2 Women Health and Reproductive Health

Over the past eight years, the Arab region has increasingly faced up to the challenges of achieving ICPD[39] PoA goals; comprehensive sexual and reproductive health services within a rights framework that are accessible to women and young people. On the ground, several efforts have focused on addressing reproductive health and integrating it into family planning and maternal health services, with additional emphasis on young people, STIs/HIV/AIDS, unsafe abortion and gender-based violence.

"Significant advances in the recognition, promotion and protection of reproductive health were achieved in the Program of Action resulting from the United Nations' 1994 International Conference on Population and Development, held in Cairo. And in the Platform for Action resulting from the United Nations' 1995 Fourth World Conference on Women, held in Beijing. The Cairo and Beijing documents provide an important basis on which health care providers and organizations can build in order to develop reproductive health laws"[40].

Currently, the region is experimenting with cultural trends of conservative and westernized influences that are reflecting on social relations, attitudes and behaviors. Due to cultural restrictions sometimes based on misinterpretation of religious codes as well as gaps in policy and infrastructure, young people lack the skills and knowledge to appropriately make decisions that serve their best interest, including sexual and reproductive health choices. As a result, they are vulnerable to adverse health outcomes such as poor nutrition, early sexual activity, STIs/HIV, poverty, and violence.

MATERNAL HEALTH

Maternal mortality and morbidity continue to be priority challenges in the Region[41]. In most Arab countries[42], accurate information on maternal morbidity and mortality is difficult to obtain given inadequate vital registration systems and the subsequent inaccuracies due to under-reporting and misclassification of deaths. Regarding morbidity, the subjective nature of reporting illnesses and injuries correlated with pregnancy and childbirth are often influenced by gender-biased socio-cultural norms and by the absence of quality care services. , Socioeconomic status, societal support as reflected by socio cultural norm, women' access to and control over resources, and the accessibility, availability and quality of health

[39] International Conference on Population and Development, Cairo, Sept 1994.
[40] www.unfpa.org
[41] The average risk of dying from a pregnancy-related disorder in a developing country is about 250 times what it is in a developed country
[42] WHO's Regional Office for the Eastern Mediterranean estimates a maternal mortality ratio (MMR) of 440 per 100,000 live births, yielding 68,000 maternal deaths. According to UNICEF, 32,000 maternal deaths have occurred in the Middle East and North Africa regions.

care services have direct implications on women's health; High Maternal mortality rates are a good indication of the lack of support and care women suffer from during pregnancy and childbirth.

REPRODUCTIVE HEALTH IN CONFLICT AREAS

Iraq and the Occupied Palestinian Territories are two countries[43] where the impact of conflict on women's life and reproductive health is visible. In the Occupied Palestinian Territory (OPT), recent data indicates a 2% annual increase in infantile death rate between 1999 and 2001. In May 2003, the Ministry of Health reported that 52 women had to deliver at checkpoints. The new-born babies of 29 of these women did not survive while their mothers suffered extensive and painful morbidity. Moreover, health services have suffered a major decline in quality of care as the proportion of births attended by trained health staff declined from 98% in 2002 to 67% in 2003. Prevalence of anaemia increased among nursing mothers from 23.4% in 2001 to 31.5% in 2002. Women benefiting from pre-natal care decreased from 95.6% in 2000 to 82.4% in 2002. Home deliveries increased from 7.9% in 2001 to 14% in 2002.

Stillbirths occurred at an alarming rate of 5.2 per 1000 new born babies in 2001 and 2002. 2% of Palestinians (totaling about 70,000 people) have been displaced in 2000-2001 as a result of house demolition and military incursions.

In Iraq maternal mortality has tripled to 370 per 100,000 live births over the past decade, while anemia has been affecting about 70% of pregnant women, increasing the risk of mortality and morbidity. Furthermore, aid agencies are expressing serious concerns for the high percentages of miscarriages and stillbirths caused by limited antenatal care and emergency obstetric care ,and by high levels of stress.

