K4D | Knowledge, evidence and learning for development

Barriers to family planning in Iraq and KRI

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Question

What does evidence tell us on the barriers to access to family planning (FP) across Iraq (including Kurdistan Region of Iraq/ KRI)?

- *Based on available literature, please include an analysis of evidence of factors such as geographical factors, socio-economic, age, disability, the influence of attitudes and social norms, logistical barriers (e.g. cost, distance), attitudes of providers, and availability of services.*

Contents

1. Summary

Although family planning (FP) services, including sexual and reproductive health (SRH) care, are available in Iraq, there is little information on their uptake by women (Al Ameen & Al Deen, 2016). This rapid review is on the reported social and cultural barriers, as well as logistical barriers, to FP in Iraq and the Kurdistan Region of Iraq (KRI). Data on internally displaced people (IDP) in Iraq and refugees in Jordan and Turkey are also included. Attitudes of SRH service providers (qualitative research and anecdotal evidence) are also discussed. Key points to highlight:

- *Availability of services:* Although free FP care is provided in government health centres, research has shown poor utilisation of public services, as well as a general preference to use private services in women who can afford it (Shabila et al., 2014). This may be due to inadequate provision of information and poor interpersonal communication, which has been found in primary health care centres (PHCCs) (Shabila et al., 2014). **Technological advances in FP are unavailable**, and both health care providers and women alike are unaware of newer FP options (Aldabbagh & Al-Qazaz, 2020). Women and youth often do not access SRH information and services due to fear of discrimination or stigma, which can affect access to health and promotional services (UNFPA, n.d.). The key concerns for women seeking health care include respect, trust, privacy, and confidentiality – values that are often compromised in busy facilities (Allami, 2015).

  In Jordan, some Iraqi women were too scared of deportation to access camp services (Chynoweth, 2008). Médecins Sans Frontières (MSF) provide the majority of SRH services there. However, even women who have previously undergone caesareans, and are therefore at high risk of complications, often deliver at home and do not access FP services post-partum. This is either because they **cannot afford the fee** charged by local facilities and are **unaware of free services** like MSF's, or because their **families believe it is better for them to deliver at home** attended by a traditional midwife, who may not have appropriate FP training (Allami, 2015; MSF, 2019).
- *Geographical factors:* Contraceptive pills are reported to be available in most pharmacies across Iraq (Abd, 2017; The Arab Weekly, 2018). However, there are significant geographical disparities (World Bank Group, 2017), with **less access in rural locations** (Allami, 2015; Balinska et al., 2019).
- *Socio-economic factors:* Contraception use is higher for both men and women of higher socio-economic groups (Agha & Rasheed, 2007; Ismael & Zangana, 2012). In central Iraq, only 0.6% of people were happy with the charging or payment of fees for maternal health services provided at ten PHCCs (Ismael & Farhood, 2019). Research shows that socio-economic conditions also **impedes women's free access to FP services** (Allami, 2015).
- **Health reasons and side effects** were noted in four in ten (44.4%) people as a reason for not using contraceptives in Basrah (Ebrahim & Muhammed, 2011). Perceived harmful effects of condoms were reported by 30.2% of men from Erbil (Ismael & Zangana, 2012).
- *Education/ Knowledge:* In Erbil, condom use is low. Only a quarter (25.8%) of men reported having enough information about proper condom use, and 71.7% required more information (Ismael & Zangana, 2012). Although research shows that there is high knowledge of SRH in women, women of poor households have the highest unmet contraceptive need. This is probably because they fall short in terms of information on access to methods. **Lack of schooling** is a key underlying reason for the high adolescent birth rates for Iraqi girls (World Bank Group, 2017). **Risks** have also been

noted by adolescent girls in using the internet for sourcing SRH information (Women's Refugee Commission/ UNICEF, 2019).

