

**United Nations (UN) and Partners
Humanitarian Response for Syrian Refugees in Jordan**

**Inter-Agency Task Force (IATF)
Health Sector Gender Analysis**

Final Report

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Health Sector Gender Analysis Report
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Abbreviations

ANC	Ante Natal Care
C/S	Caesarian Section
CHVs	Chronic Hyperventilation Syndrome
FGDs	Focus Group Discussions
FP	Family Planning
GBV	Gender Based Violence
GenCap	Gender Capacity
HCT	Humanitarian Country Team
HIS	Health Information System
IASC	Inter-Agency Standing Committee
IATF	Inter-Agency Task Force
IEC	Information, Education and Communication
IMC	International Medical Corps
JHAS	Jordan Health Aid Society international
KIIs	Key Informant Interviews
KPIs	Key Performance Indicators
M&E	Monitoring and Evaluation
MISP	Minimum Initial Service Package
MoH	Ministry of Health
Mol	Ministry of Interior
NFIs	Non Food Items
NGO	Non-Governmental Organization
NVDs	Normal Vaginal Deliveries
PHC	Primary Health Care
PNC	Post Natal Care
RH	Reproductive Health
SGBV	Sexual and Gender Based Violence
SGFPN	Sector Gender Focal Points Network
STIs	Sexually Transmitted Infections
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAF	Vulnerability Assessment Framework
WGBM	Women, Girls, Boys and Men

Executive Summary

Background: Syrian refugees have been seeking safety, shelter, and dignity in Jordan since the start of the Syrian crisis in 2011. As of April 2016, there are 638,633 registered Syrian refugees residing in the kingdom, with roughly 520,000 registered outside of camps. Without an end to the conflict in sight, the integration of gender dimensions into humanitarian health services - delivered under three overarching areas of Community Care, Primary Care and Secondary & Tertiary Care - remains an imperative.

Purpose and Objectives of the Gender Analysis: The health sector gender analysis was undertaken to identify the different needs of women, girls, boys and men and potential barriers that they face and to ensure that they can access health services equally. The specific objectives of the gender analysis were to analyze: (i) Refugee population demographics; (ii) Biological factors of refugee women and men against health-related dimensions; (iii) Sociocultural factors affecting women and men against health-related dimensions; (iv) Access to and control over resources by women and men against health-related dimensions; and (v) Review gender Key Performance Indicators (KPIs) in the Health Sector M&E System.

Gender Analysis Methodology: A mixed methods approach characterized by the deployment of quantitative and qualitative methods was used to answer gender analysis questions. Data was collected using different methods including desk review (extracting both quantitative and qualitative information), Key Informant Interviews (KIIs), and Focus group discussion (FGDs). Qualitative data from KIIs and FGDs was categorised by gender analysis objectives and trends in each objective analysed by grouping similar responses on each gender dimension.

Gender Dimensions of Health Risk Factors and Vulnerability: The gender analysis found that at the primary health care level, females seek health services under reproductive health (RH) more than males. While women seek antenatal care services and family planning, men under report sexually transmitted infections (STIs). However, demand for access to health services related to chronic medical conditions is relatively equal for both males and females. For instance, primary follow up and advanced healthcare referral for breast/ovarian cancers and prostate cancer are regularly sought by both females and males.

At the secondary health care level, and in view of limited resources, referral is prioritized to emergency cases starting with women referred for obstetric emergencies. There is equal referral priority to Girls, Boys, Women and Men in (i) need for lifesaving health services and (ii) need for limb saving or sight saving and other services.

Gender considerations affect both the patient and health service provider and are related to socioeconomic status, cultural factors and education. Health service providers' inability to respond to health problems in a sensitive manner can affect service use. On reproductive health matters, female patients prefer female physicians.

Other major sociocultural aspects influencing utilization and needs for health services by Syrian refugees in Jordan include: Early pregnancy; Limitations on women's movement and consequent poor compliance to ante natal care (ANC); Under reporting of male genito-urinal related conditions, which exposes women to STIs; Compromised access to quality hygiene services by females; and Adult males who are more affected with injuries related to armed conflicts or physically demanding jobs. Similarly, bloody diarrhea secondary to food poisoning and colon cancer complications are more expressed in males than females (information from key informants/clinic practitioners).

The gender analysis found that females are usually not the decision makers when it comes to breastfeeding. To have more information regarding breastfeeding, a barrier analysis need to be conducted. Other factors that limit women's access to primary health care services are transportation costs and child minding. Sexual and Gender-Based Violence (SGBV) is stigmatizing, under reported and usually the offender is a relative. Most SGBV survivors are unaware of protection services.

Gender Dimensions of Access and Use of Health Services: Women's ability to bear children increases their access to and utilization of health services for RH and newborn and young children's healthcare. As a result, they are more likely to be diagnosed with STIs. Nonetheless, majority of pregnant women in both camp and urban settings said that even if transportation cost was secured, movement is difficult in latter gestational weeks.

Although eligibility for advanced healthcare referral relates to beneficiaries' legal documentation in terms of UNHCR and Jordanian Ministry of Interior; patients with obstetric emergencies or high risk pregnancies regardless of the vulnerability status; SGBV survivors, mental health and malnourished children are prioritized for treatment.

The gender analysis noted that marriage can prevent women - especially young women - from accessing RH information and they instead rely more on information conveyed by their mothers and siblings. The health system is still lacking specific reproductive health messages with sensitivity to the stigma attached to STIs.

Costs associated with health conditions under consideration influence the choices made by families, which usually are in favor of secure health needs of male children and adolescents over females. In both camp and urban settings, refugees are obliged to either utilize whatever support is offered by NGO clinics or otherwise pay for MoH or private services. Compromised immunity and consequent vulnerability to other infections is the natural complication of continual deprioritization of health needs.

Gender Dimensions of Health Seeking Behavior: The gender analysis established that due to costs associated with health care, Syrian refugees can be compelled to seek healthcare for a given condition after they start showing symptoms. For the same reason some females indicated lack of commitment to seek antenatal care. Likewise, fear of stigma and other social consequences for STIs perpetuates transmission in the Syrian refugee population in Jordan. Male resistance to condom use and women's inability to negotiate safer sex are key factors in STI transmission. In addition, stigma of being a "refugee" has been reported by refugee women and men approaching MoH facilities. Specifically for RH, pregnant women are often criticized for getting pregnant within current "unstable war condition".

Gender Dimensions of Health and Socio-Economic Outcomes: Some health conditions are chronic and debilitating, as such, entire families (and especially women) are significantly burdened by the need to care for affected individuals. Family members are differently affected by the consequences of living with or supporting someone affected by a chronic health condition or disability. Moreover, the gender analysis noted that mothers and older sisters are the first-line family members to be infected with health conditions transmitted via: fecal matter of young children, live infections in children, microbial contamination of raw food and caring for disabled members of the family.

Undergoing treatment for some health conditions has different economic effects on men and women. Economic insecurities have so far lead households, especially mothers, into adopting different coping practices to mitigate ever increasing financial burdens; that is, reduction in food consumption,

withdrawing children from school and taking on informal, exploitative or dangerous employment. Male and female youth find themselves equally burdened by family obligations beyond their ability to manage, both financially and psychologically. Poverty and desire to satisfy basic socio-economic needs increases adolescent's vulnerability to drop out of schools and eventually, exacerbating illiteracy among the growing Syrian refugee population in Jordan. The combination of illiteracy and economic insecurity (poverty) creates an unsafe environment generally for Syrian refugees in Jordan, and particularly for adolescents/youth.

Conclusions: Overuse and misuse of male gender power privilege is a factor limiting appropriate health seeking practices. Moreover, health ignorance and illiteracy among different refugee population groups has further victimized women, young boys and girls - in particular - as all are dependents of the male head of household and thus, are obliged to abide by rules endorsed by male providers of the household.

