and informed choice is the critical component that makes a

[30] United Nations, Programme of Action (POA) adopted at the International Conference on Population and Development, Cairo, 5–13 September 1994.

family planning program respectful of human rights. As such, it will be a major focus of the analysis I will conduct of Jordan's Family Planning NFPS. A rights-based approach also requires a particular focus on addressing discrimination and inequality, focusing on marginalized, disadvantaged and excluded groups.

In a rights-based framework, reproductive health care should contribute to reproductive health by preventing and solving health problems and increasing sexual health. It is important to note that the purpose of sexual health in the rights-framework is related to the enhancement of life and personal relations, and not merely to reproduction and sexually transmitted diseases as it is in the population-control framework.

All of these components make up a reproductive-rights framework for family planning and reproductive health. In the next Chapter, I will evaluate the extent to which the NFPS incorporates and upholds these rights principles and make recommendations for improvement.

Section 6. Jordan's Obligations to Human and Reproductive Rights:

Under the **UN High Commissioner for Human Rights**, states and governments are obligated to respect, protect and fulfill human rights. Jordan has specifically ratified CEDAW and has restated its commitment to the ICPD. In 2012, Jordan hosted the Eleventh International Conference of the National Institutions for the Promotion and Protection of Human Rights in, which focused on "the human rights of women and girls, promoting gender equality, the role of national human rights institutions." At the Conference, the Amman Declaration to protect and promote reproductive rights as specifically laid out in the ICPD was adopted.[31]

It is important to note, however, that countries that sign onto international conventions and declarations have no real obligation to abide by the documents because the documents have no enforcement mechanism. This extends to the requirement to respect human rights, no matter how much the international community emphasizes the universal importance of these rights. Furthermore, Comments like **UN Comment 14** are not binding. Simply put: these rights principles are moral standards, but the obligation is in name only, for no entity could routinely place sanctions on them. Of course, governments impose sanctions on each other in the face of extreme human rights violations like genocide or chemical warfare, but this kind of intervention typically does not occur in the realm of reproductive rights. Furthermore, the right to family planning is not explicitly mentioned in the **United Nations Universal Declaration of Human Rights**. It has been argued, however, that the right to family planning may be inferred from the

[31] *Reproductive Rights Are Human Rights: a Handbook for National Human Rights Institutions. 2014, Reproductive Rights Are Human Rights: a Handbook for National Human Rights Institutions*.

rights to privacy, conscience, health and well-being set forth across many United Nations documents.

Despite the lack of an enforcement mechanism, the recommendations in the Programme of Action are not merely symbolic. We might still argue that governments have a moral duty to take a reproductive-rights approach to their family planning programs and to respect, protect and fulfill the human and reproductive health rights of their citizens. Though international agreements like the ICPD Programme of Action are not legally binding under international law, they place expectations on states, international agencies, and NGOs to uphold the commitments codified in the consensus documents. The Programme of Action is no exception.

To meet these three obligations, countries must adopt appropriate policies and laws, and moreover, they must demonstrate the appropriate sturdiness of content and support unhindered by national politics and societal conditions that keep women from their rights. This makes the rights framework, if truly adopted by a country, powerful because it places a moral duty on the government to fulfill the rights of its people, or the rights-holders. The Cairo approach is not only fair for women's health, well-being, and rights, but it has the potential to help Jordan meet its goals by giving women the tools to control their fertility if they wish to do so.

Chapter Two: Full Analysis of Jordan's National Family Planning Strategy and Policy Recommendations

Section 1: Introduction

Policymakers involved in creating family planning programs must be held accountable for respecting and honoring the rights of their constituents by human rights advocates. Policymakers play a vital role in championing high quality services and the resources needed to provide such services. They are the door-keepers to avoiding quotas or other numerical incentives that may compromise the extent to which family planning services and contraceptive usage are based on full, free and informed choice. On the other hand, policymakers can be the players invoking harmful or neutral policies that infringe upon, or ignore, the full reproductive and sexual rights of citizens.

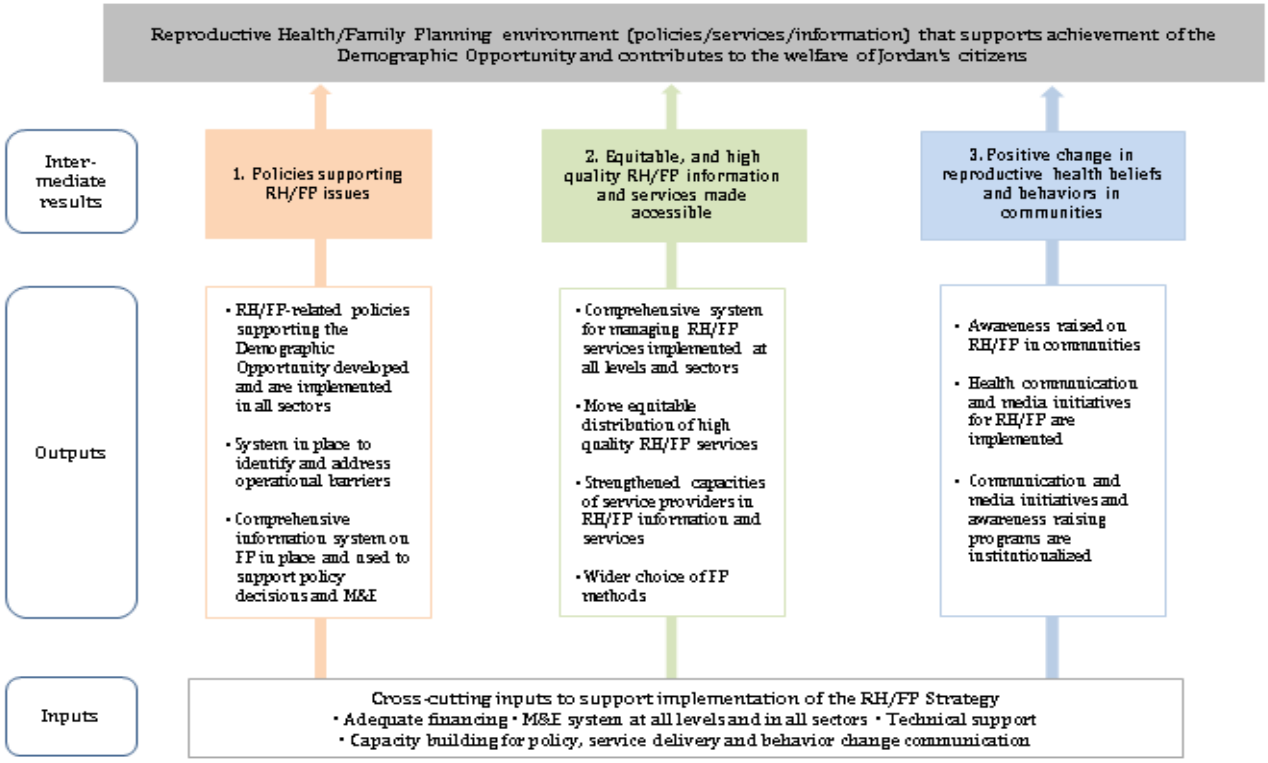
The ICPD Programme of Action thoroughly discusses reproductive and sexual health and rights, as this thesis has thoroughly summarized in Section 5, and then has a specific chapter on family planning programs that lays out how reproductive rights principles should take shape within and guide these programs. The ICPD repeatedly stresses that the aim of family planning programs must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children, to have the information and means to ensure informed choices, and to make available a full range of safe and effective family planning methods. The Programme of Action again invokes the principle of **full, informed, free choice**, this time not just as the cornerstone of reproductive rights, but also as the essential component to the long-term success of family planning programs. The theory, based on previous successful programs, is that when individuals are informed, they can and will act responsibly towards the needs of their families, communities, and selves. Coercion has no part to play.[30]

The Jordan NFPS outlines three main goals:

1. Development of policies supporting RH/FP issues
2. Equitable and high quality reproductive health and family planning information and services made accessible (to Jordanians)
3. Changing citizen attitudes regarding RH/FP to be more positive in nature

The NFPS begins with a preface and executive summary that lay out the context and purpose for the its development. The NFPS is then organized based on these three main goals, referred to as "Immediate Results 1/2/3". The Intermediate Results are the government's anticipated long-term results for the NFPS. Each Intermediate Result is followed by a brief explanation of its intended pursue that is only two to three sentences long. This is then followed by outputs, which include both steps to reach the Intermediate Result and performance indicators to measure improvement

Figure (1): Logic Framework of Jordan's National RH/FP Strategy, 2013–2017



between the current status and the goals indicated in the outputs.

Before diving into the full NFPS, it is worth comparing the goals of Jordan's NFPS, to the goals that the Programme of Action Family Planning chapter instructs governments to follow when enacting their programs. As mentioned, Jordan's Intermediate Results are the following:

1. Development of policies supporting RH/FP issues
2. Equitable and high quality reproductive health and family planning information and services made accessible (to Jordanians)
3. Changing citizen attitudes regarding RH/FP to be more positive in nature

In contrast, the recommended objectives of family planning programs listed in the ICPD POA are the following:

> (a) To help couples and individuals meet their reproductive goals in a framework that promotes optimum health, responsibility and family well-being, and respects the dignity of all persons and their right to choose the number, spacing and timing of the birth of their children;
>
> (b) To prevent unwanted pregnancies and reduce the incidence of high-risk pregnancies and morbidity and mortality;
>
> (c) To make quality family-planning services affordable, acceptable and accessible to all who need and want them, while maintaining confidentiality;
>
> (d) To improve the quality of family-planning advice, information, education, communication, counselling and services;
>
> (e) To increase the participation and sharing of responsibility of men in the actual practice of family planning;
>
> (f) To promote breast-feeding to enhance birth spacing.