- *Young age:* Information is scarce on the actual needs and priorities for adolescents and youth in Iraq, including the most vulnerable, such as IDPs, refugee and returnee adolescents (UNICEF, 2018a). However, **unmarried adolescents** have reported difficulty accessing services, as premarital sex is disapproved of (Chynoweth, 2008; Tanabe et al., 2017).
- *Disability:* Although there are laws against it (2013 Law 38), **disabled adolescents** are also discriminated against (UNICEF, 2018b). However, there is no data available on their actual use of SRH services.
- *Influence of cultural attitudes and social norms, and religion:* Most of those who do not use contraceptives and FP methods refrain from doing so out of social beliefs (Vilardo & Bittar, 2018). **Negative attitudes to contraceptive methods** have been found (Al Ameen & Al Deen, 2016; Al Abedi et al., 2020: 1887). **Patriarchal attitudes** impede women's free access to FP services (Allami, 2015). Husband objection was also stated as a reason for women not using contraception (Ebrahim & Muhammed, 2011). Religion, however, was not reported as a major barrier by Iraqi refugees in Amman, Jordan (Tanabe et al., 2017).
- *Legalities:* The Iraqi Public Health Law No. 89 of 1981192 of 1981 provides broad measures aimed at supporting maternal health, FP, and children's health. However, it fails to address the full range of women's SRH issues and concerns (**especially adolescent girls**, and including gender-based violence, GBV) (Allami, 2015).
- *Attitudes of providers:* **Poor knowledge of contraceptives** (including emergency contraception) has been found in public health physicians (Tawfeeq et al., 2020) and informally trained midwives (Aldabbagh & Al-Qazaz, 2020). Poor information technology in PHCCs and poor leadership/ governance are also important obstacles to FP (Raoof & Al-Hadithi, 2011; Shabila et al., 2012; Shabila et al., 2014).

  Provider biases include discrimination, which has been reported against Iraqi refugees in Jordan (Tanabe et al., 2017) and Turkey (Spahl & Österle, 2019). It is reported that many representatives, from local and international organisations as well as UN agencies, did not think SRH was a priority activity in refugee crises (Chynoweth, 2008) – **especially for women or adolescent girls**. Although abortion is illegal in Iraq, there is said to be an "unwritten" agreement among Iraqi authorities to permit abortions for Yazidi rape victims – although doctors have refused to cooperate (Hussein, 2016).

2. Availability of FP and SRH services

Government health centres

Although Iraq has had an official policy of providing family planning (FP) and contraception, it is unclear to what extent women are able to access FP services, as almost one-third of FP institutions have been destroyed since 2003 (Allami, 2015).

In its 2015 annual report, the Ministry of Health refers to a total of 2,680 primary health care centres (PHCCs) - 1,330 main centres and 1,350 sub centres (UNAMI/ OHCHR, 2017: 11). These offer basic integrated and comprehensive services in the preventive and therapeutic fields. Other services provided by some of these PHCCs, but to lesser extent, include promotion

of breastfeeding, FP, and postnatal care.[1] An additional 128 centres were established following the implementation of a new family health care system in 2013.

More current data shows that sexual and reproductive health (SRH) services are provided via 24 medical facilities staffed with 544 medical personnel (OHCHR, 2019). Six hospitals provide emergency obstetric care in Telafar, Hawija, Qaim, Hammam Aleel, Qayarra and Shirqat; Basic Emergency Obstetric Care in four facilities in Beiji, Ana, Qayarra airstrip and Sunoni, and 26 SRH clinics in West Anbar, West Ninewa, North Salahuddin and Kerbala (UNFPA, 2018).

Free FP services provided in government health centres remove the financial burden and may explain the increasing rates of the use of contraception methods (Aldabbagh & Al-Qazaz, 2020). Using Service Provision Assessment (SPA) survey[2] data, Ismael and Farhood (2019) showed a high level of satisfaction with the quality of maternal health and SRH services in PHCCs among antenatal attendees. However, research has shown poor utilisation of public antenatal services, as well as **a general preference to use private services** in women who can afford it (Shabila et al., 2014).

Public vs non-public institutions

In Iraq, most women buy contraceptive (oral pills) from community pharmacies as over the counter drugs (69%) (Abd, 2017). However, the Ministry of Health is turning to private businesses to help with upgrading equipment and health services (Aboulenein & Levinsn, 2020). Non-public sources in the form of private pharmacies represented the major source (74.7%) of FP services in Basrah, followed by private clinics and local markets (9.5% & 8.0%, respectively). Health care and access to medicines are reportedly better in KRI, especially pharmacies (Aboulenein & Levinson, 2020).