In primary health care, females seek health services under reproductive health (RH) more than males. Male resistance to condom use and women's inability to negotiate safer sex are key factors in STI transmission. While men under report STIs, women get checked and treated in the process of seeking antenatal care and family planning services. However, movement is difficult for pregnant women in latter gestational weeks.

Food poisoning and colon cancer complications are more expressed in males than females. Meanwhile, primary follow up and advanced healthcare referral for breast/ovarian cancers and prostate cancer are regularly sought by both females and males. At secondary health care level, patients with obstetric emergencies or high risk pregnancies regardless of the vulnerability status; SGBV survivors, mental health and malnourished children are prioritized for treatment.

Sociocultural aspects influence utilization of health services. On reproductive health matters, female patients prefer female physicians - health service providers' inability to respond to this issue in a sensitive manner can affect service use. Other sociocultural aspects influencing utilization of health services include, for example, Early pregnancy; Limitations on women's movement which result in poor compliance to antenatal care; and Compromised access to quality hygiene services by females.

SGBV, usually perpetuated by close relatives, is stigmatizing, under reported and most women are unaware of protection services. Among basic concerns limiting provision of quality SGBV survivors are having such services linked to healthcare facilities instead of having "all social" community based services easily approached by all Women, Girls and adolescent boys. Lack of such none-stigmatizing services renders potential victims unable to identify abuse, report once it happens and unaware of reporting consequences.

Young married women do not readily access RH information and services and instead rely on information conveyed by their mothers and siblings. The health system is still lacking specific reproductive health messages with sensitivity to the stigma attached to STIs. Due to costs associated with treatment of some health conditions, choices made by families usually are in favor of the health needs of male children and adolescents over females. As such, compromised immunity and consequent vulnerability to other infections is the natural complication.

Family members are differently affected by the consequences of living with a family member affected by a chronic health condition or disability. The burden of caring for the affected family members rests, especially on women - mothers and older sisters.

The combination of illiteracy and economic insecurity (poverty) creates an unsafe environment generally for Syrian refugees in Jordan. Due to economic insecurities households take drastic measures such as reducing amount of food consumed, withdrawing children from school and taking on informal, exploitative or dangerous employment. Some male and female youth have dropped out schools due to Poverty.

Recommendations: Health service providers present the following recommendations for consideration.

Community mobilization and participation

- 1) Cultural practices which still resist gender equality and subjugate women are persisting among Syrian refugees. As such, health sector service providers should identify and address cultural/traditional practices that perpetuate gender inequality and limit health seeking practices.
- 2) Support community-based health promotion activities. Specific emphasis should be on importance of following up with health services (e.g. for young married women who do not readily access health services, food poisoning which is more expressed in males than females) to avoid preventable complications and/or facilitate timely referral for advanced healthcare services. This should include IEC materials with culturally appropriate information for all population groups. Health messages tackling sensitive issues (SGBV and STI) should be provided by all practitioners, not only RH practitioners.
- 3) Health service providers should find ways of encouraging men to participate in RH and family planning services together with their spouses so they can equally be checked and treated for STIs, and look up for opportunities to scale up outreach capacities to support primary healthcare at the community level.
- 4) Support pregnant women in late gestational phases' to ensure physical accessibility to healthcare.
- 5) Gradually work on spreading social awareness to decrease age gap in married couples.
 - Clarify how an abused female or SGBV survivor can seek healthcare confidentially and that further protection will be secured after such incidents are reported (even if the offender is a husband, sibling or a relative). Female protection and dignity will be regarded a priority, thus, none-stigmatizing intervention shall take place for each case individually.
- 6) Gradually work on spreading messages related to gender equity in terms of caring for children, elderly, disabled and other dependents.
- 7) Steps should be taken to protect the dignity of SGBV survivors and to minimize stigma associated with their seeking SGBV services by assuring their confidentiality and security/wellbeing. E.g. by creating an info-line service for consultation by GBV survivors, in a way that creates confidence for clients as their identity will be kept anonymous. This should be coordinated with the Protection Sector.
- 8) Integrate hygiene promotion and distribution of hygiene kits into health interventions to advocate better hygiene practices and its link to health status promotion.

Provision of health services

- 9) To promote utilization of health services by both female and male patients, health service providers' should identify and respond to their gender specific needs. In addition, other sociocultural aspects influencing utilization of health services should be addressed including early

pregnancy, limitations on women's movement, compromised access to quality hygiene services by females.

- 10) Actively engage female healthcare practitioners equally and at all levels in the design and management of health service delivery.
- 11) Ensure ongoing inter-agency coordinated health service delivery strategies that address the health needs of women, girls, boys and men. For instance: Ensure that Minimum Initial Service Packages (MISP) of reproductive health services is available in all accessible healthcare static and mobile facilities so that women and men and adolescent girls and boys have access to priority sexual and reproductive health services in the earliest days and weeks of new emergencies.
- 12) Ensure continual updating to RH services' map, so that women and men and adolescent girls and boys have access to comprehensive sexual and reproductive health services, including GBV-related services, for non-emergency conditions.
- 13) Ensure privacy for health consultations, examinations and care.
- 14) From health perspective, promote awareness for men and women on health risks associated:
 - Early marriage
 - Early weaning of children or "no-breastfeeding at all". Successive pregnancies (Less than two years between pregnancies)
 - Successive Caesarian sections
 - Not seeking professional healthcare to treat STI
 - Risks of Sexual intercourse in the presence of an active STI
- 15) Advocate importance of reproductive health seeking if needed among adolescent (unmarried) girls and boys.
- 16) Identify culturally appropriate, none stigmatizing locations for social and psychological support to women, girls, boys and men (safe zones where different social activities can take place and not only for SGBV survivors).
 - Through focus group discussions within those centers, SGBV survivors are to be encouraged to specify the social help they need so that appropriate interventions can be designed in ad hoc.
- 17) The health needs and challenges of female as well as male children and adolescents should be identified and addressed equally by health service providers.

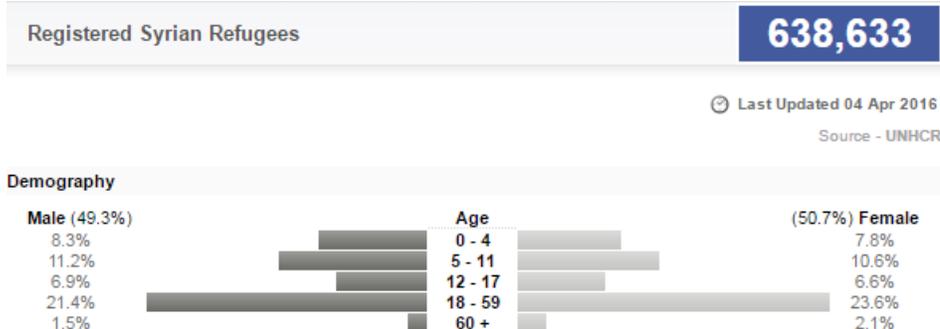
Inter-sector coordination

- 18) Eligibility criteria for receiving different types of humanitarian assistance, whether health or non-health related so that vulnerable population groups won't find themselves obliged to deprioritize health seeking and spare money to secure other basic needs.
- 19) The national health sector must maintain strong coordination with MoH representatives in each directorate to continually address challenges manifested by refugee population groups accessing MoH affiliated PHCs.
- 20) To address health related economic needs of Syrian refugees, livelihoods opportunities should be extended to them.

1. Background

Since the start of the unrest in Syria in 2011, Syrian refugees have been seeking safety, shelter, and dignity in Jordan. While the larger waves of entering refugees have subsided, a few dozen Syrians enter Jordan daily from the border. As of April 2016, there are 638,633 registered Syrian refugees residing in the kingdom, with roughly 520,000 registered outside of camps.

Figure 1: Registered Syrian Refugees (as on 4th April 2016)



Approximately 23.6 % of all Syrian refugees are women over the age of 18 and 53% are children. 16 % of the Population is under the age of five.