This initial review of the objectives signals that the 2013-2017 Jordan NFPS is missing a majority of the objectives that the international community agreed upon almost two decades before the NFPS was written. My analysis will explore this initial hypothesis in detail.

Section 2. The NFPS's Introduction and Executive Summary - Demographic Opportunity:

In its introduction, the NFPS says that it seeks to progress in the field of family planning *as part of its goals for development*. It claims that it is working on "linking demographic transition with economic and social development, with an aim towards achieving a balance between population growth rates and economic growth rates (5)." Moreover, it is introduced as a tool to increase national commitment to reproductive health and family planning issues as a way, first and foremost, to "reach the demographic opportunity" by 2030.

The term Demographic Opportunity refers to a concept that originated in a separate policy document issued by the Jordan Prime Ministry in 2009.[28] The document claims that Jordan's current population growth will strain resources and economic flourishment, and must be stopped by meeting lowered fertility goals. In other words, the NFPS employs reproductive health and family planning as a *means to* a demographic *end*.

The ICPD stresses that the basis of rights-based family planning programs should be to serve the needs and fulfill the rights of citizens. The introduction of the Jordan NFPS clearly violates this principle because its stated purpose is vastly economic. This purpose is present throughout the NFPS, for it even states that its "results, outputs and interventions….will contribute to the achievement of [the Demographic Opportunity]." In contrast, a rights-based program incorporates ICPD objectives into its design, output and evaluation. It could not be clearer that the Higher Population Council developed the NFPS as a population-control mechanism that bears striking similarities to the population-control programs the international community pledged to change through the ICPD. In fact, the term reproductive rights only appears once in the Introduction when the Higher Population Council says that it "considers

family planning as a right for married couples under the umbrella of reproductive health rights," before going on to describe the role of family planning in the DO.

Even furthering this point, USAID's Health Policy Project, which as mentioned is a major source of funding for the family planning program, has a history of funding the original population-control programs[1] and seems to have continued to operate within the population framework. For instance, it claims that in Jordan, "key stakeholders and policymakers recognize the importance of slowing population growth for maternal and infant health, economic development, and the preservation of precious natural resources."[32] In 2015, US Ambassador to Jordan, Alice G Wells, told the Jordan Times that the importance of the NFPS lies in its economic benefits, for "more sustainable population growth stands to save Jordan 27 billion JD in the education sector, 14 billion JD in the health sector and raise per capita income by 29 percent by the year 2050." The USAID, Wells and the NFPS regularly employ key terms from the population-control movement like "scarcity in resources" and "slowing population growth." This term was also used in President Johnson's previously cited State of the Union address.

The literature surrounding the population-control approach recognizes major problems with resulting programs and policies. First, the approach can lead to coercive policies to 'persuade' women to 'accept' fertility regulation methods, such as China's infamous one-child policy that forced women to endure abortions, involuntary sterilizations, and financial penalties should they fail to meet the restriction. There have also been incentive payments to women who undergo sterilization, which is the most common fertility control method in the developing world. Coercive policies can be aimed not just to limit fertility, but also to meet pro-nationalist

[32] "A New Roadmap to Guide Family Planning in Jordan." Health Policy Project, USAID, 7 Aug. 2013, www.healthpolicyproject.com/index.cfm?ID=JordanFPSuccessStory.

ends. The Ceasescu Regime outlawed all family planning methods and abortions in Romania until it was overthrown in 1989. These implications have occurred in recent history and must be regarded as potential consequences of a population-control approach, though they are not visibly taking place in Jordan.

The approach can also lead to ethical issues by prioritizing the goal of fertility limitation over individual rights and autonomy. For instance, the USAID Office of Population sent a letter to the International Planned Parenthood Foundation in 1991 urging against pelvic and breast exams, "unnecessary laboratory tests" and conservative thinking in deciding safety issues for the women who visit family planning clinics. The population-control approach simply eschews considerations of the ethical implications of treating women as family planning targets.

As the final implication, the literature agrees that population-control policies do not work as well as those that seek to meet the needs of citizens. Both governments and couples have many reasons to utilize family planning programs, but these reasons do not align when the government adopts population-control motivations. Judith Fortney, a professor at the UNC Gillings School of Global Public Health, made this point, "couples do not choose to use contraception to protect the environment; they want contraception to protect the mother's health, to devote more attention to fewer children..and so on."[11] In other words, women use contraception for their reproductive desires or to reach sexual fulfillment without pregnancy. Governments seeking population-control use contraception for ideal economic development and so there is no room to weigh women's desire in the design, implementation, or evaluation of their family planning programs or policies. Thus, governments, like Jordan, risk developing and enforcing reproductive policies that are out of touch with the wants and needs of the people.

Rights-based family planning programs are in touch with citizens' desires and thus result in fewer unintended pregnancies, fewer females dying from pregnancy and childbirth, and fewer infant deaths. A rights-approach provides solid protection against coercive practices and advances women's agency

It has been established that the NFPS begins with population-control objectives that the literature argues can be harmful in a number of ways. A second problematic component of the NFPS's objective is the numerical goal set forth in the Demographic Opportunity that the NFPS sets out to reach. The Demographic Opportunity policy document requires a total fertility rate of 2.5 births per woman by 2017 and 2.1 by 2030. The Higher Population Council altered the latter number in the NFPS to 3.0 births per woman by 2017. Jordan's fertility rate was 3.31 at the end of 2017. Fertility rate goals do not belong in a rights-based structure. According to ICPD Section 7.12, "Governmental goals for family planning should be defined in terms of **unmet needs** for information and services. Demographic goals, while legitimately the subject of government development strategies, should not be imposed on family-planning providers in the form of targets or quotas for the recruitment of clients."

Instead of imposing numerical goals, the NFPS should focus on unmet need.

Building a national family planning NFPS for the purpose of achieving a specific TFR, can lead to coercive provisions that infringe on the rights of Jordanians to freely control their reproduction. The TFR goal ignores the fact that big families are typically desired in the Arab culture.[24] The Jordan NFPS implies that it wishes to change this desire, noting that, "despite the campaigns and awareness raising initiatives that were conducted, there are still cultural and social barriers affecting the use of RH/FP services….This is confirmed by the fact that the ideal number of children for a Jordanian family has not declined despite the increased level of

education (11).” First, awareness campaigns seem to imply that a Jordanian’s desire to have a large family is a harmful value rooting from a lack of education. In actuality, the Arab culture has been for centuries a collectivist culture, in which family relationships and interconnectedness play an integral role in each person’s identity. Second, a rights-framework restricts governments from seeking to change their people’s informed choices and desires. The only cultural barrier that the ICPD recognizes is one that limits the autonomy of people, such as barriers to women’s empowerment. An informed, free cultural desire to have more children is not a cultural barrier the rights-based government should alter.

Section 3. Process for Developing the NFPS:

The Jordan NFPS was developed in coordination with the **HPC** and a range of participants, including the private sector, donor agencies and non-governmental organizations. All of the information that went into the NFPS's development was gathered through interviews, questionnaires and focus group discussions with decision makers, representatives from partners, public sector health directors, and health service providers.

The process for implementing human rights standards must be grounded in human rights - in other words, it must be participatory in order to make sure health providers fulfill obligations and citizens (rights-holders) have the knowledge and ability to claim their rights. Meaningful participation gives stakeholders real opportunities to get involved in the decisions that impact them at both local and systemic levels.

The design and development of the NFPS should have included the meaningful participation of diverse stakeholders, including women's groups, a full range of citizens, health providers that are specifically involved in providing contraceptive information and services, and community-based organizations working to promote women's rights and to represent those susceptible to marginalization. These participants should also remain involved in the evaluation of the NFPS. It should have also made heavy use of information provided by quantitative and qualitative studies in the country as well as outside high-quality information. A well-rounded and representative group of stakeholders and information guiding the development is necessary to ensure the resulting program meets the standards of accessibility, acceptability, and quality.

The development process falls significantly short of taking into account the unmet needs of women, men and families that the ICPD says should define the goals family planning programs. The input and perspectives of the women and men whom the NFPS is serving are

notably missing. It is impossible to meaningfully determine unmet need by only asking the providers, and not the recipients, of information and services. Furthermore, unmet need cannot be assessed to a high-quality (AAAQ) standard by solely relying on surveys and questionnaires, and not on broader systematic data and studies. Studies show that laws, policies and programs better reflect and respond to the needs of affected populations when members of those populations take an active part in their development. The ICPD also clarifies that a rights-based family planning program should involve women at all stages of planning, including adolescent, poor, vulnerable and marginalized women. ICPD Section 7.13 says, "family-planning programmes work best when … women are fully involved in the design, provision, management and evaluation of services." The criticisms of women's groups and female advocates can uniquely contribute to meaningful improvements in policy and program design. It is not even clear if the group of professionals who guided the NFPS's development as it stands was predominantly, half, or included women at all.