According to a reproductive health survey[44], the number of women who die of pregnancy and childbirth in Iraq has nearly tripled since 1990. Bleeding, ectopic pregnancies and prolonged labour are among the causes of the reported 310 deaths per 100,000 live births in 2002, which the study found had risen sharply from 117 deaths in 1989. Miscarriages have also risen, partly due to stress and exposure to chemical contaminants. As a result, more women -- some 65 per cent -- are giving birth at home, the majority without skilled help. Between 50-70 per cent of all pregnant women in Iraq suffer from iron-deficiency anemia, as well as malaria and other problems. Yet, only 60 per cent of women receive some form of prenatal care, down from 78 per cent in 1996.

Contraceptive rates have also fallen due to a breakdown in supplies. A considerable proportion of women and men are not aware of family planning methods and there has been an increase in unsafe abortions. The survey also noted that Iraq has a very young population -- 50 per cent are under age 15 -- and teenage pregnancies are on the rise.

The study further pointed to an increase in the incidence of sexual violence and abductions in Baghdad, but said that most cases are not reported or investigated. Health personnel are not trained to deal with the problem and reporting a rape often brings further problems for victims, including social rejection.

[43] Ibid.
[44] The survey, conducted by UNFPA in collaboration with the International Centre for Migration and Health, was shared during the recent Madrid donor conference on the reconstruction of Iraq.

Statistical evidence also indicates a changing pattern of occurrence in all forms of cancer, augmented by an aggregate increase in the number of patients since the Gulf war.

While Iraq has a strong cadre of well-qualified health personnel, their skills urgently need to be updated since sanctions limited their access to new scientific findings for over 10 years. Breakdown in security, as well as weakened communication and transport systems, have made access to medical facilities difficult for women. The health system is in desperate need of rehabilitation. Many clinics have been damaged and looted, water and electricity supplies have been disrupted and drugs and medical equipment are grossly lacking.

ADOLESCENT CHILDBEARING

In the last 20 years, adolescent fertility has been on the decline in the Arab region; however, it is still a major health policy concern with significant variation across countries. Young girls continue to be at risk of early marriage and early pregnancy; socially dictated conviction of the need to prove their childbearing capacity. Evidence from Sudan, Syria and Yemen document sociocultural pressures that reward teenage pregnant women with peer acceptance and family appreciation.[45] According to PAPCHILD and Gulf surveys for 1990-98, fertility rates for young women ages 15-19 ranged from 18 per 1000 in Tunisia to 103 per 1000 in Yemen, with Saudi Arabia and Sudan towards the higher end. Recent research has revealed that Arab women use contraception after having reached a large family size early in life; thus, contraception is more a method of seizing rather than limiting childbearing. Given the lack of access to SRH information and services, women's health is compromised due to multiple, closely spaced pregnancies at younger ages. With their bodies not yet fully developed and already compromised by malnutrition and often anemia, pregnant young girls are subjugated to high risk of maternal and neonatal morbidity/mortality.

Although some Arab countries have increased the legal age for marriage, this has not had the intended impact in traditional rural-based societies like Yemen where ¼ of ever-married women are between ages 15-19.[46] What might make the most impact in reducing adolescent fertility is the availability and access of accurate SRH information and products. With regards to Arab women who desire no more children, a more individual approach to contraceptive counseling and prescription would both solicit and respond to desired fertility, which would in fact contribute significantly to reductions in fertility rates, unsafe abortions and high discontinuation rates for some birth control methods. For example, the IUD would be an optimal choice for many of these women, however; its supply may be lacking due to deficiencies in logistics management, and weak technical and counseling skills on the part of the provider.

UNSAFE ABORTION

Of all the Arab countries[47], only Algeria and Egypt have recent data on abortion (unofficial) from community surveys conducted in 1990-92. In a random sample of 5024 Algerian married women, 4.3% reported having an abortion with an average of 1.2 abortions per woman. Additionally, abor-

[45] Farah and Abu-Nuwar, 1996.
[46] Farid, 1999.
[47] Press Release WHO/28 "Abortion in the Developing World", 17 May 1999, http://www.who.int/inf-pr-1999/en/pr99-28.html (10 December 2002).

tions were more frequent in urban areas with 11.3% of live births in contrast to rural areas (9.9%.) In Egypt, abortion caused 4.5% of 772 maternal deaths.[48] Unfortunately, data on unsafe abortion tends to be inaccurate and unreliable, particularly in countries where abortions are illegal or prevailing socio-cultural norms weigh heavily on women's sexuality and reproductive health.