In November 2014 the Jordanian government reversed its previous policy of providing free medical treatment to Syrian refugees, in an attempt to cope with the burden on its healthcare system since the Syrian crisis started. As a result, Syrians have to pay in cash for medical care, which is putting even more pressure on their financial situation. Since April 2016 partial ANC, FP and PNC is free of charge for Syrian refugees.

Syrians who have a valid MOI card can use Ministry of Health (MOH) services at a subsidised rate (equal to the non-insured Jordanian rate), but many still cannot afford this lower rate. Refugees who do not have a valid UNHCR registration in combination with a valid MOI card are expected to pay foreigner rates, which are 4 or 5 times higher than the subsidised rate.

In early 2015, the government and UNHCR began a re-verification exercise for the roughly 520,000 registered refugees. Of these, roughly 350,000 urban refugees have applied for and received Ministry of Interior identification cards. These cards allow refugees' access to public services such as health and education services.

Male refugees from Syria but also men in Jordan play a key role in decisions making. In that sense male involvement can be a more effective strategy than including women alone. Men can play a key role in determining women's access to critical health services, including antenatal and intra partum care through such mechanisms as determining the availability of transport for women to reach a clinic and decisions that affect whether a woman can be successfully referred to a higher-level facility if required.

IMC Health Access assessment 2014 showed a major discrepancy between men's and women's comments regarding decisions to seek care was that men placed much more emphasis on cost as a factor in where they sought medical attention.

In order to make informed decisions, men need to know why ANC and skilled birth attendance are important, the risks associated with pregnancy and childbirth, how to prepare for childbirth and how to recognize signs of complications. Involving men in awareness sessions led by male facilitators can help to overcome the gender barrier. In this program Medair will use female and male CHVs to target women, men, boys and girls.

An equity-based approach identifies those who are the most vulnerable and hard to reach, consequently those with the highest burden of disease and at risk. As such, targeting key PHC services for these populations is a cost effective strategy to avert avoidable illnesses and death. This can be done through community health projects and programs which have a long history of improving access to and coverage of communities with basic health services.

Having strong community health programs is a cost saving practice because it promotes preventative care, which in turn reduces the likelihood for costly reactive treatments for communicable and non-communicable diseases. Linking communities to primary and reproductive health services is a cost effective strategy to avert avoidable illnesses and death. This can be done through evidence-based community health projects and programs, which work towards improving access to and coverage of communities with basic health services.

In emergency situations, the health of women, girls, boys and men is affected differently. Social, cultural and biological factors increase the risks faced by women and particularly girls. Conflict and the resulting forced displacement create an environment that increases the vulnerability of women and girls. Women and girls remain refugees or displaced for longer periods of time without status and are more vulnerable at every stage of displacement compared to men.

During the Syrian conflict gender and violence, gender and age and gendered division of labor have consistently emerged as determinants of women`s health vulnerabilities. Life in Jordan is for Syrian refugees conducive to gender-based and sexual violence. Gender inequality is shown as men are granted nationality for their wives and children. Women often required having a male guardian to conduct health access for their children and make decisions.

WHO has reported in the past that the Eastern Mediterranean region had a high prevalence of intimate partner violence with 37% of women suffering from intimate partner violence in the region. The Syrian crisis has only further exacerbated this problem.

Young Syrian girls experience double marginalization due to both age and gender. This intersection is most easily visible through the rising numbers of early ages at marriage among Syrian refugees. Early marriage is used as a coping strategy for young girls in abusive home environments and poor living conditions. Sexual exploitation and violence also contributes to early marriage. Families marry off their daughters with the idea that they are providing protection for young girls, continuing family traditions, alleviating poverty or helping daughters escape the environment. In general, girls under 18 are more likely to experience obstetric and neonatal complications and death.

For the health sector, two sector gender focal points have been appointed since August 2014. The health sector has become more gender responsive with a continued commitment to mainstreaming gender in the health sector related interventions and to ensure that humanitarian responses do not

further perpetuate gender inequalities through the distribution of goods and service provision. The gender marker was applied to Emergency response fund call for proposals and health agencies received Gender marker training beginning 2015. Focal points received Gender in Humanitarian aid training. The Sector Gender Focal Points are supported by the IASC Senior Gender Capacity Advisor to IATF and HCT.

2. Taxonomy of the Health Sector Services

Humanitarian health services are being delivered under three overarching areas of (i) Community Care; (ii) Primary Care; and (iii) Secondary & Tertiary Care (see *Appendix 2* for details).

3. Purpose and Objectives of Gender Analysis

3.1 Purpose

The purpose of the health sector gender analysis was to take account of the different needs of women, girls, boys and men; identify the potential barriers that they may face and to ensure that they can access health services equally. This helps to ensure that response plans objectives are relevant and grounded in the reality of refugee needs. Gender analysis also identified issues arising from impacts of existing programs, gaps between men and women in participation and representation, the gaps in capacity and awareness, and proposed solutions to redress inequality.

3.2 Objectives

The main objective of the health sector gender analysis was to assess gender related dimensions (Biological factors, Sociocultural factors, Access to and control over resources, etc.) against health-related dimensions (Risk Factors and Vulnerability, Access and Use of Health Services, Health-seeking Behavior, and Experiences in health care settings, etc.). This assessment was to generate gender related data/information for sector program design, implementation, monitoring and evaluation.

The specific objectives of the gender analysis were to analyze¹:

1. Refugee population demographics.
2. Biological factors² of refugee women and men against health-related dimensions.
3. Sociocultural factors³ affecting women and men against health-related dimensions.
4. Access to and control over resources⁴ by women and men against health-related dimensions.
5. Review gender Key Performance Indicators (KPIs) in the Health Sector M&E System.

¹ Each specific gender dimension against all identified health-related dimensions.

² As a gender dimension

³ Ibid

⁴ Ibid

4. Gender Analysis Methodology

A mixed methods approach characterized by the deployment of quantitative and qualitative methods was used to answer gender analysis questions. Data was collected using different methods including desk review (extracting both quantitative and qualitative information), key informant interviews (KIIs), and focus group discussion (FGDs).

4.1 Approach and Data Sources

Gender Focal Points worked with the health sector partners to select sites for the gender analysis based on (a) Classification of health Services (Community care, Primary care and Secondary & tertiary care); (b) Refugee camps and other sites where Syrian refugees are residing; (c) Health programs and projects that could provide richer data for examination of gender-related dimensions against health related dimensions. The gender analysis framework is presented in *Appendix 1*. Table 1 below presents the methodology used in the examination of each gender analysis objective.

Table 1: Gender Analysis Methodology and Data Source by Objective

Objectives	Methodology	Data/Information Source
1. Analyze Refugee population demographics.	Literature review	Health sector project documents, researched materials and other documentations that provide information on the demographics of the refugee population.
	Health Service Portal Review	UNHCR, UNICEF, MEDAIR, JHAS, etc. Portal review.
2. Biological factors of refugee women and men against health-related dimensions.	Literature Review	Health sector project documents, researched materials and other documentations that document current water and sanitation practices of the refugee population.
	Key informant interviews (KII)	Health Sector partners and Actors, project/field staff
	Focus Group Discussion (FGD)	Refugees
3. Sociocultural factors affecting women and men against health-related dimensions.	Literature Review	Health sector project documents, researched materials and other documentations that shed light on social and cultural relations of Refugees on health.
	KII	Health Sector partners and Actors, project/field staff
	FGD	Refugees
4. Access to and control over resources by women and men against health-related dimensions.	Literature Review;	
	KII	Health Sector partners and Actors, project/field staff
	FGD	Refugees
5. Review Gender Key Performance Indicators in the Health Sector M&E System.	Review of gender KPIs in the M&E System/Portal.	M&E System review, UNHCR, MEDAIR, JHAS, UNICEF, etc. Portal review. M&E Staff
	Plenary /Workshop Session	Health Sector project/field staff

4.2 Data Analysis

Both qualitative and quantitative research methods were used to analyse the data. Qualitative data from KIIs and FGDs was categorised at gender analysis objective level with analysis of trends in each objective - by grouping similar responses on each gender dimension. The focus group data was also reviewed against type of respondent by age and gender. Quantitative methods were used to analyse the data with tabulations and frequencies to supplement the qualitative data. Triangulation of these methods was used to confirm validity of data and reliability was ensured through use of standard data collection tools.