In the three sections that follow, I will analyze each of the three Intermediate Results and their corresponding outputs according to the AAAQ.

Section 4. Intermediate Result 1 (IR1): Policies supporting RH/FP issues

IR1 seeks to enable the development and implementation of "RH/FP-related policies supporting the Demographic Opportunity (13)." The indicator to measure IR1 is simply the "number of policies supporting RH/FP issues adopted." Based on the previous discussion on the Demographic Opportunity, this entire Result fails to meet the rights-based standard.

The interventions, or specific actions to reach the outputs, listed in this part of the NFPS intertwine the concept of Demographic Opportunity with reproductive health and family planning services, further eroding the ability of reproductive health services in Jordan to operate for their rights-based merits of enhancing the lives, personal relations and health of Jordanian people, and not for the government's development goals. For instance, one reads, "Integrate the interventions of the RH/FP NFPS and DO in the plans, programs and budgets of various stakeholder institutions." This intervention makes it nearly impossible to treat, fund or develop family planning and reproductive health services as separate entities from the goals of the economic sector.

Another intervention seeks to strengthen the capacities of decision makers, media professionals, and religious and civil society leaders to advocate to "change RH/FP policies in accordance with the Demographic Opportunity." In other words, current positive policies could potentially be altered to fit the country's economic goals. Such policies can include the streamlining health funding or programming to only services that decrease a woman's fertility. Though the NFPS calls for creating an information database that includes "information on services, geographic maps, contraceptive logistics and training data", this step is listed as an intervention in this section to achieve DO-affirming policies, and not to identify and address

unmet need in order to achieve policies that can help citizens realize their reproductive rights and improve their reproductive health.

It is most alarming that IR1 calls for policies, but it does not call for the most obvious first step to policy-making: evidence generated through studies. The only call for evidence in this section is listed as an intervention, "Design and implement studies in the area of population and RH/FP that will improve the policy environment." The studies are only meant to increase support for the passage of policies, and not to increase the information driving the policy-making in the first place. Therefore, this entire section of the NFPS calls for policies that further DO, and that are not based on any designated studies, sources of information or problems to address. The interventions surround the process of implementing DO-affirming policies without push-back, such as "identify barriers to implementing a new or existing policy and identify the need for a new policy."

This entire section should be redesigned. Jordan should aim to develop policies not to serve the DO, but to serve the reproductive health and well-being of its people, using the definitions and reproductive rights principles outlined in the ICPD. As I continue to analyze and make recommendations for the next two Results in the NFPS, many will come in the form of policies that should be in this section. A few are listed here, but the majority will be found throughout the analysis:

- Encourage policy-makers to research community views about family planning service needs and then act on the information learned
- Encourage policy-makers to fund information and education on sexual and reproductive health and rights

- Urge policy-makers to track and fund the contraceptive supply chain, guaranteeing the availability of a wider range of safe and effective contraceptives
- Create policies that restrict health providers from discriminating against or questioning women based on marital status

Section 5. Intermediate Result 2 (IR2): Equitable and high-quality information and services made accessible

IR2 "aims to equitably distribute high quality RH/FP services that guarantee economic, social and geographic equity, as well as the establishment of a comprehensive system for managing the RH/FP program that is implemented at all levels." IR2 seems to have the most similarity to the ideas in the ICPD and in the AAAQ criteria. It is the only Result out of the three (Intermediate Result 1: Improve Policy Environment; Intermediate Result 3: Increase Positive RH/FP Attitudes) that explicitly addresses the accessibility, quality and availability of family planning and reproductive health services. Thus, it is vital that IR2 is well written and fleshed out to truly meet the reproductive needs of Jordanians.

This section in the NFPS is structured the following way: Indicators for Intermediate Result, Outputs, Indicators for the Outputs. Each will be analyzed separately, beginning with the primary indicators.

The indicators to measure progress towards IR2 are made up of crude, numerical measures that do not take into account individuals' preferred methods of contraception or potential desire to have children. They only push to guarantee that couples are using some sort of family planning method, whether or not they wanted to use one or are using their preferred method, and that they do not discontinue use.

I analyze each of three such indicators in more detail below:

Indicator 1/3- Modern Contraceptive Prevalence Rate:

The rights literature recognizes many problems with the use of the Modern Contraceptive Prevalence Rate (MCPR) indicator, especially when there is not a healthy range of quantitative and qualitative rights indicators, which is the case with the indicators in this Section. By only

measuring the number of users or additional users of modern contraceptive methods (additional users are repeated and bolded throughout the NFPS), there is a potential for ignoring the importance of the method mix, defined as the relative level of use of different contraceptive methods, even if the MCPR appears high. For instance, female sterilization is predominant in India, but the country has a high MCPR because sterilization is considered a modern method. A rising MCPR would reflect progress made toward achieving the numerical goal, but an increasingly skewed method mix could reflect inhibiting users' rights.

If Jordan narrowly prioritizes its MCPR as a means to reach DO, and as a result overlooks its method mix, it can breach the Availability standard in the UN General Comment and restrict the full choice of women and men related to their contraceptive methods. Expanding access to a wider method mix can be more responsive to the diverse needs of the population and help women meet their fertility goals. Thus, method mix should be an indicator under this Result.

Indicator 2/3 – Discontinuation Rate of Family Planning Methods in the First Year of Use:

The Discontinuation Rate indicator does not recognize that most women rely on different methods at different points in their reproductive lives, and may want and need to switch from one method to another for health, personal preference and other reasons. Furthermore, the vast majority of women will spend time experimenting between methods when they first begin using contraception. This is a normal and healthy way to exercise their reproductive right to full, free and informed choice. This indicator incentivizes health providers to discourage and prevent such choice. Notably, Section 7.23 of the ICPD forewarns governments against such indicators, stating governments should meet their objectives "through education and voluntary measures rather than schemes involving incentives and disincentives."

Indicator 3/3- Percentage of centers providing RH/FP services that provide four long-term modern family methods:

A final problematic indicator calls for the availability of 4 long-term methods at centers. It should at least employ the terms "safe," "high-quality" and "effective," though to be in compliance with the ICPD, it should provide for a full range of methods to be available, including short-term methods that many couples may seek for their reproductive goals. It seems that the government is only prioritizing the availability of long term methods because that prevents couples from having children and thus helps it meet its TFR goals. This seems inherently coercive and restricting. Principle 8 of the ICPD Programme of Action emphasizes, "Reproductive health-care programmes should provide the widest range of services without any form of coercion." The population control framework often focuses on attempting to convince women to use contraceptives. In contrast, the 'woman centered' reproductive rights framework focuses on satisfying family planning clients. The former is in use here.

These three indicators solely focus on increasing the number of protected couples, likely in order to reach the TFR goal. This might harm the delivery of services, which is exactly what happened in many nations prior to the ICPD: an overemphasis on reducing fertility, and ultimately population growth, adversely affected the delivery of services, especially as the gap between the goal and its achievement grew.

It is important to remember that these are the indicators that the government has identified to measure *equitable access to quality services.* The indicators imply that the reason to ensure RH/FP services are of a high quality and accessible is to make sure people are using some

method of birth control, rather than to strengthen the health and well-being of citizens. Major indicators missing here that actually measure equitable access to quality services include the percent demand for modern contraception satisfied, percentage of unwanted pregnancies, and infant mortality and morbidity. Other necessary indicators include "percentage of women using a contraceptive method who wanted to use one," "percentage of women using their preferred method," and "percentage of families with real access to family planning services." One indicator in this section does positively measure unmet need, but the provision should explain "unmet need for good-quality information and services."

Policy Recommendation:
Add the following indicators:
- Availability of multiple methods that is responsive to the multiple needs of the population
- Percentage of women using a contraceptive method who wanted to use one
- Percentage of women using their preferred method
- Percentage of families with real access to family planning services

So, IR2 (Equitable and high-quality information and services made accessible) is followed by crude indicators, as mentioned above. Then, three outputs are listed to reach IR2 and the indicators. The Outputs are then followed by a list of indicators that are specifically meant to measure progress towards the listed Outputs. They are essentially smaller shorter-term steps to reach IR2. Finally, there is a list of interventions that stakeholders, and more specifically health providers, should take to meet the three Outputs and indicators.

To summarize, the chapter for IR2 follows this structure: IR2, indicators for IR2 (listed above), three outputs for IR2, indicators for the outputs, interventions (specific actions to take to reach the outputs and indicators). The three outputs will now be analyzed separately:

The Outputs for Intermediate Result 2 are:

1. Comprehensive system for managing RH/FP services implemented at all levels
2. More equitable distribution of high quality RH/FP services
3. Wider choice of FP methods

Output 1/3 for IR2. More Equitable Distribution of High Quality RH/FP services:

There are many positive indicators the NFPS lists that directly relate to this Output, such as unmet need by geographic and economic group, the percentage of centers with a physician and midwife/nurse, the percentage of subsidiary health centers introducing FP services, hospitals providing post-natal and post-abortion FP services, the number of providers trained on topics related to RH/FP, and client satisfaction.