It is reported that most pregnant women in Mosul receive no care before giving birth, even those who have paid for an ultrasound scan at a private clinic (MSF, 2019), therefore the chances of receiving FP services are also slim. The role of public institutions in FP is limited (Ebrahim & Muhammed, 2011: 72). Technological advances in FP are reportedly unavailable, and both health care providers and women alike are unaware of newer FP options. The key concerns for women seeking health care include respect, trust, privacy, and confidentiality – values that are often compromised in busy facilities (Allami, 2015).

Lack of SRH-care workers

Iraq has some of the lowest number of nurses and midwives in the Middle East and North Africa (MENA) region.[3] More than two years after the battle for Mosul was officially declared over, the health system has been very slow to recover. With many gynaecologists and other female medical staff having fled the city or the country during ISIS rule, and most of the city's maternity

[1] MOH WHO: UNICEF, UNFPA, WFP (2005). Maternal and child health and reproductive health strategy in Iraq 2005-2008. Baghdad: Ministry of Health.

[2] The SPA is a nationwide facility-based survey that measures the ability of health facilities to provide quality preventive, diagnostic, and treatment services for key maternal, child health, and HIV/AIDS programmes.

[3] 2.1 per thousand people, compared to 3.2 nurses and midwives per thousand people in Jordan.

facilities damaged, the need for midwives who can assist with SRH never been greater (MSF, 2019). Therefore, due to the lack of such health workers, many women still struggle to access FP services (MSF, 2019). According to Ministry of Health analysis, the health care system in Basra has been chronically underfunded, and is also run by overworked doctors and nurses (Aboulenein & Levinson, 2020).

Local and military organisations

In order to bridge the gap left by the government in terms of the medical assistance provided to affected areas, local organisations have worked in cooperation with the security forces to grant access to health care services. The limited possibility of mobile clinics to operate due to the dire conditions of the roads, and mud and rain making some areas impossible to reach, coupled with the reduced capacity of medical facilities meant that health care treatment, in certain instances, has had to be provided by military facilities (WILFP, 2019: 22-23). However, as these hospitals are dedicated for military forces, services extended to civilians are limited to basic health care, not FP.

Refugee camp services

The following section shows how different camps provide services for Iraqi refugees, as well as for refugees based in Iraq:

Iraq

There are five clinics in Jadaa, Salameya and Hamman Al-Aleel camps that provide SRH services (UNFPA, 2018). However, like Lebanon and Turkey, since the beginning of the Syrian conflict in 2011, Iraq has been hosting large numbers of refugees, thereby straining local capacities to provide SRH services (Balinska et al., 2019).

Women who have previously undergone caesareans, and are therefore at high risk of complications, often deliver at home, either because they **cannot afford the fee** charged by local facilities and are **unaware of free services** like Médecins Sans Frontières (MSF)'s, or because their **families** believe it is better for them to deliver at home attended by a traditional midwife (MSF, 2019). As part of the response to the Mosul operations, UNFPA positioned 25 mobile SRH teams and established 20 maternal health facilities. The clinics provide gynaecological services, FP care, antenatal care, safe delivery services, and post-natal care (UNFPA, 2016).

Jordan: Amman

While contraceptives were available and free at public health facilities, many Iraqis reportedly obtained them at pharmacies (Tanabe et al., 2017: 7). Data shows that the Jordanian government did not recognise Iraqis fleeing the war as refugees; thus, most live in the country illegally and can be deported at any time. Therefore, some women are **too scared of deportation to access SRH services** (Chynoweth, 2008).

3. Access to FP services

In Islamic countries, the use of contraception is allowed to conserve mother's health (as well as health of subsequent children), rather than to restrict the family size (Aldabbagh & Al-Qazaz,

2020). In Iraq, there has been a steady increase in the use of contraception methods. However, there is awareness of pregnancies that were unplanned, as over 10% of married women have had induced abortion to control births (Al-Ridhwany et al., 2018). The following barriers to FP services have been reported in the literature:

Geographical factors

Security has been the number one biggest challenge to achieving FP goals in Iraq (WHO, 2011). Conflict has taken a heavy toll on the health system, once considered the best in the MENA region. Geographical disparities in access to health services are significant (World Bank Group, 2017). According to the 2018 Multiple Indicator Cluster Survey (MICS), Erbil in KRI has the lowest unmet need for contraceptives at 7%, with Muthana in the south of Iraq reporting the highest (24%) (UNFPA, 2019). It has been reported that contraceptive pills are available in most pharmacies across Iraq (The Arab Weekly, 2018). However, **obtaining reliable supplies of contraceptives** is a problem for both private and public FP clinics (WHO, 2011).