5. Findings

5.1 Gender Dimensions of Health Risk Factors and Vulnerability

5.1.1 Biological Factors

The gender analysis found that the need for different health services under reproductive health (RH) are naturally expressed more by females than males. At the primary care level, women seek RH services mainly for antenatal care services and family planning, yet, according to urban and camp 2015 Health Information System (HIS) data, one of the currently manifested gaps in primary healthcare records is the under reporting of sexually transmitted infections (STIs) in men. For reasons related to critical hygienic status of women during menstruation, dermal infections are expressed more in females than males.

In contrast, demand for access to health services related to chronic medical conditions is relatively equal in both males and females. For instance, primary follow up and advanced healthcare referral for breast and ovarian cancers and prostate cancer are naturally sought by both females and males.

At the secondary care level and in view of limited resources, referral is prioritized to emergency cases as follows:

- 1) Women referred for obstetric emergencies.
- 2) Equal referral priority to Girls, Boys, Women and Men (WGBM) in need for Lifesaving health services.
- 3) Equal referral priority to WGBM in need for limb saving or sight saving and other services unless provided, will result in serious permanent disability.

None emergency cases are prioritized as follows:

- 1) Registered vulnerable WGBM with medical conditions that are likely to develop into life-threatening emergencies are prioritized for referral.
- 2) Registered vulnerable WGBM are equally eligible for none-emergency conditions.

5.1.2 Sociocultural Factors

Three aspects of geographical barriers to access to health care services were identified: (i) transport, (ii) regional variations and (iii) rural-urban inequalities. Specific health service provision measures need to be taken to alleviate costs, help reduce travel hurdles or to ensure the proximity of facilities.

Gender affects both the patient and the provider and is related to socioeconomic status, cultural factors and education. The analysis suggests that providers' inability to respond to health problems in a sensitive manner can affect service use. In general, women prefer women physicians, especially concerning reproductive health matters. As a consequence of this, concepts such as gender-based or gender-sensitive care should be integrated into health care strategies and services for Syrian Refugees in Jordan.

The gender analysis identified major sociocultural attributes/concerns influencing WGBM utilization and needs for health services in Jordan:

- 1) Early marriage and consequent pregnancy at a very young age, which:
 - Increased expression of micronutrients deficiencies among women in childbearing age.
 - Increased expression of delivery complications and newborn conditions obliging urgent hospitalization (obstetric and newborn emergencies) among young women.
- 2) Limitations on women's movement in urban settings and consequent poor compliance to ANC.
- 3) Under reporting of male genito-urinal related conditions.
- 4) Compromised access to quality hygiene services by females (in the camp particularly). Main attributes include:
 - Home-care for young children, disabled and elderly
 - Living as extended families sharing one household and associated compromised hygiene
 - Poor skin exposure to sunlight - particularly among women - aggravates outcomes of poor hygiene status.
- 5) Favoring high average number of children in each family influencing RH related complications due to successive child bearing episodes, miscarriages and deliveries.
- 6) Under reporting of male genito-urinal related conditions exposing women to recurrent STIs progressing to advanced complications.

Adult males are more affected with injuries related to armed conflicts or physically demanding jobs. As such, war-wounded patients' rehabilitation, bone fractures and wounds' care are sought more by males than females.

For reasons related to environmental/sociocultural attributes including smoking and street foods consumption, bloody diarrhea secondary to food poisoning⁵ is more expressed in males than females. For the same factors, males suffer colon cancer complications sooner than females, and thus, are diagnosed at an earlier age in comparison to females.

⁵ Ibid

5.1.3 Access to and Control over Resources

The gender analysis established that gender norms of Syrian refugees about interpersonal relationships between women and men might decrease women's access to and control over essential resources.

In consideration of gender aspects of primary healthcare the analysis found that:

- 1) Females are usually not the decision makers when it comes to breastfeeding.
- 2) Transportation cost and matters of leaving children behind or other dependents compromises primary healthcare access.
- 3) For some women, violence is considered "normal" and it is not reported.

Sexual Gender - Based Violence (SGBV) is stigmatizing, under reported and usually the offender is a relative and also because a woman is unaware of protection services after reporting.

Meanwhile, in consideration of gender aspects of secondary health care:

- 1) Females are usually not the decision makers when it comes to hospitalization for non-urgent matters, either for themselves or young children.
- 2) After multiple normal vaginal deliveries (NVDs) women favor c/s deliveries because:
 - They feel their bodies have become weak.
 - Lower pelvic floor muscle strength and noted greater sexual dissatisfaction expressed by their partners.
- 3) Again, some women considered physical violence "normal" and is not reported.

Hospitalization for all RH matters for unmarried girls is stigmatizing, thus, compromising reporting and comprehensive management of rape cases plus neglecting other conditions until evolved into complicated conditions.

5.2 Gender Dimensions of Access and Use of Health Services

5.2.1 Access and Use of health services by Women of Child Bearing Age

The gender analysis found that women's ability to bear children increase their access to and use of health services for Reproductive health conditions.

- 1) Naturally, women seek utilization of health services more than males; not only for RH but also for newborn and young children healthcare. Thus, women are more likely to be diagnosed with STIs.
- 2) One challenge reported by majority of pregnant women in camp and urban settings is that even if transportation cost was secured, movement is difficult in latter gestational weeks.

WGBM have equal access to proper refugee registration with UNHCR; eligibility for advanced healthcare referral relates to beneficiaries' legal documentation in terms of UNHCR and Jordanian Ministry of Interior.

WGBM with Listed medical categories below remain eligible for referral services; correction of documentation status can take place after service is received.

- i. Obstetric emergencies or high risk pregnancies regardless of the vulnerability status
- ii. Sexual and Gender Based Violence Survivors
- iii. Mental health patients
- iv. Malnourished children under 5 years of age and other nutrition services in children

5.2.2 Access to Reproductive Health Information and Services

Marriage can prevent women -especially young women - from accessing RH information and services. In relation to this, the gender analysis established that:

- 1) Women of all ages, if capable of accessing healthcare are eligible to receive whatever primary RH service they need, yet, women in the current context are poorly educated and rely mainly on knowledge conveyed by their mothers and siblings.
 - Women are likely to exhibit abnormal symptoms and manage it symptomatically using traditional remedies without knowing the underlying cause of symptoms.
- 2) The health system is still lacking specific reproductive health messages that tackle sensitivity of STIs to be either communicated or available in a written brochure.
- 3) Socio-cultural Limitations on women's movement particularly and generally high transportation costs in urban settings, thus, poor healthcare seeking behavior (medical conditions evolve and become obliging referral).
- 4) Compromised health seeking behavior in case service provider was male practitioner.
- 5) Males do not fill the gap for their female partners/sisters, etc in terms of household responsibilities in case those women had to be referred to receive hospitalized services (women favor shorter slayings).

5.2.3 Indirect Costs Associated with Health Condition under Consideration

The analysis noted that costs associated with health conditions under consideration influence the choices made by families.

- 1) Families are usually in favor to secure health needs of male children and adolescents over females.
 - In camp settings, women complained that quality medication is not always prescribed by NGO clinics (only basic essential medication).
 - In urban settings families deprioritize none-urgent medical conditions in favor to utilize whatever resources they have to secure basic needs (shelter and NFIs).
- 2) In both camp and urban settings, refugees are obliged to either utilize whatever support is offered by NGO clinics or otherwise pay for MoH or private services.
- 3) Compromised immunity and consequent vulnerability to other infections is the natural complication of continual deprioritization of health needs.