Some of the interventions also directly address this Output, including

A. Expand services to areas where family planning services are not available

B. Provide necessary equipment, methods, infrastructure, and qualified and sufficiently trained medical staff in the areas most in need at the primary health care and hospitals level

C. Strengthen capacities of service providers in counseling and service provision to reduce unmet need and missed opportunities, and integrate FP within primary health /maternal and child health packages, as well as integrating RH/FP counseling and services in hospitals for post-natal and post- abortion women before discharge from hospital

D. Implement protocols and quality standards of family planning services based on scientific evidence

E. Update and maintain the content of training programs for family planning service providers based on scientific evidence, and unify the terminology and concepts for RH/FP used in service delivery points

I will attempt to break down this analysis by the key terms in the Output - quality, equity, information - but, as is the case for all human rights standards, the concepts and the discussion will naturally overlap. Many recommendations and action categories can only take place if other actions are also taken, and many reproductive rights standards will apply to one specific action or category of action. It is important to recognize that the principles are part of an integrated whole, but this paper will attempt to break them apart in order to tackle the analysis of such a large Result:

Quality:

The Output seeks to achieve high quality RH/FP services. As a reminder, the **Quality criterion** in General Comment 14 refers to health facilities, services, and commodities that scientifically and medically appropriate and of good quality. This requires, among other things, skilled medical personnel and scientifically approved and unexpired drugs and equipment. This is a vital aspect of the ICPD, which holds that access to quality care is an integral human right. Additionally, studies show that contraceptive use is higher when individuals feel that they are receiving high-quality care. Furthermore, studies show that achieving higher-quality standards attracts individuals to reproductive and sexual health services and improves their effectiveness. Thus, it is in the government's interest to meet the quality standard in its FP/RH program and services in order to decrease unwanted pregnancies and thus slow down its population growth.

In order to meet the quality of range of services listed in the ICPD and truly ensure "full" choice for individuals, the NFPS should first define the term FP services as the full range of

services outlined in the ICPD, including family-planning counseling, education and services for prenatal care, safe delivery and postnatal care, breast-feeding and infant and women's health care, prevention and treatment of infertility, abortion as legal, treatment of reproductive illnesses including infections and STDs, and information and education.

The indicators and interventions, or actions to take, listed in this section of the NFPS related to quality are:

1. Number of health centers that achieved primary health care/family planning accreditation standards
2. Percentage of health directorates implementing an effective supervision system for maternal and child health care services
3. Implement protocols and quality standards of family planning services based on scientific evidence
4. Provide necessary equipment, methods, infrastructure, and qualified and sufficiently trained medical staff in the areas most in need at the primary health care and hospitals level
5. Staff trained in specific RH/FP topics aggregated by topic.

These are good first steps to reach higher quality standards in services. The rights community calls for health facilities to be scientifically appropriate and for technically competent trained health workers, as mentioned in these provisions. In order to improve the existing provisions, the fourth provision should say "skilled" medical staff, rather than just sufficiently trained medical staff, and while it is plausible that the provision seeks to fill unmet need, its seems that the terms should stand alone. In other words, a provision must say "provide necessary equipment….at *all* primary health care and hospitals providing services." The first

provision should also say "number of health centers…. that are meeting quality of care standards based on the 2014 World Health Organization definition," rather than just meeting national accreditation standards, which could potentially represent a lower standard of quality care.

Quality of services, however, goes beyond accredited centers, protocols, and necessary equipment and staff in areas of need. The NFPS relates quality of services to scientifically-approved methods, but to secure conformity to human rights standards, all services should be provided in accordance with ethical guidelines (ICPD Programme of Action 7.17) and integrate rights-based values and skills before and during treatment.

Policy summary:
- All services should be provided in accordance with ethical guidelines and integrate rights-based values and skills before and during treatment
- Ensure that every legally eligible woman has access to safe abortion care and every individual has access to high quality STD care if needed

In other words, the principle of quality inherently means *more* than providing the bare-minimum to meet safety standards. For instance, knowing that IUDs are the most commonly used contraceptive method in Jordan, the NFPS could measure the availability of sites equipped to provide easy access for IUD removal, including the services and supplies to support women's ability to easily switch between methods should they wish to do so. Indeed, Section 7.13 of the ICPD Programme of Action recognizes that the quality of family-planning programmes is often directly related to the level and continuity of contraceptive use and to the growth in demand for services. The NFPS should also call for the research and implementation of evidence-based information on the effectiveness, risks and benefits of different contraceptive and family planning methods and services. Finally, the NFPS should institutionalize a system for quality assurance.

The NFPS addresses the topic of abortion, which is only legal in Jordan for cases of incest or rape, in indicators calling for women to receive FP counseling and services post-abortion. The ICPD respects the abortion laws of countries and does not call for the legalization of abortion. In cases that it is legal, women need to access safe abortion. The NFPS should add a provision under this Result enabling the environment to ensure that every legally eligible woman has access to safe abortion care and access to care if she has undergone an unsafe abortion. The NFPS fails to address the topic of sexually transmitted diseases (STD), though individuals suffering from these diseases have a right to quality care. Policy makers should review and update current strategies for STD prevention and care within the NFPS. The ICPD specifically calls on countries to make accessible through the primary health care system the treatment of sexually transmitted diseases (7.6).

Quality of care covers a multitude of aspects of the provision of RH/FP information and services. High quality services in a rights-framework must include open access to and satisfaction with information and services, as well as a contraceptive method mix in order to uphold the principle of autonomy, which is a central theme in medical ethics. Quality should simply be a conscious priority that is interwoven throughout the entire NFPS. Arguably, most provisions can be phrased in a way that improves quality. For this reason, it is difficult to discuss quality in a separate block, and I will include my quality discussion throughout the rest of this section.

Output 2/3 for IR2. More equitable distribution of high quality RH/FP services:

The NFPS lays out the challenge that Jordan faces with equitable family planning outcomes. It concedes in an introductory background section, “There is a clear disparity between regions and cities in terms of unmet need for family planning and variation in the rate of use of

family planning methods, with both linked to socioeconomic factors." Equity is also a cornerstone of a rights-based approach, for human rights are inherently universal, regardless of socioeconomic background. General Comment 14 recognizes four components of equitable accessibility: nondiscrimination, physical accessibility, economic accessibility, and information accessibility. These four will be considered in the analysis of this section, for the NFPS should consider underserved areas and populations, as well as confront barriers to accessibility such as distance, cost, availability of health providers and facilities. The indicators and interventions listed for this Output take steps to address these three factors, but there is room for improvement.

First, the NFPS calls for the expansion of services into areas they are not available, of necessary equipment into areas most in need at the primary health care and hospital level, and of strengthening the capacities of service providers in counseling and service provision to reduce unmet need and integrate family planning within primary health care/maternal and child health packages. These provisions again provide the minimum. For instance, rather than an indicator measuring the number of health centers that introduced family planning services, the NFPS should ensure the services are accessible, affordable and convenient to all users through the primary health-care system, not just *there.* They must be there in sufficient quantity, as indicated by the UN General Comment **Availability criterion**, to meet needs and close existing gaps in services.

The NFPS does not include as part of the intervention a direction to actually identify and remove all the major barriers to the utilization of family-planning services, including a provision to identify areas of unmet need in the first place. The direction should set a goal for public, private and non-governmental family-planning organizations to remove all programme-related barriers to family-planning use through the redesign or expansion of information and services.

According to the book *Reproductive Rights in a Global Context*, as well as studies on Jordanian women's satisfaction with their health care services, there are many barriers determining women from reproductive care, especially in public clinics. Though women find centers physically accessible, they are often understaffed, overcrowded, have limited and inconsistent hours of operation and lack privacy. They also lack trained female providers, and studies show the majority of Jordanian women will not undergo procedures like IUD insertions, with male providers due to cultural values.[33] The NFPS should sufficiently address these barriers through indicators and interventions under this Result, and specifically focus on public clinics. It should call for clean and stocked public clinic that are open at convenient and clearly-indicated times for women, and female health providers should be available.

Other potential barriers for Jordanians are the inadequacy of the health infrastructure specifically in rural areas, the availability and visibility of high-quality FP posters in the Arabic and English languages, the costs and insurance coverage of contraceptives, and access to privacy and friendly care-personnel.

To tackle cost barriers, the NFPS should include a provision to eliminate financial barriers to contraceptive use, especially by poor populations. One way to do this is including the full range of contraceptive methods in the benefits package of all insurance options. In some cases, policy makers must keep in mind that those living in poverty may not be able to afford access to even the most basic contraceptives because the majority of their income is spent on food and shelter. The NFPS should consider free or subsidized access to contraceptives for those with limited resources, including migrant workers. This idea would both uphold the rights of

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[33] Knudsen, Lara M. *Reproductive Rights in a Global Context: South Africa, Uganda, Peru, Denmark, United States, Vietnam, Jordan*. Vanderbilt University Press, 2006.

those populations, and help the government with its goal of increasing the number of people utilizing contraceptive methods.

The NFPS positively includes the development of a new service model, integration, but it should use this model as well as other models such as mobile services to reach disadvantaged populations. In Jordan, contraceptive prevalence rates are lower in rural and less-developed areas than in urban and more developed areas. Mobile outreach services, defined by USAID as FP services provided by a mobile team of trained providers, from a higher-level health facility to a lower-level facility, in an area with limited or no FP or health services, have been identified as a way to fill this gap. Mobile services emphasize both supply and demand for contraceptive services and can generate demand for contraceptive services in communities and provide more consistent follow-up services. The NFPS should map the different models for service delivery and based on those findings initiate a process to introduce different service delivery models to meet unmet need in the country.