Location: urban vs rural and humanitarian setting

Women are legally free to make independent decisions about their health and reproductive rights, but they are less able to exercise this freedom **outside large cities** (Allami, 2015).

The highest levels of condom use in Erbil males were observed among urban residents (Ismael & Zangana, 2012). Condoms are more accessible in those areas, and there is a higher percentage of educated families with positive attitudes toward condom use.

Multivariable analysis shows that location is a predictor of unplanned pregnancy in humanitarian settings (Balinska et al., 2019). Sometimes, referral hospitals which can provide FP advice are located far from many Iraqi refugees' homes, and money for transportation is too scarce (Chynoweth, 2008).

Socio-economic factors

Low socio-economic status (SES)

Among 800 18-49-year-old respondents in Dohuk district of Kurdistan region, northern Iraq, unmet need for any contraception was 29.3%. Unmet need was most common among women of low socio-economic status (Agha & Rasheed, 2007). Unmet need for modern (effective) contraception was 28.5% (most common among women of high socio-economic status) (Agha & Rasheed, 2007). The lowest levels of condom use in Erbil males were also observed among lower SES couples (Ismael & Zangana, 2012).

High costs of SRH services

Cost of contraceptives was found to have a role in non-use of contraception methods in Basrah city (Ebrahim & Muhammed, 2011: 73). Pills, condoms, and intrauterine contraceptive devices (IUDs) are available in the Iraqi PHCCs at low cost (Al Ameen & AL-Ayoubi, 2016: 227). However, only 0.6% were happy with the charging or payment of fees for maternal health services provided at ten PHCCs in Babylon province, central Iraq (Ismael & Farhood, 2019).

Research also shows that **socio-economic conditions also impede women's free access to FP services** (Allami, 2015).

4. Perceived health complications and side effects

Out of 417 non-users of contraceptives in Basrah city, south Iraq, the main reasons stated for not using contraceptives were **health reasons and side effects** (44.4%) (Ebrahim & Muhammed, 2011: 73). According to the Iraq Woman Integrated Social and Health Survey (I-WISH), health complications mentioned relate to **menstrual cycle** and other issues (Ministry of Planning CSO, 2012: 41). **Perceived harmful effects of condoms** were reported by 30.2% of men from Erbil (Ismael & Zangana, 2012).

5. Young age

Iraq has one of the highest adolescent birth rates in the region with 59 births per 1,000 females (World Bank, 2015).[4] However, in terms of research data on selected SRH outcomes, adolescents in Iraq are invisible (UNICEF, 2018a). Limited data is generated primarily through nationally representative household surveys such as the MICS (UNICEF, 2018b: 39). However, information is scarce on the actual needs and priorities for adolescents and youth in Iraq, including the most vulnerable, such as internally displaced people (IDPs), refugee and returnee adolescents (UNICEF, 2018a).

Level of female education

For girls, particularly those in conflict zones, school attendance can combat illiteracy and exclusion. Therefore, **lack of schooling** is a key underlying reason for the high adolescent birth rates for Iraqi girls (World Bank Group, 2017: 110).

6. Disability

More than 10,000 persons in the Kurdistan region have been disabled by the recent wars in Iraq, including those who worked in de-mining (OHCHR, 2019). Survivors of explosive weapons attacks suffer from different kinds of long-term consequences, including disability, psychological harm, and social and economic exclusion (WILFP, 2019: 14).

Women with disabilities are more likely to be unemployed and thus deprived of financial independence (UNAMI/ OHCHR, 2017: 9). The 2013 Law 38 on the *Care of Persons with Disabilities and Special Needs* starts from the care of women with disabilities "during pregnancy, child delivery and afterwards" (art.15, I, e).[5] However, no data is available on disabled women's access to SRH services.

[4] Compared to 46 in Egypt, 39.2 in Turkey, and 29.5 in Iran (World Bank, 2015).

[5] See: http://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=&p_isn=96874 (in Arabic)

Discrimination to disabled adolescents

Adolescents with disabilities are one of the most marginalised groups in society. Facing daily discrimination in the form of negative attitudes, lack of adequate policies and legislation, adolescents with disabilities are effectively barred from realising their rights to health (UNICEF, 2018b: 39). This can include SRH services; however, there is no data is available to confirm this.