GBV and SGBV remain under-reported not only because of stigma but also because of not knowing what would happen after reporting.

Findings specific to advanced healthcare settings show that:

- 1) Women are more likely to escort their children, referral policy specifies that all patients under age 18 should have a responsible adult as an escort
- 2) Women are more likely to escort disabled and elderly referral policy specifies that escorts in adults will be supported only in cases where the patient needs assistance with activities of daily living which are not able to be provided by hospital staff or the patient is mentally or intellectually impaired.

5.3 Gender Dimensions of Health Seeking Behavior

5.3.1 Health Seeking Behavior of Women and Men

In view of scarce resources and transportation related limitations, WGBM may sometimes be compelled to seek healthcare for a given condition after they start showing symptoms, even if overt symptoms of a given condition take long duration to show.

- 1) Females are not committed to ANC visits.
 - Utilization of supplemental treatment and vaccination services is challenged by this fact.
- 2) Females do seek healthcare for dermal infections.
- 3) Males (unless disabled) do seek healthcare for all acute and chronic conditions.

5.3.2 Impact of Stigma and Discriminatory Consequences of Health Conditions

Fear of stigma and other social consequences may - for some health conditions (i.e. RH - related illnesses) - affect health-seeking behavior for males and females. STI transmission patterns have conformed to the cultural patterns of gender expression in the Syrian refugee population in Jordan, which include:

- Culturally imposed silence about discussing sex.
- Unequal norms about sexual morality, rights, power and educational opportunities between the sexes and changing traditions.

For married Syrian refugee women in Jordan, STI transmission has been largely attributed to male resistance to condom use and women's inability to negotiate safer sex.

The matter of confidentiality is maintained by different healthcare providers, yet, women fear being abandoned by their partners if they ever were diagnosed with an STI or fertility related conditions.

SGBV remains under reported not only because of stigma but also because of not knowing what would happen after reporting.

5.3.3 Experiences of Women and Men in Health Care Settings

Further to reported experiences of men and women at health care settings/ facilities, women's and men's feelings of stigmatization can result in reduced health-seeking behavior.

- 1) Stigma of being a “refugee” has forever been reported by refugee women and men approaching MoH facilities.
- 2) Specifically RH, pregnant women are often enough criticized for getting pregnant within current “unstable war condition”.

5.4 Gender Dimensions of Health and Socio-Economic Outcomes

5.4.1 Physiological Manifestations of Health Conditions

Men and women differ in the physiological manifestations of some health conditions, (e.g. Women may experience vaginal thrush and require screening for STIs), in other words, women are more susceptible to be screened for different STIs, which leaves the STI matter under reported among males.

Below are listed physiological gender issues attributing differences in the efficiency of transmission of some pathogens and the ease with which infection can be detected:

- 1) Contact with pathogens after sexual exposure is more extended among women than among men. That is, if the male partner has an STD, the infected semen remains in the vagina following intercourse; in contrast, if the female partner is infected, the male's exposure to the pathogens is limited to the duration of intercourse.
- 2) The cervix may also be more susceptible to infection than the male's urethra.
- 3) STIs - for physiological/anatomical reasons - in women are usually detected in late stages after the condition has become medically critical. Moreover, the large number and variety of cells and bacteria that are normally present in the vaginal vault reduce the sensitivity of certain specimen tests.

Culturally, men are much more likely than women to have more than one lifetime sexual partners, and to have concurrent regular and casual partner.

- Humanitarian health aid organizations all adhere to standard packages of services for both males and females.
- Legal issues and authorization to use some medications remains problematic and limits utilization of full services package for some conditions in none-camp settings.

For some conditions, the staff members themselves remain untrained on gender sensitive RH practices. Thus, standard application of service package usually follows solid instructions.

5.4.2 Chronic and Debilitating Health Conditions

Some health conditions are chronic and debilitating, as such, entire families (and especially women) are significantly burdened by the need to care for infected individuals. Family members are differently affected by the consequences of living with or supporting someone affected by a chronic health condition or disability.

Mothers and older sisters are the first line family members to be infected with health conditions transmitted via:

- Fecal matter of young children.
- Live infections in children.
- Microbial contamination of raw food
- Caring for disabled members of the family.

5.4.3 Economic Effects of Treatment

Undergoing treatment for some health conditions has different economic effects on men and women. Lack of education and economic security for women and girls may force women to adopt survival strategies to cope with their own illness or that of those for whom they care - that could also increase their chances of contracting and transmitting different diseases including STIs. Common among the targeted population is early marriage or marriage for a limited period of time. Throughout the first half of 2015, STIs in Za'atri camp among women aged 18-59 was 1898, while STIs among young girls was 178 representing only 8% of total STIs of that period. For the time being, early marriage either by culture or as a survival behavior does not significantly contribute to STIs epidemiology.

5.4.4 Impact of Illiteracy and Economic Insecurity on Coping Ability

Secondary data collected for this gender analysis shows that gender interacts with the social, economic and biological determinants to create different health outcomes for males and females. Such interactions result in different approaches to prevention, treatment, and coping with illness. According to 2016 data, the young adults' age groups (12-35) constitutes (43%) of the total urban refugee population followed by children group (5-11; 21.5%), which suggests a high reproductive capacity. The special health and nutrition needs of children and pregnant women have gradually become economic burdens. Economic insecurities have so far lead households, especially mothers, into adopting different coping practices to mitigate ever increasing financial burdens; that is, reduction in food consumption, withdrawing children from school and taking on informal, exploitative or dangerous employment.

Meanwhile, data from the Vulnerability Assessment Framework (VAF)⁶ on Urban Syrian refugees in Jordan (more than 85% of the total refugee population) published in 2015 indicates that: (i) 46% of Syrian households have severe vulnerability scores for expenditure on food and 72% are severely vulnerable due to the adoption of emergency coping strategies to meet food needs; and (ii) 10% of households report that they spend more than 25% of their expenditure on health related items⁷.

Male and female youth find themselves equally burdened by family obligations beyond their ability to manage, both financially and psychologically. For young men, the financial expectation to provide economic support to families is an added obstacle in their completion of secondary education. Young women, who are seen as caretakers, are more likely to stay home to look after younger siblings, thus impacting their ability to access secondary education or complete it. Poverty and desire to satisfy basic socio-economic needs increases adolescent's vulnerability to drop out schools and eventually, exacerbating the epidemic illiteracy among the growing Syrian refugee population in Jordan.

Clearly, the combination illiteracy and economic insecurity (poverty) creates an unsafe environment generally for Syrian refugees in Jordan, and particularly for adolescents/youth. This lack of sustainable access to quality healthcare services is confirmed by the VAF report, which states “families with ongoing health issues or complicated health needs face considerable financial and other burdens in securing appropriate healthcare.”

6. Conclusions

Overuse and misuse of male gender power privilege is a factor limiting appropriate health seeking practices. Moreover, health ignorance and illiteracy among different refugee population groups has further victimized women, young boys and girls - in particular - as all are dependents of the male head of household and thus, are obliged to abide by rules endorsed by male providers of the household.

In primary health care, females seek health services under reproductive health (RH) more than males. Male resistance to condom use and women's inability to negotiate safer sex are key factors in STI transmission. While men under report STIs, women get checked and treated in the process of seeking antenatal care and family planning services. However, pregnant women are often criticized for getting pregnant in their refugee status and movement is difficult for pregnant women in latter gestational weeks.

Bloody diarrhea due to food poisoning and colon cancer complications are more expressed in males than females. Meanwhile, both females and males regularly seek primary follow up and advanced healthcare referral for breast/ovarian cancers and prostate cancer. At secondary health care level, patients with obstetric emergencies or high risk pregnancies regardless of the vulnerability status; SGBV survivors, mental health and malnourished children are prioritized for treatment.