Furthermore, though areas of unmet need are listed in the NFPS, due to Jordan's high refugee population, it is important to explicitly add "migrants and displaced persons" in this section. These populations are recognized in the ICPD as having limited access to reproductive health care and facing serious threats to their reproductive health and rights. Studies of Syrian refugees in Jordan found that the population has high rates of early marriage, sexual violence, and unwanted pregnancies.[34] The ICPD Programme of Action recognized such risks as common to vulnerable populations around the globe, and specifically called on governments to provide

[34] Cherri, Z., Julita, G. C., Rodriguez-Llanes, J., & Guha-Sapir, D. (2017). Early marriage and barriers to contraception among syrian refugee women in lebanon: A qualitative study. *International Journal of Environmental Research and Public Health, 14*(8), 836. doi:http://dx.doi.org.ezproxy.lib.utexas.edu/10.3390/ijerph14080836

services to these populations that also take into account their high risk of facing sexual violence. If the NFPS fails to serve the specific needs of the refugees, not only will it fail to honor the moral obligation of upholding the reproductive rights of all populations, but also it will weaken its own health sector. There were about half a million Syrian refugees in Jordan as of 2013, the majority of whom reside among Jordanian communities. A minority resides in refugee camps.

According to Professor Mujalli Murshidi, chairman of Urology at the University of Jordan, the Jordanian government will significantly erode the gains it has made over decades of investment in health and health systems if it does not work to support the Syrian refugees.[3] Syrian refugees in Jordan refugee camps told researchers they desired psychosocial services for sexual violence as well as prevention and medical care. They also voiced support for local female gynecologists to visit the camps. These are examples of unmet needs that the ICPD calls on governments to identify and then take steps to address. It must develop a plan to integrate comprehensive reproductive health services into primary care for refugees.[35]

Next, adolescents are largely missing from this entire NFPS, though they make up the largest age group in Jordan and thus the principle of equitable distribution is moot without their involvement. The ICPD calls of governments to give "full attention" to "meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality." Though the culture and predominant Islamic religion in the Middle East, and specifically in Jordan, strongly discourages pre-marital sex, it is still important for the government to be unequivocally committed to the human rights of young people. After all,

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[35] Krause, Sandra, et al. "Reproductive Health Services for Syrian Refugees in Zaatri Camp and Irbid City, Hashemite Kingdom of Jordan: An Evaluation of the Minimum Initial Services Package." *Conflict and Health*, vol. 9, no. Suppl 1 Taking Stock of Reproductive Health in Humanitarian, 2015, pp. S4.

adolescents are among the most vulnerable groups with regards to reproductive rights and the necessary societal behavioral changes to secure reproductive rights must start with adolescents. Furthermore, 7% of Jordanian college students admitted to non-marital sex in a 1994 study, as did 4% of the general population aged 15–30 years in 1999.[36] The rise of social media and increased numbers of women in college and the workplace may have caused this number to rise since then. In a rights-framework, governments are obliged to take into account the reality of adolescent lives and ensure nondiscriminatory access to information, life skills and preventative measures.

This is especially significant because surveys show that an adolescent girl without formal education is more than four times as likely to become pregnant than if she had secondary education.[37] This reflects the cost paid when FP information access is restricted from youth and it illustrates a situation in which an adolescent girl can be coerced into marriage. Child, early and coerced marriages are among the many harmful practices infringing on the reproductive rights and health of young girls, primarily in the Middle East and the developing world. Empowering girls with information can be a powerful way to enable them to enter their sexual lives and marriages with a greater level of autonomy and thus remain in education or their societal roles, should they wish to do so.

Though adolescents should have the right to receive sexual education both before and while they are sexually active, any indicators or interventions in the NFPS calling on clinics to

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[36] Khalaf, Inaam, "Youth-friendly Reproductive health services in jordan from the perspective of the youth." *Scandinavian Journal of Caring Sciences* 24.2 (2010);321-331

[37] *Reproductive Rights Are Human Rights: a Handbook for National Human Rights Institutions*. 2014, *Reproductive Rights Are Human Rights: a Handbook for National Human Rights Institutions*.

provide sexual education, much less to adolescents, are missing. The Jordanian government should collaborate with non-governmental organizations to meet the special needs of adolescents and to establish appropriate programmes to respond to those needs that take into account both cultural acceptability and the principles of the ICPD. Such programmes should include support mechanisms for the education and counselling of adolescents in the areas of gender relations and equality, responsible sexual behavior, responsible family-planning practice, reproductive health, and the prevention of sexually transmitted diseases. Such programmes should aim to strengthen positive social values and should not have any sort of mandatory parental or guardian authorization/notification. This paper's policy recommendations called on the full involvement of adolescents in the development of the NFPS in order to better develop sections like this one to meet their specific needs.

Policy Summary:

- Laws and policies must ensure that comprehensive contraceptive information and services are provided to all segments of the population. Special attention should be given to disadvantaged and marginalized populations in their access to these services.
- Eliminate financial barriers to contraceptive use, especially by disadvantaged populations, and make contraceptives affordable to all.

A second group that is missing from the NFPS is men. The ICPD broke ground by recognizing the role of men in reproductive health. Men have the right to access sexual and reproductive health services, but they often, and especially in Jordan, underutilize reproductive health services or fail to see a place for themselves within the services. If men are not involved in matters related to reproductive health, they will be poorly prepared for adulthood, contraceptive usage and safe sex. Especially in a society like Jordan where men are in charge of many decisions within a marriage, they can play a positive, neutral or harmful role in the

empowerment of women in their lives. The NFPS should include provisions to make information, counseling and services available to adult men, who also need information on contraception such as condoms and voluntary vasectomy, and on the prevention of STDs. The information should also push the need for men to share the burden of preventing diseases and pregnancies with their sexual partners.

These are just a few examples of the kinds of barriers the NFPS must identify and address to truly achieve the equitable distribution of services across its population. Access barriers affect individuals on such a large scale that greater efforts in these areas are vital.

A Further Note on Output 2 under IR2. On the Distribution of High-Quality Information:

Intermediate Result 2 calls for the accessibility of high quality information, but the word information is not repeated through the indicators or interventions. A few of the above indicators positively call for updated training content and strengthened counseling capacities. These steps do not safeguard that comprehensive and factual information is provided to providers and, in turn, passed on to the population. As discussed, the right of men and women to be fully informed is inherent in their ability to freely control their reproduction and achieve optimum well-being, which is the ultimate goal of a rights-framework. Thus, this must be a huge focus of the NFPS, though it is not. Furthermore, the NFPS should include an intervention to study the unnecessary legal, medical, clinical and regulatory barriers to information and to remove them. As we can see, the concepts of quality and equitable access without barriers will remain present throughout the following discussion.

Health providers must have the environment, training and tools needed to provide quality information, counseling and service delivery. First, they must receive high quality and comprehensive training on RH/FP issues as well as on the reproductive rights of their clients.

Both the intervention to "strengthen capacities of providers in counseling" and the intervention to update the training given to providers to meet scientific standards must go further. The terms should include "counseling based on comprehensive and factual information about childbearing, methods of family planning and other matters related to reproductive health including sexually transmitted diseases, sexual health and responsible parenthood." These recommendations align with Section 7.23 of the ICPD Programme of Action, which states: "Expand and upgrade formal and informal training in sexual and reproductive health care and family planning for all health-care providers, health educators and managers, including training in interpersonal communications and counselling." The training content must be updated to reflect these changes.

Providers must be urged to provide counseling that is, first, free of bias or judgement. Health care providers cannot discriminate against young people, people living with disabilities, indigenous peoples, ethnic minorities, people living with HIV, and homosexual people. This ethnic minority provision is especially relevant in Jordan because the country has a large service class made up of migrant workers who live with the families that employ them. Over half of middle class families employ live-in migrant workers to nanny their children and clean their homes. These migrant workers are typically left out of the health sector, especially in regard to their reproductive rights, even though a pregnancy could effectively end their employment in the country because they will no longer fulfill the services in their contracts. An article in the New Yorker shed light on this problem by telling the stories of migrant workers in Jordan who underwent extreme measures to abort their pregnancies. It is vital that the government tackles and confronts discrimination against this population. It must honor their rights as human beings with dignity and the right to access high-quality reproductive services and information. This begins with the training given to health providers. Furthermore, the NFPS should create a policy

that requires families to provide transportation and coverage of reproductive health services for any migrant workers they employ.

Second, providers must provide counseling that is confidential, and enables and supports voluntary decisions. The ICPD recognizes the right to privacy, because, and as is the case in Arab cultures, sexual and reproductive health involves many sensitive and personal issues. Providers must be trained on their duties to keep the information they receive from clients private and to protect an individual's privacy. The counseling must also protect clients' dignity and agency, and discourage harmful practices. To truly ensure these provisions are upheld, it is important that training includes thorough language on reproductive rights and health as agreed upon in the ICPD and specifically the importance of medical ethics and individual preferences. The central theme of free, full and informed decision making should be emphasized as a central theme in the training, counseling and providers' knowledge of medical ethics. The ICPD says, "Governments should secure conformity to human rights and to ethical and professional standards in the delivery of family planning and related reproductive health services aimed at ensuring responsible, voluntary and informed consent and also regarding service provision (7.17)"

Furthermore, the NFPS should include an intervention to not just update the training content, but make sure it is actually used. It should include a review of whether different types of health-care providers — including midwives and pharmacists— are accredited to deliver contraceptive and family planning information and services. If not, the NFPS should support the adoption of relevant policies to enable providers to build their capacity in the RH/FP field in accordance with the ICPD.

