PILLAR 1:

HEALTH AND WELLBEING

OVERVIEW AND KEY CONSIDERATIONS

The region as a whole has made significant progress on improving key general health indicators including lowering maternal and under-five mortality and decreasing the disease burden generally. Further, non-communicable diseases have replaced nutritional disorders and communicable diseases as major causes of women's death and disability. Throughout the region, emergency and conflict settings continue to have significant health impacts on populations, and disproportionately on women and girls.

Despite significant progress on several health indicators, the 2020 report by the Economic and Social Commission for West Asia (ESCWA)[146] on the status of the SDGs in the Arab region noted that levels of health and well-being remain significantly uneven within and between countries, with health services fragmented and often supply-driven, and access to universal health coverage varying widely within and among countries and social groups. Most health systems continue to focus largely on curative health services instead of primary and preventative care and pay little attention to the social determinants of health.[147]As such, there is an overall lack in the essential elements of the right to health: ensuring availability, accessibility, acceptability and quality.

Evidence shows that women and girls throughout the region face major barriers in accessing Mental Health and Psychosocial Support Services (MHPSS), programming, and information. While many women throughout the region suffer from depression and stress at higher rates than men, cultural stigma around mental health often prevents both access to services and effective treatment.[148] Further, the lack of dedicated mental health legislation in half of the countries within the region and a lack of national policies and plans in 30 per cent of the countries may indicate that a large proportion of women are likely left without prevention and response services.[149] Overall, there is a lack of psychosocial support across the region[150] which has been amplified and exacerbated by the COVID-19 pandemic.

Ensuring that Sexual and Reproductive Health and Rights (SRHR) are met for all women and girls in the region requires that norms and practices that are embedded in society are challenged and confronted. Barriers to SRHR are present in laws, policies, and the economy worldwide, and prevent women and girls from gaining access to knowledge and services that contribute to healthy and equitable lives for women and girls at all stages of their lifecycle. Securing adequate and appropriate sexual and reproductive health care for every woman and adolescent girl hinges on the realisation of reproductive rights, which are often overlooked.[151] These barriers are not unique to the region and are present throughout the globe, however, the MENA and Arab States region present a particularly challenging operating environment as SRHR is a culturally sensitive topic for many societies in the region, especially within the context of the ongoing conflicts and fragilities. For example, reluctance to teach sexuality has meant that young people often rely on the Internet or peers for information, which may be inaccurate. Furthermore, a prevalent tendency among socially conservative societies

146 ESCWA, Arab Sustainable Development Report 2020, 2020.
147 Ibid.
148 Dalacoura, Katerina, Middle East and North Africa Regional Architecture: Mapping Geopolitical Shifts, Regional order and Domestic Transformations, Women and Gender in the Middle East and North Africa: Mapping the Field and Addressing Policy Dilemmas at the post-2011 Juncture, 2019.
149 Ibid
150 UN Women, Accountability for Sexual Violence in Conflict: Identifying Gaps in Theory and Practice of National Jurisdictions in the Arab Region, 2018.
151 Starrs, Ann M, et al, Accelerate progress – sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission, 2018.

of the region to only consider SRHR in the context of marriage means that unmarried adolescents, men and women, face social barriers in raising issues concerning their SRHR with health-care providers.[152] Moreover, data and evidence on adolescent health in particular continues to be a gap throughout the region.

Overall, however, the region exhibits a lack of a rights-based approach to SRHR, despite commitments to and efforts to comply with the range of global instruments noted above. Countries in the region still face challenges in granting access to sexual and reproductive health care for all, without discrimination based on sex, nationality, displacement status or marital status. Services related to maternal health, family planning, and the prevention and treatment of sexually transmitted infections and HIV/AIDS are not fully integrated within primary health care. Accessibility and quality vary across countries, among social classes and from urban to rural areas. Cultural barriers significantly prevent women and couples from deciding freely and responsibly on their sexual and reproductive health, including family planning.[153]

Similarly, as discussed below legal frameworks do not reflect a rights-based approach that promotes well-informed individual choices, and often stipulate exemptions from the legal age to marry, leading young girls into marriage and early pregnancy.