7. Influence of attitudes and social norms

While FP services are available in Iraq, there is little qualitative information on their uptake (Al Ameen & Al Deen, 2016).

Socio-cultural beliefs and traditions

Cultural beliefs and traditions are big contributions to barriers to FP. This was confirmed by the expert consulted for this rapid review. Most of those who do not access contraceptives and FP methods refrain from doing so out of social beliefs (Vilardo & Bittar, 2018: 50) – which are listed below:

Disapproval of premarital sex

Adolescents have reported difficulty accessing SRH services, as premarital sex is disapproved of (Tanabe et al., 2017: 8). Early marriage is on the increase in Iraq's: it has jumped to 24%, including nearly 5% who married before age 15.[6] Early marriage can be associated with poorer knowledge of FP methods (Balinska et al., 2019). It means girls drop out of school; this also jeopardises the overall reproductive and mental health of these girls who are unlikely to be physically or mentally prepared to give birth (Allami, 2015).

Patriarchal attitudes

Patriarchal attitudes impede women's free access to FP services (Allami, 2015). Therefore, women are unable to choose the spacing and number of children in their families alone.

Male involvement: Husbands

Contraception and FP decision-making are almost always the responsibility of both partners, therefore involvement of men in contraception knowledge issues is important (Aldabbagh & Al-Qazaz, 2020). **Husband objection** has been stated as a reason for women not using contraception (Ebrahim & Muhammed, 2011: 73).

Poor knowledge, attitude, and practice (KAP)

There are very few KAP studies of contraception in Iraq (Aldabbagh & Al-Qazaz, 2020). A recent study conducted among rural and urban women in Baghdad in 2017 found that all (100%) of the women were well aware of the concept of contraception. A vast majority of them (96%) were

[6] 2017 UNCEF figures: https://www.girlsnotbrides.org/child-marriage/iraq/

currently using a contraceptive method[7] (AlYamani et al., 2020: 3). However, barriers to knowledge were clear in **the way contraceptives are used** (Al Abedi et al., 2020: 1887). It has been found that the female sterilisation method is never used, suggesting the possibility of **lack of awareness of this procedure** (Abd, 2017).

Cross-sectional research in Bagdad showed that nearly half (49.1%) of the women interviewed had **negative attitudes towards FP,** e.g. fear of side effects (Al Ameen & Al-Ayoubi, 2016; Al Ameen & Al Deen, 2016). A more recent KAP study in Al-Amara (Al Abedi et al., 2020: 1887) confirms that barriers preventing the use of contraceptive methods were related to bad attitudes to contraceptives (mean 1.91 ± 0.277 SD).

Poor education: gender differences

Different types of concerns were found in research in women of different educational levels and SES from Erbil (Shabila et al., 2014). Higher head of household education level was significantly associated with higher uptake of FP and antenatal care (Balinska et al., 2019).

Women: **Uninformed** attitudes and practices, and **insufficient knowledge about FP**, and – more importantly – **methods for FP**, have led to an increased number of unwanted pregnancies (Vilardo & Bittar, 2018: 48).

Males: in KRI, the main reason for non-condom use among 600 males aged 15-49 years in three Erbil Governorate districts was lack of need (45.5%), fertility related reasons (17.0%), and the use of other methods by the female partner (13.6%) (Ismael & Zangana, 2012). However, the low level of condom use in this study may be related to the observation that **only a quarter (25.8%) of the respondents reported having enough information about proper condom use** and 71.7% stated that they required more information.

Risks of using technology

Targeted interventions to respond to the **needs expressed by adolescent girls** – specifically related to their SRH – is an emerging area of research and programming in humanitarian contexts globally (Women's Refugee Commission/ UNICEF, 2019). When one study asked if mobile phones would be a good way to access SRH-related information, adolescent girls were at first hesitant, as they did not know a reliable source on the internet to do so (Women's Refugee Commission/ UNICEF, 2019: 3). Also, girls and their parents and caregivers were fearful that if girls searched for such sensitive topics on the internet, they would get incorrect information or see inappropriate images.