⁶ Designed to Inform “targeting of assistance” at the refugee household (case) level, by providing a vulnerability ranking for each household and Provides a vulnerability profile of refugee households by welfare and sector models

⁷ Jordan Response Plan, Vulnerability Assessment Baseline Survey, 2015.

Sociocultural aspects influence utilization of health services. On reproductive health matters, female patients prefer female physicians - health service providers' inability to respond to this issue in a sensitive manner can affect service use. Other sociocultural aspects influencing utilization of health services are: Early pregnancy; Limitations on women's movement which result in poor compliance to ante natal care; Compromised access to quality hygiene services by females; and Injuries related to armed conflict. Females are usually not the decision makers when it comes to breastfeeding, and child-minding limits their access to primary health care services.

SGBV, usually perpetuated by close relatives, is stigmatizing, under reported and most women are unaware of protection services. Among basic concerns limiting provision of quality SGBV survivors is having such services linked to healthcare facilities instead of having "all social" community based services easily approached by all Women, Girls and adolescent boys. Lack of such none-stigmatizing services renders potential victims unable to identify abuse, report once happens and unaware of reporting consequences; whether their dignity will be at risk if confidentiality is not maintained or their security/wellbeing is threatened in case offenders were family members or family providers.

Young married women do not readily access RH information and services and instead rely on information conveyed by their mothers and siblings. The health system is still lacking specific reproductive health messages with sensitivity to the stigma attached to STIs. Due to costs associated with treatment of some health conditions, choices made by families usually are in favor of the health needs of male children and adolescents over females. As such, compromised immunity and consequent vulnerability to other infections is the natural complication.

Family members are differently affected by the consequences of living with a family member affected by a chronic health condition or disability. The burden of caring for the affected family members rests, especially on women - mothers and older sisters.

The combination of illiteracy and economic insecurity (poverty) creates an unsafe environment generally for Syrian refugees in Jordan. Due to economic insecurities households take drastic measures such as reducing amount of food consumed, withdrawing children from school and taking on informal, exploitative or dangerous employment. Some male and female youth have dropped out schools due to Poverty.

7. Recommendations

Community mobilization and participation

- 1) Cultural practices that still resist gender equality and subjugate women are persisting among Syrian refugees. As such, health sector service providers should identify and address cultural/traditional practices that perpetuate gender inequality and limit health seeking practices.
- 2) Support community-based health promotion activities. Specific emphasis should be on importance of following up with health services (e.g. for young married women who do not readily access health services, food poisoning which is more expressed in males than females) to avoid preventable complications and/or facilitate timely referral for advanced healthcare

services. This should include IEC materials with culturally appropriate information for all population groups. All health practitioners, not only those working in RH, should provide health messages tackling sensitive issues such as SGBV and STIs.

- 3) Health service providers should find ways of encouraging men to participate in RH and family planning services together with their spouses so they can equally be checked and treated for STIs, and look up for opportunities to scale up outreach capacities to support primary healthcare at the community level.
- 4) Support pregnant women in late gestational phases' to ensure physical accessibility to healthcare.
- 5) Gradually work on spreading social awareness to decrease age gap in married couples.
 - Clarify how an abused female or SGBV survivor can seek healthcare confidentially and that further protection will be secured after such incidents are reported (even if the offender is a husband, sibling or a relative). A female protection and dignity will be regarded a priority, thus, none-stigmatizing intervention shall take place for each case individually.
- 6) Gradually work on spreading messages related to gender equity in terms of caring for children, elderly, disabled and other dependents.
- 7) Steps should be taken to protect the dignity of SGBV survivors and to minimize stigma associated with their seeking SGBV services by assuring their confidentiality and security/wellbeing. E.g. by creating an info-line service for consultation by GBV survivors, in a way that creates confidence for clients as their identity will be kept anonymous. This should be coordinated with the Protection Sector.
- 8) Integrate hygiene promotion and distribution of hygiene kits into health interventions to advocate better hygiene practices and its link to health status promotion.

Provision of health services

- 9) To promote utilization of health services by both female and male patients, health service providers' should identify and respond to their gender specific needs. In addition, other sociocultural aspects influencing utilization of health services should be addressed including early pregnancy, limitations on women's movement, compromised access to quality hygiene services by females.
- 10) Actively engage female healthcare practitioners equally and at all levels in the design and management of health service delivery.
- 11) Ensure ongoing inter-agency coordinated health service delivery strategies that address the health needs of women, girls, boys and men. For instance: Ensure that Minimum Initial Service Packages (MISP) of reproductive health services is available in all accessible healthcare static and mobile facilities so that women and men and adolescent girls and boys have access to priority sexual and reproductive health services in the earliest days and weeks of new emergencies.

- 12) Ensure continual updating to RH services' map, so that women and men and adolescent girls and boys have access to comprehensive sexual and reproductive health services, including GBV-related services, for none-emergency conditions.
- 13) Ensure privacy for health consultations, examinations and care.
- 14) From health perspective, promote awareness for men and women on health risks associated:
 - Early marriage
 - Early weaning of children or “no-breastfeeding at all”.
 - Successive pregnancies
 - Successive Caesarian sections
 - Not seeking professional healthcare to treat STI
 - Risks of Sexual intercourse in the presence of an active STI
- 15) Advocate importance of reproductive health seeking if needed among unmarried girls.
- 16) Identify culturally appropriate, none stigmatizing locations for social and psychological support to women, girls, boys and men (safe zones where different social activities can take place and not only for SGBV survivors).
 - Through focus group discussions within those centers, SGBV survivors are to be encouraged to specify the social help they need so that appropriate interventions can be designed in ad hoc.
- 17) The health needs and challenges of female as well as male children and adolescents should be identified and addressed equally by health service providers.

Inter-sector coordination

- 18) Eligibility criteria for receiving different types of humanitarian assistance, whether health or none-health related so that vulnerable population groups won't find themselves obliged to deprioritize health seeking and spare money to secure other basic needs.
- 19) The national health sector must maintain strong coordination with MoH representatives in each directorate to continually address challenges manifested by refugee population groups accessing MoH affiliated PHCs.
- 20) To address health related economic needs of Syrian refugees, livelihoods opportunities should be extended to them.

References

1. INTER-AGENCY EMERGENCY STANDARD OPERATING PROCEDURES FOR PREVENTION OF AND RESPONSE TO GENDER-BASED VIOLENCE and CHILD PROTECTION IN JORDAN, (<http://jordan.unfpa.org/>)
2. Regular reports on Syrian refugees health profile (regular health information system reports (HIS)) available at: <https://data.unhcr.org/syrianrefugees/download.php?id=6071>
3. UNICEF, Promoting Gender Equality: An Equity-Focused Approach to Programming; an operational overview (<http://unicefinemergencies.com/>)
4. USAID, Tips for Conducting a Gender Analysis at the Activity or Project Level, (<https://www.usaid.gov>).
5. WHO; department of gender; women, Gender mainstreaming for Health Managers: a practical approach (<http://www.who.int/gender-equity-rights>)
6. Y. Marta, K. Young and C. Jacky. The Psychological Experience of Refugees: A Gender and Cultural Analysis, Ch.2; 17-28. School of Psychology. University of Ottawa.
7. UNHCR portal, Demographique data April 2016, <http://data.unhcr.org/syrianrefugees/country.php?id=107>
8. Humanity in Action. Goleen Sabari. 2014. Vulnerabilities of Women and Girls in Times of Conflict. The Response to Syrian Refugee Women's Health Needs in Lebanon, Turkey and Jordan and Recommendations for Improved Practice. <http://www.humanityinaction.org/knowledgebase/583-the-response-to-syrian-refugee-women-s-health-needs-in-lebanon-turkey-and-jordan-and-recommendations-for-improved-practice>
9. IMC, Population-Based Health Access Assessment for Syrian Refugees in Non-Camp Settings throughout Jordan. 2014
10. UNHCR, At a glance. Health access and utilization survey among non-camp refugees in Jordan. May 2015
11. Vulnerabilities of Women and Girls in Times of Conflict. The Response to Syrian Refugee Women's Health Needs in Lebanon, Turkey and Jordan and Recommendations for Improved Practice.