In general, women commonly fail to report the number of abortions they have had and whether these abortions were spontaneous or induced. The majority of these women are married or are in stable relationships and have several children. They seek abortions to restrict or space their pregnancies because they lack access to contraceptive methods or are victims to contraceptive failure. In 1997, only 35% of the demand of married women for contraceptives in Yemen was satisfied, and more than one-third (38.6%) had unmet needs for family planning. In contrast, unmet need was not as high in Egypt (10.7%), Jordan (14.2%) and Morocco (11.2%), all of which fall in the TFR range 3-5.[49] Adolescents, particularly in urban areas, are increasingly having unsafe abortions. These young women may have limited or no access to youth-friendly sexual and reproductive health (SRH) services, which can provide them with information on sexuality, sexual practices, contraceptive options, and counseling and support on unwanted pregnancies.

CONTRACEPTION/FAMILY PLANNING

The Arab States region has seen a substantial increase in contraceptive use and the subsequent decrease in fertility in the last four decades. In 2000, more than half (54%) of Arab women in relationships were using contraceptives, and the regional fertility rate was down to 3.7 (from 5.0 in 1990).[50] Recent statistics (2002) document the use of modern contraceptives by married women ranging from 50+% in Algeria, Egypt and Tunisia, to as low as 10% in both Iraq and Yemen and 7% in Sudan. Rates for other Arab countries were recorded in Morocco (42%), Kuwait (41%), Jordan (38%), Lebanon (37%), Saudi Arabia (29%), Syria (28%), Libya (26%), UAE (24%) and Oman (18%). Contraceptive use in Arab countries is outpacing traditional methods such as calendar rhythm and withdrawal. In seven countries, traditional methods were used by more than 10% of married women – Lebanon (24%), Algeria and Libya (14%), Jordan (15%), and Kuwait and Yemen (11%).[51] Yemen is the only country where use of modern and traditional methods is nearly equal. Understandably, Yemen (7.6) and Somalia (7.3) ranked second and third highest in fertility rates worldwide, with practically no change since 1990. Closely following are women from Occupied Palestine Territories and Saudi Arabia who have six children on average. [52]Contraceptive use and recent plateauing trends in the Arab world are challenged by several factors, including gender and socio-cultural norms which value fertility, lack of comprehensive and quality SRH services, provider bias, etc.

[48] WHO, Division of Reproductive Health, Unsafe abortion: Global and regional estimates of incidence of and mortality due to unsafe abortion with a listing of available country data (WHO/RHT/MSM/97.16). Geneva, Switzerland: WHO, 1998, pg. 35.
[49] DHS - Egypt (2000), Jordan (1997), Morocco (1992) and Yemen (1997), www.statcompiler.com.
[50] UNFPA, Population Estimates and Projections, 2000 Revisions. In Progress Since the World Summit for Children, pg. 16.
[51] The State of the World's Population 2002, pgs. 69-70.
[52] Ibid, pgs. 72-3; Progress Since the World Summit for Children, pg. 16.

SEXUALLY TRANSMITTED INFECTIONS, INCLUDING HIV/AIDS

The Arab States region first experienced the HIV/AIDS epidemic in the late 80s, and the spread of infections occurred at a much slower rate, in contrast to other parts of the world. Even tough prevalent social and cultural conservative norms influenced HIV's slow movement to and within the region, recent information suggests that HIV+ infections are steadily on the rise within individual countries, and the region is no longer shielded from its impacts. In 2002, an estimated 550,000 adults and children were living with HIV/AIDS, of which 83,000 were new infections in that year alone.[53]

Women and children have borne severe burdens as both primary and secondary victims to HIV/AIDS. More than half (54%) of HIV-positive adults are women, and children ages 0-14 account for 7% (35,000). 65,000 children ages 0-14 have lost one or both parents to the disease.[54] Young people are particularly vulnerable given their susceptibility to high-risk behavior, misconceptions regarding disease and prevention, and lack of access to affordable health care. 160,000 young people 15-24 years old (of which 41% are female) are living with HIV/AIDS.[55] Only 8% of Sudanese women and 18% of women 15 – 19 years old in the Occupied Palestinian territories knew where to go for an HIV/AIDS test (1998-2001).[56]