Cultural and religious views on family size

Religious beliefs were stated as a main reason for not using contraceptives (Ebrahim & Muhammed, 2011: 7) or having an abortion (eCALD, n.d.: 9). However, religion was not reported as a major barrier to FP by Iraqi refugees in Amman (Tanabe et al., 2017: 8).

[7] The most widely used method of contraception was Oral Pills with 42% users, followed by IUDs with 32% users, and male condoms, with 27% users claiming to use it.

Cultural beliefs also impede women's free access to FP services (Allami, 2015). Birth control is largely rejected by the tribal and conservative Iraqi society, which shuns the idea of limiting childbirth (Kadi, 2018). Research shows that there is still culture of silence that surrounds the topic, regardless of religious belief (Al-Ridhwany et al., 2018). The desire to have more children was stated by 23.2% of non-users of contraceptives in Basrah (Ebrahim & Muhammed, 2011: 73). However, anecdotal evidence states that newly-wed couples often seek to delay starting a family until they become more comfortable financially, and that many modern couples are satisfied with two or three children (Kadi, 2018; Tull, 2018).

Influence of legalities: Laws on abortion

ISIS members sexually abused women from ethnic and religious minorities unacceptable to ISIS. A high number of Yazidi[8] women were raped by ISIS fighters, many of them got pregnant as a result, and were not allowed to abort the pregnancy due to Iraqi legislation that bans abortion, unless there were special health reasons (The Danish Immigration Service, 2018: 15). The ban on abortions in Iraq covers the KRI as well, and applies even in the case of rape.

Yazidi women who became pregnant by ISIS fighters were forced to have abortions.[9] To avoid legal consequences and public shame, the Yazidi rape victims turned to backstreet abortion clinics, according to the Kurdistan Regional Government's Ministry of Health (Hussein, 2016). Therefore, cases of women who have been raped and opt to keep their babies without accessing any SRH service are not uncommon (Hussein, 2016).

8. Logistical barriers: Internally displaced people (IDPs)

Providing SRH services is an important component of humanitarian response. IDPs while fleeing for safety, are often cut off from accessing FP and priority SRH services (UNFPA, 2016; Balinska et al., 2019). Sinha et al. (2008) highlighted a clear unmet need in FP services among Iraqis in Amman, Jordan, especially among the long-term displaced.

Pregnant women and girls must **present a marriage certificate** to receive any pregnancy-related care (which includes FP) in camps. In addition, women **must register with the UN refugee agency** before receiving care.[10] According to UNHCR, a little over 50,000 Iraqi refugees

[8] The majority of the Yazidi population lives in Iraq, where they make up an important minority community. Estimates of the size of these communities vary significantly, between 70,000 and 500,000. They are particularly concentrated in northern Iraq (Nineveh Governorate). They are a small religious minority and an insular group, keeping mostly to themselves despite the often bloody realignments the borders and political structures around them have gone through (Hussein, 2016).

[9] US Department of State (US DoS) (2018). pp. 1, 20, 40-42.

[10] Although this policy was officially rescinded, it was still being enforced at the time of the mission.

had registered in Jordan in 2007; the vast majority had not registered.[11] In Turkey 2016 data shows that only 9% Iraqi refugees registered.[12]

9. Attitudes of providers

Humanitarian agencies

In the Middle East, Iraq is the only country where access to FP is a core component of the package of awareness campaigns and services Family Planning 2020 (FP2020) implement directly to act on the issue more long-term (Tull, 2018). Between 2017 and 2020, Médecins du Monde (Doctors of the World, MdM) implemented SRH activities in Iraq.[13]

However, provider biases have been found, including discrimination against refugees (e.g. Iraqis in Amman, Jordan) (Tanabe et al., 2017: 8). International guidelines set by the World Health Organization (WHO) state that **religious relief agencies are not required to provide services that violate their mandate**. Therefore, it is critical that other agencies be allowed to provide or support health services to ensure Iraqis have access to comprehensive SRH care, which is protected under human rights law.[14] Anecdotal evidence shows that many representatives, from local and international organisations as well as UN agencies, do not think SRH was a priority activity in the Iraqi refugee crisis in Jordan. One representative from a prominent non-governmental relief organisation said: “Why focus on women and girls? It’s the men and boys who need help.” Another representative from a UN agency “chuckled” when he heard that the field team was focused on SRH (Chynoweth, 2008).