1. Appendix 1: IATF Health Sector Gender Analysis Framework

Factors that Influence Primary Healthcare Outcomes			
Health-related Considerations	Gender-related Considerations		
	Biological Factors	Sociocultural Factors	Access to and Control Over Resources
Risk Factors and Vulnerability	<ul style="list-style-type: none"> ▪ RH related conditions are naturally expressed more by females. ○ HIS data; Reproductive tract infections are higher in females. ▪ War wounded patients' rehabilitation and wound care are needed more by males. ▪ Demand on chronic conditions primary counseling and medication is equal in both elderly men and women. ▪ Dermal infections are expressed more in females. ▪ Bloody diarrhea secondary to colon cancer is more expressed in males. 	<p>Highlight sociocultural factors (in the area/group of study) which increase vulnerability to for a given health condition - for men and boys and for women and girls.</p> <ul style="list-style-type: none"> ▪ Early marriage and consequent child bearing influence increased expression of micronutrients deficiencies among women in child bearing age. ▪ Limitations on women's movement in urban settings and consequent poor compliance to ANC. ▪ Under reporting of male genitourinal related conditions. ▪ Compromised access to quality hygiene services by females in the camp particularly. <ul style="list-style-type: none"> ○ Caring for young children and lacking skin exposure to sunlight aggravates hygiene status. 	<p>Show how gender norms about interpersonal relationships between women and men may decrease women's access to and control over essential resources</p> <ul style="list-style-type: none"> 8. Females are usually not the decision makers when it comes to breastfeeding. 9. After multiple NVD's women favor c/s deliveries because: <ul style="list-style-type: none"> ○ They feel their bodies have become weak ○ Lower pelvic floor muscle strength and noted greater sexual dissatisfaction expressed by their partners. ▪ Transportation cost and matter of leaving children behind compromises primary healthcare access. ▪ For some, violence is normal and it is not reported. ▪ SGBV is stigmatizing, under

			reported because usually the offender is a relative and also because a woman is unaware of protection services after reporting.
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Secondary and Tertiary Healthcare

<p>Risk Factors and Vulnerability</p>	<ul style="list-style-type: none"> ○ <u>Within limited resources referral is prioritized to emergency cases as follows</u> <ol style="list-style-type: none"> 4) Women referred for Obstetric emergencies 5) Girls, Boys, Women and Men (WGBM) in need for Lifesaving health services 6) WGBM in need limb saving or sight saving and other services unless provided, will result in serious permanent disability ○ <u>None emergency cases prioritized as follows:</u> <ul style="list-style-type: none"> - Registered vulnerable WGBM with medical conditions that are likely to develop into life-threatening emergencies are prioritized for referral. - Registered vulnerable WGBM are equally eligible for none-emergency conditions. 	<p>Highlight sociocultural factors (in the area/group of study) which increase vulnerability to a given health condition - for men and boys and for women and girls.</p> <ul style="list-style-type: none"> ▪ Early marriage, consequent pregnancy at a young age influencing increased referral for birth complications related conditions (obstetric emergencies) ▪ Favoring high average number of children in each family influencing RH related complications due to successive deliveries. ▪ Under reporting of male genitourinal related conditions exposing women to recurrent STIs progressing to advanced complications. 	<p>Show how gender norms about interpersonal relationships between women and men may decrease women's access to and control over essential resources</p> <ol style="list-style-type: none"> 10. Females are usually not the decision makers when it comes to hospitalization. 11. After multiple NVD's women favor c/s deliveries because: <ul style="list-style-type: none"> ○ They feel their bodies have become weak ○ Lower pelvic floor muscle strength and noted greater sexual dissatisfaction expressed by their partners. ▪ For some, physical violence is normal and it is not reported. ▪ Hospitalization for <u>all RH matters</u> for unmarried girls is stigmatizing, thus, compromising reporting and comprehensive management of rape cases plus neglecting other conditions until evolved into complicated conditions.
<p>Access and</p>	<p>Show how women's ability to</p>	<p>Norms related to female</p>	<p>Indirect costs associated with</p>

<p>Use of Health Services</p>	<p>bear children may increase their access to and use of health services for Reproductive health conditions. E.g. in some settings, women are more likely to be tested for HIV in the Context of pre- or antenatal care. As a result, pregnant women may be diagnosed and access HIV-related services more often than men.</p> <ul style="list-style-type: none"> ▪ Naturally, women seek utilization of health services more than males; not only for RH but also for newborn and young children healthcare. Thus, women are more likely to: <ol style="list-style-type: none"> 3) Be diagnosed with STIs 4) Have access to report on SGBV. <p>One challenge reported by majority of pregnant women in camp and urban settings is that even if transportation cost was secured, movement is difficult in latter gestational weeks.</p>	<p>roles, sexual relations and marriage can prevent women - especially young women - from accessing reproductive health (e.g. HIV) information and services. Show how this may be the case for a health condition under consideration.</p> <ul style="list-style-type: none"> ▪ Women of all ages, if capable of accessing healthcare are eligible to receive whatever primary RH service they need, yet, women in the current context women are poorly educated and rely mainly on knowledge conveyed by their mothers and siblings. <ul style="list-style-type: none"> ○ Women are likely to exhibit abnormal symptoms and manage it symptomatically using traditional remedies without knowing the underlying cause of symptoms. ○ The health system is still lacking specific reproductive health messages that tackle sensitivity of STIs to be either 	<p>a health condition under consideration disproportionately affect women - show how this is the case in you gender analysis.</p> <p>Families are usually in favor to secure health needs of male children and adolescents over females</p> <ul style="list-style-type: none"> ▪ In camp settings, women complained that quality medication is not always prescribed by NGO clinics (only basic essential medication). ▪ In urban settings families deprioritize none-urgent medical conditions in favor to utilize whatever resources they have to secure basic needs (shelter and NFI's). <p>In both; camp and urban settings, refugees are obliged to either utilize whatever support is offered by NGO clinics or otherwise pay for MoH or private services. Compromised immunity and consequent vulnerability to other infections is the natural complication of continual deprioritization of health needs.</p>
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		communicated or available in a written brochure.	
Secondary and Tertiary Healthcare			
Access and Use of Health Services	<p>Show how women's ability to bear children may increase their access to and use of health services for Reproductive health conditions.</p> <p>12. WGBM have equal access to proper refugee registration with UNHCR; eligibility for referral relates to beneficiaries' legal documentation in terms of UNHCR and Jordanian Mol. WGBM with Listed medical categories below remain eligible for referral services; correction of documentation status can take place after service is received.</p> <ul style="list-style-type: none"> v. Obstetric emergencies or high risk pregnancies regardless of the vulnerability status vi. Sexual and Gender Based Violence Survivors vii. Mental health patients viii. Malnourished children under 5 years of age and other nutrition services in children 	<p>Norms related to female roles, sexual relations and marriage can prevent women - especially young women - from accessing reproductive health (e.g. HIV) information and services. Show how this may be the case for a health condition under consideration.</p> <ul style="list-style-type: none"> ▪ Socio-cultural Limitations on women's movement particularly and generally high transportation costs in urban settings, thus, poor healthcare seeking behavior (medical conditions evolve and become obliging referral) ▪ Compromised health seeking behavior in case service provider was male practitioner. ▪ Males do not fill the gap for their female partners/sisters...etc in terms of household responsibilities in case those women had to be referred to receive hospitalized services (women favor shorter slayings) 	<p>Indirect costs associated with a health condition under consideration disproportionately affect women - show how this is the case in your gender analysis.</p> <p>13. Women are more likely to escort their children , referral policy specifies that all patients under age 18 should have a responsible adult as an escort</p> <p>14. Women are more likely to escort disabled and elderly referral policy specifies that escorts in adults will be supported only in cases where the patients needs assistance with activities of daily living which are not able to be provided by hospital staff or the patient is mentally or intellectually impaired</p> <p>Families are usually in favor to secure health needs of male children and adolescents over females</p> <ul style="list-style-type: none"> ▪ In camp settings, women complained that quality medication is not always prescribed by NGO clinics (only basic essential medication). ▪ In urban settings families reprioritize none-urgent medical conditions in favor to utilize whatever