Third, it is vital to the rights of individuals to guarantee clinics, centers and hospitals are openly and fully relaying information and education to clients. An additional intervention and related indicators should be added that read, "ensure all providers at primary and hospital levels provide comprehensive and factual information and education to clients so that they can make decisions based on complete, accurate, unbiased information about all family planning options, including benefits, side effects and risks, and information about the correct use of the method chosen, as well as the risks of non-use."

The NFPS should capture quality from the client perspectives by utilizing indicators that reflect more accurate and consistent measures of client satisfaction and capture the right to reproductive self–determination. For instance, they should measure the number of clinics that provide information or education services, community norms and service providers' attitudes around reproductive autonomy, and separate indicators to measure both knowledge, confidence in and feelings of dignity and agency among Jordanians who use services. Indicators can also include client retention and community trust in their local family planning services. Such indicators may require special investments like special studies to support such quantitative measures. These indicators recognize and reward providers for respecting the rights of their clients. The NFPS must be mindful of only incentivizing behavior that increases agency.

Fourth, I previously argued for the inclusion of adolescents in the NFPS and mentioned that pre-marital sex is frowned upon in most sectors of the Jordanian population. This section must include the expansion of information to fulfill specific adolescent issues. UNFPA has collaborated with the Ministry of Education to include basic elements of sexual health in the school curriculum, but many teachers skip over this in their courses and consider such topics uncomfortable or sensitive. In terms of cultural sensitivity, Islam calls for the collection of

knowledge and there is much history in Arab cultures of addressing basic aspects of human nature. Religious leaders regularly discuss the naturalness of sexual feelings and the cultural heritage allows for teaching youth what happens during puberty.

The NFPS can build a system that teaches youth the basic elements of sexual health, safety and hygiene in a manner that stresses the need to act responsibly and to understand and manage one's needs. It is important to address sex education in a way that is culturally sensitive so it is not viewed as a Western product. The book "Reproductive Rights in a Global Context" cites studies that that Jordanian youth prefer to receive information through media and health centers.[33] The NFPS should create innovative programs to get information to youth through these mediums. For instance, it should call for the development of peer education programs that transmit accurate information and solve the teacher problem by building a program for third-party health professionals to visit classes and teach sex education to students. It should also build a requirement for clinics and medical schools to adolescent reproductive health information.

Next, there is a major Jordan-specific barrier to access that can be addressed through the reproductive rights training given to health providers - and that is bias against unmarried women. Unmarried women in Jordan likely feel uncomfortable accessing reproductive health services due to the social stigma related to sex outside of marriage and to the open discussion of sex in general. Providers show these biases by assuming women are married and asking questions like "how long have you been married?" before conducting a service like inserting an IUD. Even worse, providers at certain clinics or hospitals may ask if a woman is married, prompting women to avoid services or to lie and say they are divorced. This is yet another reason why it is important to update training content for all health providers to include discussions on

reproductive rights and the importance of operating in a non-judgmental way that recognizes reproductive health as essential health care for all people.

In addition, NFPS makers must keep in mind that laws and policies themselves can be barriers to individuals accessing services. Result 1 on Policies Related to RH/FP services should include the removal of such barriers, perhaps by the implementation of a policy restricting providers from being able to ask about or discriminate based on marital status or to require third-party authorization for individuals/women seeking contraceptive and related information and services.

The concept of access means that the government must require that services are accessible to everyone without barriers, including the requirement for authorization by spouse. For instance, according to the website Gymnopedia, where Jordanian women share experiences related to reproductive health care in Jordan, "you should be aware that certain hospitals and clinics only provide IUDs to married women." This should not be legal and it is not acceptable in a rights framework. Also, according to online forums, if a Jordanian woman visits a gynecologist, the gynecologist may ask her for the name of her husband. This is first an invasion of privacy for women who do not wish to include their husbands in their results or decisions. Even worse, this effectively removes non-married women from the health arena. In another effort to tackle this barrier, the Policy must extend insurance coverage for reproductive health and sexual health, such as pap smears, to non-married women.

Finally, the counseling the NFPS refers to is likely related to reproduction, but this omits conversations related to sexually transmitted diseases (STDs) or sexual health. The latter is recognized in the ICPD as a right that is related to the "enhancement of life and personal relations (7.2)." Part of the training must be to reduce stigma regarding STDs because women in Jordan currently face such widespread judgement and shaming that they may stay away from an STI test all together.

Policy Summary:
- Remove mandatory third-party consent
- Remove bias and judgement and teach providers to uphold the full and free choice of clients.
- Strengthen metrics to ensure strong indicators of informed choice

Output 3/3 for IR2: Wider Choice of FP Methods:

The intervention that directly relates to this Output is "Increase choices of family planning methods by adding new family methods to the available mix of methods." The indicators that relate to this Output are the number of choices of methods available in the country, the percentage of centers whose stocks of FP methods have run out, and the number of clinics offering at least 4 long-term modern methods. Building off the initial discussion of the Result indicators that narrowly focused on getting individuals on a form of contraception, there are also similarly focused indicators listed for the Outputs that will be discussed in this section.

There are many issues with this Result under the rights framework. First, family planning methods are not defined in the NFPS. Readers can only assume the NFPS is referring to contraceptive methods. Second, it is not clear where, when or how the wider choice of methods should be available - e.g. allowed into the country, available throughout the country, at specific clinics, in big cities? A wider choice at one clinic, at all clinics, under insurance? This argument relates to the previous discussions on the necessity of *equitable access* to FP methods, meaning they are accessible, affordable, convenient, and acceptable, not just *there.* This argument also

relates to the discussion on agency and autonomy. The previous recommendation on the removal of third-party authorization is particularly important to truly ensure the wider "choice" of FP methods -women must access and use the contraceptive methods of their choice without outside authorization, whether in the form of spousal consent, parental consent, or religious leaders. The previous recommendations to add human rights and bias training to the providers training content and counseling services can help support these recommendations.

With regards to this specific Output, it is strikingly missing provisions regarding the quality and range of FP methods made available. The **Availability criterion** in the AAAQ is largely ignored. One new birth control brand available at a few clinics could theoretically and realistically satisfy "wider choice." Even the NFPS indicator for this provision seems effortless, only measuring the "number of new methods available," without regard for the definition of available, the quality of the methods, or the ICPD principle of the full range of choice. The NFPS needs to consider not only the number of methods provided but also how methods work and the quality of the methods, and ensure its policies, supply chains and service protocols take into account that couples must be able to and will want to choose to switch methods. Moreover, if the NFPS focuses on the availability of multiple methods, this is not the same as the method mix. A method mix can be skewed toward or against a specific method because of provider bias, low stocks, program design or user preferences. Should the skew be due to the first three reasons, the NFPS would be inhibiting user rights.

The core principle of **full, free and informed** choice really takes hold in this Output. A rights-based family planning program must ensure that individuals can exercise full choice from a full range (including methods that are short-acting, long-acting, reversible, permanent and emergency contraception) "of safe and reliable (quality) methods which are legal (ICPD 7.16)."

This language must be present in the NFPS. Furthermore, it is important to note there is nothing about removal services in the NFPS. As part of availability of the full range of methods, the NFPS must include removal services for implants and IUDS.

To help develop these recommendations, the **HPC** should examine what is known about unmet need for contraception, focusing on practical barriers to access; the reasons for discontinuation of methods, and the potential demand for different methods, depending on the risk-factors of the population. Then, it should advocate for the transparent political and financial commitment to contraception. Finally, it should review the national essential drugs list and advocate for the inclusion of the full range of contraceptives.

The ICPD also recognizes emergency contraceptives (ECPs) as a health part of this range. In Jordan, a woman or man cannot legally obtain emergency contraception at pharmacies and no brands are officially registered in the country, though some pharmacies may secretly carry ECPs. Removing access to emergency contraceptives, especially in a country where abortion is restricted, can cause dangerous situations for women. In fact, forums on the website Gymnopedia shed light on the reality that Jordanian women are guiding other women through the process of using birth control pills as do-it-yourself emergency contraceptives. This is a clear breach of the women's basic right to autonomy, choice and safety in health care.

Restrictions on emergency contraceptives tend to result from ideology-based rather than evidence- based factors. For example, in Jordan emergency contraception may be stigmatized on the false grounds that it causes abortion. ECPs do not cause abortion and do not affect established pregnancies. It is also important to note that abortion is allowed in Islam for up to two months after conception. These arguments cannot sufficiently justify the breach of reproductive rights regarding ECPs in a rights framework. For instance, ECPs can prevent

pregnancy after sexual intercourse or contraceptive failure. Widespread access and use can also significantly reduce the incidence of unintended pregnancy in the country. Studies have shown that ECPs are effective in preventing pregnancy up to 120 hours after unprotected sexual intercourse or contraceptive failure. The stigma begins with policy makers and will not change until they are encouraged through education to develop positive attitudes towards ECPs as a tool to increase their citizens well-being and to reach their goals by reducing unmet need. The NFPS can then include, in the policy section, an effort to legalize and expand access to emergency contraceptives.