While aid agencies provide care according to international standards, they often operate within host country national guidelines, which can particularly affect sensitive issues such as FP and delivery care (Casey, 2015; Balinska et al., 2019).

Governments

Iraq: Alongside the 2005 constitutional provisions, which aim to promote the health of all Iraqi citizens through provision of public health services, the 1981 Iraqi Public Health Law No. 89 of 1981192 provides broad measures aimed at supporting maternal health, FP, and children’s health. The Iraqi Public Health Law forces the state to guarantee the right of each citizen to physical and mental health, and obliges the state to regulate maternity care and family health care. However, **the Law does not make provision, nor does it refer to the prevention and treatment of illnesses specific to women, and a full range of women’s SRH issues and concerns** (Vilardo & Bittar, 2018: 46-47), especially adolescent girls and including gender-based

[11] UNHCR (2007). Iraqi refugees: fresh research studies. 14 December 2007. https://www.unhcr.org/afr/news/briefing/2007/12/47626dbe14/iraqi-refugees-fresh-research-studies.html

[12] 2,471 registered from 27,616 Iraqi refugees. See UNHCR Turkey (2016). Iraqi Refugees and Asylum Seekers registered with UNHCR. September 2016: https://data2.unhcr.org/en/documents/download/51781

[13] FP2020 (2017). FP2020: Doctors of the World joins global push to help women access contraception. 10 July 2017. https://www.doctorsoftheworld.org.uk/news/doctors-of-the-world-commits-to-providing-1-million-people-with-family-planning-by-2020/

[14] Convention on the Elimination of All Forms of Discrimination Against Women, 1990.

violence (GBV) (Allami, 2015). It is also reported that health has not been a government priority for some years (Aboulenein & Levinson, 2020). Therefore FP and SRH services have also been severely underfunded.

Non-Iraqi: In Amman, UNHCR's two partners were not providing any FP methods, one citing religious reasons. However, the Ministry of Health of Jordan was providing free contraceptives to Iraqi refugees, and encouraging them to access public health services (Tanabe et al., 2017: 7). Research from Turkey shows that Iraqi Turkmen[15], being Sunni, might have easier health care access than Shia Afghan refugees due to Turkish government's embracing of Sunni Muslims (Spahl & Österle, 2019).[16]

Health professionals

A deficit in knowledge of emergency contraception has been shown by health care physicians in Baghdad (Tawfeeq et al., 2020). Interviewed refugees reported that pharmacists would not sell contraceptives to young or unmarried women and girls (Chynoweth, 2008).
Abortion and sterilisation are prohibited in Islamic religion, except on medical grounds. There is said to be an "unwritten" agreement among Iraqi authorities to permit abortions for Yazidi rape victims. However, doctors refused to cooperate at first (Hussein, 2016).

Poor SRH communication

Information education and communication strategy is included in antenatal care to inform and educate pregnant women on topics related to pregnancy, care of newborns, and FP (Raoof & Al-Hadithi, 2011). However, **inadequate provision of information** and **poor interpersonal communication** has been reported (Shabila et al., 2014).

Poor leadership/ governance and **poor information technology in PHCCs** are also important obstacles (Raoof & Al-Hadithi, 2011; Shabila et al., 2012; Shabila et al., 2014). While some PHCCs possess computers, they are not used efficiently (Shabila et al., 2012). In KRI, collection of information on women's awareness of danger signs and their experiences at PHCCs showed that health education provided at antenatal clinic level in Erbil city was relatively poor (Raoof & Al-Hadithi, 2011). Women and youth often do not access information and services due to fear of discrimination or stigma, which can affect access to health and promotional services (UNFPA, n.d.). This was confirmed by the expert consulted for this rapid review.

Non-health professionals

Knowledge obtained from non-health professionals on contraceptive devices or oral pills might be **incorrect or incomplete** (Aldabbagh & Al-Qazaz, 2020). Ignorance about women's health issues leads many families to resort to folk remedies and informally trained midwives, especially in high poverty areas (Allami, 2015).

[15] Iraqi Turkmen and Afghans are the two largest refugee groups in Turkey, after Syrians.

[16] Current President Erdogan has stated that Muslim families cannot "understand and accept" birth control and FP: https://www.yahoo.com/news/family-planning-not-muslims-says-turkeys-erdogan-001816630.html

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