			<p>resources they have to secure basic needs (shelter and NFI's).</p> <p>In both; camp and urban settings, refugees are obliged to either utilize whatever support is offered by NGO clinics or otherwise pay for MoH or private services. Compromised immunity and consequent vulnerability to other infections is the natural complication of continual reprioritization of health needs.</p>
Health-related Considerations	Biological factors	Sociocultural Factors	Access to and Control Over Resources
Health-seeking Behavior	<p>Show if a health condition under consideration has visible symptoms or not. Then, show how men and women may only be compelled to seek health care in the light of those symptoms. Also show how they each are likely to seek health care for a condition which takes long to show visible symptoms.</p> <ul style="list-style-type: none"> ▪ Females are not committed to ANC visits. <ul style="list-style-type: none"> ○ Utilization of supplemental treatment and vaccination services is challenged by this fact. ▪ Females do seek healthcare for infectious dermal infections ▪ Males (unless disabled) do seek healthcare for all acute and chronic conditions. 	<p>Fear of stigma and discriminatory consequences may for some health conditions (e.g. Reproductive health and HIV-related illness) may affect health-seeking behavior for women and men differently. Show how this plays out for men and women for the group under consideration.</p> <ul style="list-style-type: none"> ▪ The matter of confidentiality is maintained by different healthcare providers, yet, women fear being abandoned by their partners if they ever were diagnosed with an STI. ▪ GBV and SGBV remain under reported <u>not</u> only because of stigma but also because of not knowing what would happen after reporting. 	<p>In some settings, women may delay health-seeking behavior to give priority to the treatment needs of men in the family or children's nutritional needs. This is often exemplified in situations of poverty. Capture how this is playing out in your gender analysis.</p> <p>Explained under health access</p>
Experiences in health care settings		<p>What are reported experiences of men and women at health care settings/ facilities? It is important to show these because women's and men's feelings of stigmatization can result in</p>	

		<p>reduced health-seeking behavior.</p> <p>Stigma of being a “refugee” has for ever been reported by refugee women and men approaching MoH facilities.</p> <p>Specifically RH, pregnant women are often enough criticized for getting pregnant within current “unstable war condition”</p>	
<p>Health and social outcomes and consequences</p>	<p>Men and women differ in the physiological manifestations of some health conditions, e.g. Women with may experience vaginal thrush and require screening for cervical cancer; Pregnant women with HIV are more susceptible to malaria. Thus, show how this is playing out for the group being analyzed.</p> <ul style="list-style-type: none"> ▪ Humanitarian health aid organizations all adhere to standard packages of services for both males and females ▪ Legal issues and authorization to use some medications remains problematic and limits utilization of full services package for some conditions in none-camp settings. <ul style="list-style-type: none"> ○ For some conditions, the staff members themselves remain untrained on gender sensitive RH practices...thus, standard application of service package usually follow solid instructions. 	<p>Some health conditions are chronic and debilitating, as such, entire families (and especially women) are significantly burdened by the need to care for infected individuals. Show who (women or men/girls or boys) are most affected by the consequences of living with or supporting someone affected by a health condition under consideration.</p> <p>12) Mothers and older sisters are the first line family members to be infected with health conditions transmitted via:</p> <ul style="list-style-type: none"> ○ Fecal matter of young children. ○ Live infections in children. ○ Microbial contamination of raw food ○ Caring for disabled members of the family. 	<p>Undergoing treatment for some health conditions has different economic effects on men and women. Lack of education and economic security for women and girls may force women to adopt survival strategies (such as survival sex) to cope with their own illness or that of those for whom they care - that could also increase their chances of contracting and transmitting HIV. Show how this is playing out in your gender analysis.</p> <p>13) Common among the targeted population is early marriage or marriage for a limited period of time.</p> <ul style="list-style-type: none"> ○ Throughout the first half of 2015, STIs in Zaatri camp among women aged 18-59 was 1898, while STIs among young girls was 178 representing only 8% of total STIs of that period. <p>For the time being, early marriage either by culture or as a survival behavior does not significantly contribute to STIs epidemiology.</p>

ANNEX 1 - Main Responsibilities for Health Sector Gender Focal Points

1. Gender mainstreaming strategy

Support the Sector Lead within their nominated sector to mainstream gender into the Sector Response Plan. This should include gender analysis within situation analyses and a clear disaggregation of the gender needs of refugees, which will be monitored and reported on.

2. Technical Support within Sector Meetings

- Advocate for the inclusion of gender issues in project formulation, raising relevant gender issues relevant to project;
- Advocate for sector assessments to disaggregate data by sex and age;
- Support the sector to interpret and analyse the differences for women, girls, boys and men and encourage this in order to shape the development of appropriate activities;
- Support the inclusion of gender equality measures (ADAPT ACT C framework⁸) in implementation activities and monitoring and evaluation;
- Contribute sector information and analysis to the IASC Senior Gender Advisor to facilitate an overview of gender equality measures in humanitarian action.
- Promote inter-sector linkages for gender mainstreaming.

3. Capacity Development

- Identify the needs of colleagues for information and training in gender equality mainstreaming;
- Support the Sector Lead and the Senior Gender Advisor to develop and deliver sector-appropriate gender in programming workshops and training in the Gender Marker;
- Encourage staff to raise gender equality issues in the sector;
- On a needs basis, the IASC Senior Gender Advisor to visit with agencies to assess the gender-responsiveness of the implementation of project activities.

4. Knowledge Management

- Participate in IATF's Sector Gender Focal Point Network;
 - Share information and experiences with the Sector Gender Focal Point Network.

⁸ **ADAPT ACT C** stands for: **A**nalyze gender differences; **D**esign services to meet needs of all; **P**articipate equally; **T**rain women and men equally; **A**ddress GBV in sector programmes; **C**ollect, analyse and report sex- and age-disaggregated data; **T**arget actions based on a gender analysis; **C**oordinate actions with all partners.

Annex 2 - Taxonomy of Health Services

	Activity	Location																
		Central					North					South						
		All region	Al Balqa	Amman	Madaba	Zarqa	All region	Ajloun	Irbid	Jerash	Mafraq	All region	Aqaba	Karak	Ma'an	Tafileh		
Community Care	Community Care - Vital Stat																	
	Other population movement																	
	Death or Birth																	
	Community Care - Child health																	
	Integrated Management of Childhood Illnesses (IMCI) Community component: Information, Education and Communication (IEC) of child care taker + active case finding																	
	Home- based treatment of: fever, ARI/pneumonia, dehydration due to acute diarrhoea																	
	Community mobilization for and support to mass vaccination campaigns and/or mass drug administration/treatments																	
	Community Care - Nutrition																	
	Screening of acute malnutrition - Mid upper arm circumference (MUAC)																	
	Follow up of children enrolled in supplementary/ therapeutic feeding (trace defaulters)																	
	Community therapeutic care of acute malnutrition																	
	Community Care - Communicable diseases																	
	Vector control (IEC +impregnated bed nets+ in/out door insecticide spraying)																	
	Community mobilization for and support to mass vaccinations and /or drug administration/treatments																	
	IEC on locally priority diseases (e.g. TB self-referral, malaria self-referral, others)																	
	Community Care - STI & HIV/AIDS																	
	Community Leaders advocacy on STI/HIV																	
	IEC on prevention of STI/HIV infections and behavioural change communication																	
	Ensure access to free condoms																	
	Community Care - Maternal & newborn health																	