Policy Summary:

- Prioritize access to information about and service of a full range of short and long-term methods.
- Invest in the contraceptive supply chain
- Conduct community–based data to understand changing perceptions of and barriers to women's ability to access contraceptive services.

Third, it is not clear that the wider choice of methods should be *consistently* available, in order to increase contraceptive security. Access to a secure, reliable and steady supply of a broad range of modern contraceptive commodities is an essential part of health care to a wide range of Jordanians, including couples who desire to space the birth of their children, women whose lives could be saved if unintended pregnancy is prevented, adolescents too young to be parents, and individuals who need of protection from sexually transmitted diseases. Any service center, including community-based service centers, should have a sufficient quantity of a broad mix of contraceptive methods available at all times, to ensure that no client leaves empty handed.

Even if family planning services are in place, the program has not succeeded if specific contraceptive methods are not available when the client seeks them or needs them. In other words, where supplies are not consistently available, people will believe visiting the service is a waste of their time. The NFPS must include a provision to implement policies that ensure

contraceptive security, including consistent access to a range of methods within public, private, and non-governmental sectors. It should include as an intervention the development of an effective monitoring system to monitor and quickly address stocks and distribution.

Building on the discussion of voluntary choice, this section of the NFPS includes many crude measures in the familiar population-control spirit of getting individuals on some contraceptive method. The indicators to which I am referring include number of new acceptors of modern family planning method, number of women who received a postpartum FP method and number of women who received a post-abortion family planning method. Again, these indicators make no mention of quality, affordability, or choice. The words "who wished to receive one," is absolutely vital. Without the voluntary provision, the indicators can incentivize providers to push methods and services onto women regardless of their desires. The NFPS should also state explicitly that no person shall be forced against his/her will to accept contraception, or a specific method of contraception that is against their desires. As part of the principle of informed decision making, individuals should be able to exercise their contraception choice from across a range of options but also be free to refuse any and all options.

It is clear: where only a few methods are available, this limitation clearly compromises a full, free, and informed choice.

Section 6. Intermediate Result 3: Positive change in reproductive beliefs and behaviors in community

This result aims to address the social culture and awareness on RH/FP and population issues to change individual attitudes toward positive attitudes and adopt initiatives that enhance positive behavior in this regard. The Outputs are:

1. Awareness raised on RH/FP in communities
2. Health communication and media initiatives for RH/FP are implemented
3. Communication and media initiatives and awareness raising programs are institutionalized

Notably, the Indicators for the Result are interestingly demographic and quantitative:

1. Desired total fertility rate
2. Number of new acceptors of modern family planning method
3. Percentage of increase in CYP
4. Median-birth spacing intervals

The indicators for the Output are more qualitative:

1. Percentage of improvement in the attitudes of the target audience towards RH/FP
2. Number of effective community committees focusing on raising awareness on RH/FP
3. Number of institutions implementing awareness programs in the area of family planning
4. Number of programs/awareness campaigns implemented at the national level

The significant Interventions are:

1. Support the convention of partnerships with national institutions to increase demand for RH/FP services. Implement and institutionalize awareness and communication initiatives
2. Strengthen the capacities of health communication and media providers to develop and implement awareness programs and campaigns with relevant national partners and institutions to change community concepts on family planning, which support men's participation and reach schools, universities, mosques, churches, youth communities and local community leaders

The use of communication is vital for the success of a rights-based family planning program. In Jordan, there are still cultural and social barriers affecting the use of RH/FP services that communication initiatives can tackle. The interventions in the NFPS are positive and also positively include men as indicated in the ICPD. They also positively include partnerships with local communities as the ICPD encourages. Many times, a community member of friend who is knowledgeable about FP access can make the difference for an individual seeking such services.

The ICPD says that multichannel approaches like those in the NFPS are usually more effective than any single communication channel, when it states in Section 11.13, "Effective communication activities include a range of communication channels, from the most intimate levels of interpersonal communication to formal school curricula….All these channels of communication have an important role to play in promoting an understanding of the interrelationships between population and sustainable development…..Parliamentarians, teachers, religious and other community leaders, traditional healers, health professionals, parents and older relatives are influential in forming public opinion and should be consulted during the

preparation of information, education and communication activities. The media also offer many potentially powerful role models."

There are two main problems with the NFPS: the whole effort laid out above is for the ends of reaching the total fertility rate and getting more couples on contraception, and secondly, the provisions are very general. They all call for awareness on RH/FP issues, but they do not specify which issues. A general framework provides no tangible no guidance or accountability measures for the resulting actions. Further, there are no real goals to guide the communication initiative besides the potentially harmful numerical goals that are currently present.

The effective use of communication is a necessary condition for attitudinal and behavioral change and thus sustainable family planning development. It is best to review ICPD goals as well as quantitative literature from Jordan to find the gaps that communication efforts can be harnessed to fill. The NFPS should begin by establishing that the mission of communication is to help Jordanians make sexual and reproductive decisions freely, responsibly and in an informed manner.

Hence, when the NFPS discusses the improvement of attitudes and behaviors, or the awareness of FP issues, it will be moving towards a goal of empowerment and knowledge, and not numbers. The increase of public knowledge and commitment to these principles will create a climate conducive to responsible and informed rights-based decisions. Further, it can pave the way for open public discourse and thereby potentially strong political commitment and popular support for action at all levels. If the NFPS maintains the numerical goals as the ultimate ends of the communication initiatives, it may lead to communication campaigns that place the responsibility for population growth on women. A rights approach is gender-responsive and

refrains from ‘victim-blaming’ — in this case, blaming the women themselves for non-use of contraception. Instead, the government should use a model of the following objectives:

(a) Raise awareness through public education campaigns on priority issues as: safe motherhood, reproductive health and rights, maternal and child health and family planning, violence against women, male responsibility, gender equality, sexually transmitted diseases, responsible sexual behavior;

(b) Increase awareness, positive attitudes towards, knowledge, understanding and commitment at all levels of society so that families, couples, individuals, community leaders, non-governmental organizations and policy makers, appreciate the significance and relevance of reproductive rights -related issues, and specifically the right of couples and individuals to exercise their basic right to decide freely and responsibly on the number and spacing of their children, and to have the information, education and means to do so.

In short, the NFPS must tailor communication efforts towards increasing full knowledge of the listed family planning issues and individual’s rights in order to foster positive attitudes towards taking control of one’s reproductive health. National efforts should use data on geographic or socioeconomic unmet need to target women with unmet needs and help them through education and awareness.

My above recommended goals also include violence against women and gender equality. Communications could also help increase positive attitudes towards women empowerment and help translate these attitudes into positive actions that help women fully realize their reproductive rights. A review of literature, laws and news from Jordan demonstrate that these goals are vital components of the realization of female empowerment in Jordan. The communications absolutely must confront deeply ingrained beliefs that drive discriminatory personal status codes

and harmful behaviors against women. I recommend that the HPC include the improvement of gender relations and the empowerment of women as an Intermediate Result 4**.** A necessary component of this goal is national communications efforts. The NFPS should call for partnerships with women's issue-organizations and female leaders in order to move beyond the empowerment of women at the grass-roots level, to a focus on helping them join broader forces to assert the legitimacy of the reproductive rights approach and female empowerment at the national level. People on the ground recognize how powerful media campaigns can be to improve gender relations, especially when they are done in coordination with organized and aware women.

For instance, the NFPS can specifically set guidelines for the creation of an awareness campaign stigmatizing violence against women, rather than stigmatizing sexual behavior. Jordanian attorney and human rights activist Asma Khader told Public Radio International, "the new generation is a victim of the wrong messages that were distributed through the media — social media — even through the public speeches by community leaders and religious leaders and even in schools. So, if they hear 'it's a shame your sister is doing this, doing that,' why bother? Have her stay at home. They have the patriarchal power to say no. So, they can create problems." Calls for governments to take all steps to end violence against women are also seen over fifteen times throughout the ICPD Programme of Action.

The NFPS already utilizes local community organizations and religious leaders. These partnerships to further the integration of rights principles into society and the reproductive health arena. Local cultural and religious leaders should move away from what seems to be the focus on the restraints created by the Arabic culture or Islamic religion, and instead identify and communicate the positive power and strengths that the culture and religion have to bring about

change. This adds moral authority to human rights principles and weight to the violation of human rights. ICPD Section 11.13 confirms, "Schools and religious institutions, taking into account their values and teachings, may be important vehicles in all countries for instilling gender and racial sensitivity, respect, tolerance and equity, family responsibility and other important attitudes at all ages."

The ICPD was pivotal in placing the success of development on the equal partnerships between men and women. This paper has explained the importance for women to know their reproductive rights, to have rights based laws put in place, and to have female activists, but these are not sufficient for the true success of the FP program. Men, especially in patriarchal societies like that of Jordan, must also gain the same understanding of women's reproductive rights and change their behavior and attitudes to align with the rights principles.