In addition to the regional consensus and will to address HIV/AIDS, individual countries have also taken significant action on national levels. These included conducting comprehensive assessment, and developing a multi-sectoral national strategic plan for HIV/AIDS. Additionally some countries have introduced HIV/AIDS to STI case management and control, and designed essential packages for care and prevention. The packages include guidelines on HIV prevention through peer education strategies among sex workers, men having sex with men (MSM) and injecting drug users, community-based education and communication projects targeting young people living in slum areas, IEC campaigns with involvement of youth, and counseling activities. Countries undertaking such activities are Morocco, Djibouti, Lebanon, Egypt, Sudan, Tunisia, Yemen, Lebanon, Jordan, Oman, Syria and Tunisia.[57]

Constraints and obstacles

Despite the effort, several areas continue to remain deficient and pose significant challenges. Even though current information indicates low HIV prevalence in the Arab States region, several factors can yield a future crisis unless action is taken, as past experience has shown elsewhere in the world:

- Inadequate national surveillance systems severely inhibit an accurate assessment of STIs/HIV in the region, including patterns and trends of infection, high-risk behaviors and practices, injected drugs use, men having sex with men, sex in exchange for money or goods, etc.
- The lack of voluntary STIs/HIV counseling and testing services further complicates surveillance efforts to systematically track and address STIs/HIV prevalence in Arab populations. The region is estimated to have a high STI

[53] UNAIDS, Fact Sheet 2002: The Middle East and North Africa, 2002.
[54] WHO/UNAIDS, Report on the Global HIV/AIDS Epidemic 2002, July 2002, pg. 198.
[55] UNICEF/UNAIDS/WHO, Young People and AIDS: An Opportunity in Crisis, pg. 5.
[56] Ibid, UNICEF/MICS 1999-2001 and Measure DHS 1998-2001, pg. 31.
[57] Progress Report on AIDS in the Eastern Mediterranean Region.

prevalence rate, and more so among young people and in urban areas. In 1995, UNAIDS reported that within the age group 15-49, the region had an estimated 10 million new infections of curable STIs and an incidence rate of 60 cases per 1000 individuals.

• Socio-cultural conservative norms suppress recognition and acknowledgement of high-risk sexual behaviors and practices. These norms perpetuate the barriers to women's access to RH services. The stigma and discrimination associated with STIs/HIV strengthen-popular misconceptions about STIs/HIV transmission and prevention and impede care and support for those affected by STIs/HIV.

ROLE AND IMPACT OF NGOS

Family Planning Associations, Women NGOs, Youth, and other associations such as those working in fighting GBV/ FGC and preventing HIV-AIDS played a strong role in advocacy, lobbying and building coalitions to handle the epidemic. These players have been providing services and mobilizing communities to change negative stereotypes and to ensure that women and men have access to support services and enjoy their Health and Reproductive rights without any kind of discrimination. Proactive attempts at engaging faith based organizations in policy dialoguese specially in culturally sensitive issues like HIV\AIDS pandemic and family planning have been particularly successful.

The second half of the century has witnessed substantial changes targeting development and population in the Arab region. Arab planners, policymakers and program directors are increasingly aware of the need for sustained advocacy and policy consensus building to more efficiently match policies, program and services to the needs of underserved groups.

Nevertheless, civil society and NGOs have not yet assumed a major role in the fight against HIV /AIDS. More spe-

Through operating in rural regions, NGOs contribute to the development of needy population groups and regions through comprehensive interventions targeting reproductive Health/ Rights and women's-empowerment skills, in addition to income generating activities and literacy (Session organized by the Foundation FEKDR in rural area of Tunisia (Governorate of El Kef).

cifically, this could be done through the following:

- Motivating and mobilizing the political will to involve civil society organizations in the process of development in all its aspects, and in promoting reproductive and maternal health concerns within the context of human rights.
- Civil society organizations need to have a clear agenda, a consistent purpose and a commitment to be involved in the advocacy and policy dialogue to improve health related policies, and to address gender equality and empowerment of women as an essential and cross cutting issue. Focused efforts need to be invested in health education for all, fighting illiteracy, providing access to reproductive and sexual health services and to family planning services, reducing maternal, infant and child mortality, facing environmental challenges, and preventing the spread of HIV/AIDS.

Encouraging partnerships between government processes, market mechanisms, and civil society at all stages of population and development policies and strategies is a prerequisite to the success of all other choices and initiatives.