When this happens, men will not justify violations of women's rights on the basis of culture, but they will recognize them as violations that must be confronted. This is necessary for the true and full implementation of these rights. The ICPD pushed this idea in a Section on male responsibilities and participation. As a basis for action, the **Programme of Action** states, "Changes in both men's and women's knowledge, attitudes and behavior are necessary conditions for achieving the harmonious partnership of men and women. Men play a key role in bringing about gender equality since.. men exercise preponderant power in nearly every sphere of life. It is essential to improve communication between men and women on issues of sexuality and reproductive health, and the understanding of their joint responsibilities, so that men and women are equal partners in public and private life." The NFPS must be specific in regard to men to uphold the ideas in the ICPD. Men in Jordan may see rh/fp issues as an area that is exclusively their partner's responsibility and fail to consciously engage in decisions or

proper support. On the other hand, they may engage in negatively by preventing women from family planning behaviors and resources in ways that negatively affects women's sexual and reproductive health. **Programme of Action** Section 7.37 recognizes this as well, stating "Support should be given to integral sexual education and services for young people…. that stress responsibility of males for their own sexual health and fertility and that help them exercise those responsibilities. Educational efforts should …. reach adults, in particular men, through non-formal education and a variety of community-based efforts."

The NFPS's Communication efforts should address men as supportive partners in egalitarian decisions by: (a) increasing awareness and understanding of men about women's sexual and reproductive health needs; and (b) promoting a process of decision-making that is mutually respectful including of women's choices and decisions. This approach can enhance the positive influence that men can have on women's sexual and reproductive health — one that is supportive and respectful of women's choices. This is a vital step for governments to take in their rights-based goals.

Finally, my first recommendation included policy-makers and government officials in the target audience. Before turning communication initiatives to the public, we need to begin with policy makers and hold them accountable for the rights of the people, and more specifically and urgently, of the women. In recent news that even furthers the points raised in this paper and the notion that Jordan did not uphold ICPD commitments, King Abdullah just initiated a 2016-2025 Comprehensive National Plan for Human Rights. Less than a page is dedicated to women's rights, and there is no mention of violence against women (though there is a focus on combating violence against children) or reproductive rights. In an ideal world, UN and women's health advocates should meet with policy makers, or, as

recommended in this paper be involved in the policy creation, and ensure that the people around the table have an:

- Increased awareness and understanding of key concepts related to full, free, and informed choice
- Increased ability to consider the client perspective when designing and providing services
- Increased awareness and understanding of factors at the policy, service delivery, community, and individual levels that both support and obstruct full, free, and informed contraceptive choice
- Increased awareness about program vulnerabilities and safeguards to protect full, free, and informed choice
- Increased understanding of the importance of contraceptive choice
- Better attitudes towards good practices that programs can sustain and build upon to ensure that clients can exercise full, free, and informed choice.

Section 7. Monitoring and Evaluation:

Accountability is a key human rights principle and is vital to the **Quality criterion** in the UN General Comment. The NFPS must hold itself accountable for bringing its program in line with the ICPD standards in order to ensure the agency and choices of individuals are respected and fulfilled. To do this, it has to establish monitoring mechanisms and long term follow up mechanisms. It requires a well-designed health management information system and data disaggregated by sex, age, wealth quintile and geographic location, level of education. To be consistent with reproductive rights, all of the suggested policies and provisions mentioned in this paper should be done in tandem with mechanisms for monitoring and evaluation. Furthermore,

monitoring mechanisms must be developed for detecting, preventing and controlling abuses by family-planning managers and providers (ICPD). The current NFPS fails to include these accountability measures and its monitoring process is implemented to achieve the purpose for which the NFPS was developed - demographic opportunity. The HPC will only monitor the indicators of the outputs and measure progress.

Section 8. Gender Equality:

The NFPS fails to consider gender relations as a non-distinguishable aspect of family planning. The ICPD Programme of Action called for gender equality and the empowerment of women both as highly important ends in themselves and as key to improving the quality of life for everyone. It acknowledges that the full participation and partnership of women and men is required in reproductive life, "advancing gender equality, ending violence against women and ensuring women's ability to control their own fertility are cornerstones of population and development policies." Indeed, a women's health focus must consider non-reproductive concerns like violence against women and societal autonomy in order to not solely represent women as potential reproducers.

NFPS-makers must take steps to assess any threats women may face to their reproductive health and wellbeing due to their lack of power and influence. They must assess if women receive less formal education than men or if, and which, power relations impede women's attainment of healthy and fulfilling lives. This requires an evaluation of the educational opportunities available to women, their ease of access into the workplace, and civil codes that discriminate against them.

Achieving real and sustainable change requires the NFPS to take actions to improve women's access to secure livelihoods and economic resources, alleviate sole responsibilities with

housework, remove impediments to their participation in public life, and raise social awareness through mass communication, as discussed earlier. Improving the status of women will enhance their decision-making capacity in all spheres of their lives, and particularly in the area of sexuality and reproduction. This, in turn, is essential for the long- term success of population programmes. Population and development programmes are more effective when steps have simultaneously been taken to improve the status of women.

The Jordanian government can also reach its development goals by investing in its women. For instance, in terms of employment, Jordan has one of the world's lowest rates of women's workforce participation at only 13.2%. Among Jordanians with advanced degrees, two-thirds of those without jobs are women — despite 55 percent of graduates over the past decade being female, according to the department of statistics.[38] A case study in Senegal found that female wage employment has a significant, negative impact on fertility rates. The Senegal study also found that this relationship was highest among illiterate women, suggesting employment is even more powerful for non-educated women. Indeed, enhancing women's labor force participation is seen as a way to improve their well-being and that of their children as well as promote their empowerment.[39] These findings have implications for Jordan as it adopts a NFPS to reduce rapid population growth. Its NFPS focuses on increasing the use of modern contraceptive methods, but the creation of employment opportunities for women is an additional key to Jordan's goals, and to the realization of women's autonomy.

[38] According to 2017 USAID data

[39] Ahmed, Saifuddin, et al. "Economic status, education and empowerment: implications for maternal health service utilization in developing countries." *PloS one* 5.6 (2010): e11190.

Women's employment is also desirable on intrinsic and instrumental grounds. Work constitutes an important element of women's well-being and empowerment. Empirical studies indicate that women who access economic resources invest in their children's education and nutrition and have lower fertility rates. In fact, women's employment has been found to be a robust factor in reducing fertility, child mortality and gender bias in mortality. Thus, Jordan can improve its health and economic sectors, while realizing the rights of its female citizens, through the addition of an **Intermediate Result 4 on Improved Gender Equality.**

The Programme of Action recommends governments take steps to empower women and raise their status in society as part of the actions they should take to address population growth. These goals and recommendations are missing in the NFPS, likely because its goal was to control population growth, and thus it is behind the international shift from viewing women as passive beneficiaries to rights holders. Intermediate Result 4 should include the following provisions:

- Establish mechanisms for women's equal participation and equitable representation at all levels of the political process and public life. (Women in parliament recently succeeded in eliminating policies that allow rapists to take their rape victims as wives, in just one example of the revolutionary steps women can take when they have power.)
- Promote women's education, skill development and employment
- Encourage policies that eliminate all practices that discriminate against women including those affecting control to property or credit.
- Strictly enforce laws to ensure that marriage is entered into only with the free and full consent of the intending spouses. Strictly enforce laws concerning the minimum legal age of consent and the minimum age at marriage.

- Eliminate all forms of exploitation, abuse, harassment and violence against women, adolescents and girls.
- Enact laws that enable employees of both sexes to harmonize their family and work responsibility. (Jordan's current maternity leave is 10 weeks, and it does not have a paternity leave, making it one of the worst countries in the world in this area.)
- Jordan should also eliminate gender inequality in employment by closing gender gaps in earnings and reducing occupational segregation. Governments and employers are urged to eliminate gender discrimination in hiring, wages, benefits, training and job security with a view to eliminating gender-based disparities in income.

Section 9. Conclusion:

Access to contraceptive services and information about sexual health and family planning have been powerfully described as a reproductive right, central to gender equality and women's empowerment. The lives and well-being of millions of women and adolescent girls depend on whether they have what they need to exercise choice about when to have children, how many to have, and at what intervals. Access to the appropriate information and services, including to contraceptive choices, is also one of the most powerful ways to enable women and girls to achieve their fullest potential.

The ICPD Programme of Action fundamentally shifted the global conception of women as passive beneficiaries to women as rights holders. A rights-based approach emphasizes empowering citizens to make their own reproductive decisions, and in this way, can shape humane and effective reproductive health policies and programs. In theory, all human rights, including reproductive rights, are universal, inalienable, indivisible, and interdependent. These rights call upon nations not to impose religious, cultural or ethnic traditions that hinder women's ability to realize their full potential.

In practicality, the Jordanian government can use a rights-based framework to enact programs and policies that are in touch with the needs of its people, thereby helping to decrease unwanted pregnancies, increase birth spacing, and potentially decrease the desired fertility of women by increasing their equal involvement in society. The government can consider the relationship between population growth and economic development as an added benefit of its strategy, but placing this relationship as the key objective of its family planning program runs a high risk of being harmful, coercive, and ineffective to both its own goals and to its people reproductive and sexual health goals. Human rights advocates and public health advocates can

best achieve their common goal by taking advantage of the complementary strengths of their fields to build rights-based family planning strategies that are both compassionate and effective.

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