There is a specific gender dimension to food security and nutrition that is widely supported by established research and data. Worldwide, vulnerable women and girls experience a greater risk of malnutrition than men, and more girls die of malnutrition than boys.[154]

Food insecurity affects women and girls of all ages. While pregnant, food insecure women are more likely to experience iron-deficiency anemia, anxiety, depression, and excess weight gain; among children, food insecurity can negatively impact long-term physical, mental, and cognitive development; and food-insecure adults are more likely to have diabetes, high blood pressure, and experiencehypertension.[155]

The triple burden of malnutrition, consisting of undernutrition, overweight or obesity, and micronutrient deficiencies, is clearly visible among women and girls in the region, with high rates of obesity existing alongside both acute and chronic undernutrition, particularly in countries affected by protracted crises such as Yemen and Syria. Undernourishment is especially high in conflict-affected countries. A 2019 study of gender disparity in dietary intake noted that the MENA and Arab States region features a marked gender gap detrimental to women. It also noted that the region has experienced a major increase in the prevalence of obesity and nutrition related non-communicable diseases, with the prevalence of obesity and diabetes among the highest worldwide.[156]

Equitable access to safe Water, Sanitation and Hygiene (WASH) services has not been met in the region. Women in poor households are less likely to have access to clean, safe places for Menstrual Health Management (MHM) or other sanitation facilities that provide appropriate security and hygiene standards to maintain women's unique needs related to privacy and dignity. Furthermore, lack of access to WASH services at schools for women and girls may lead to their missing school or dropping out altogether. These access issues are exacerbated in very impoverished and/or conflict-affected countries, and more generally there are gaps in access to services between rural and urban communities throughout the region. Besides, because suitable drinking water sources are also frequently missing at a family's home site, cultural norms throughout the region that designate

152 ESCWA, Arab Sustainable Development Report 2020, 2020.
153 Ibid.
154 FAO, Gender and Nutrition, No date.
155 ESCWA, Arab Horizon 2030: Prospects for Enhancing Food Security in the Arab Region, 2017.
156 Abassi, Mohamed Mehdi, et al., Gender inequalities in diet quality and their socio-economic patterning in a nutrition transition context in the Middle East and North Africa: a cross-sectional study in Tunisia, Nutrition Journal 18:18, 2019.

women and girls as responsible for their household's water collection can involve long walks that expose them to protection and security risks. [157]

During crisis situations, gender-based water insecurity is amplified, especially for refugee or internally displaced women and girls who face major barriers in accessing basic services that are essential to their and their families' health and well-being. In addition to accessing basic services, women-headed households experience financial burdens that further limit their abilities to purchase water. In some countries water rights are tied to land rights which in certain instances restrict women's access.[158]

Moving forward, key considerations include:

- Continue fostering a rights-based and people-centred approach to health and focus on the four essential elements of the right to health: availability, accessibility, acceptability and quality. This includes ensuring a gender-based approach to health services, policies and increasing relevant investments in health.

- Ensure provision of integrated benefit packages which deliver services including the whole continuum of care at all ages with focus on maternal health, family planning, and the prevention and treatment of sexually transmitted infections, HIV/AIDS and GBV services, and strengthen cross-sectoral co-ordination to improve efficiency including aadvocating for comprehensive sexuality education in education – both in formal and non-formal settings. Ensure that services provision includes the dimensions of universal health coverage in terms of better access to services with focus on access in rural areas and innovative telemedicine approaches , the scope and quality of care, securing equitable access to health information, in addition to financial protection to those most vulnerable including women and girls.

- Addressing the health disparities and inequities through addressing the social determinants of health and focus on 'whole-of-society' approach that's ensures the engagement of women in decision making in reference to health service provision and accountability.

- Ensure essential services are provided to vulnerable populations including women's and girls in fragile countries in the region and those of humanitarian complex settings including maintaining these services amid the current COVID-19 preparedness and response.

- Address insufficient data on adolescent health and nutrition by identifying key health indicators, allocating adequate resources to relevant quantitative and qualitative research gaps, and enhancing effective data management with focus on sex and age disaggregation.

- Address the major increase in non-communicable diseases by ensuring gender-responsive research, policies as well as adequate access to training facilities.

- Advance mental health legislations and policies and expand access and quality of available medical, mental health and psychosocial support services, including to address violence against women and girls, especially for those impacted by emergencies including the COVID-19 pandemic.

157 United Nations, Women, Water Security, and Peacebuilding in the Arab Region, Policy Brief, 2018.
158 United Nations, Women, Water Security, and Peacebuilding in the Arab Region, Policy Brief, 2018.

- Build gender and adolescent-responsive health systems, including Primary Health Care systems, to provide quality non-discriminatory and integrated youth-friendly health services with an adolescent and gender-competent workforce.

- Address existing social and economic barriers to women's food security and nutrition by ensuring their equal entitlements, access to and control over assets, resources and services (financial and non-financial), and by enhancing their access to decent employment, livelihood opportunities, and social protection. Special attention should be dedicated to support women and girls in conflict-affected areas, women refugees and IDPs.

- Enhance the access of rural women to and control of agricultural assets (land, in particular) and facilitate their exposure and uptake of nutrition-sensitive agricultural practices and technologies through targeted and accessible capacity building programmes.

- Allocate adequate resources for the adoption of gender-transformative approaches in food security and nutrition-related policies and programmes, including capacity building of stakeholders in gender analysis and programming, to tackle the discriminatory social norms and gender roles that limit women's control over income and assets, and their decision-making power within households and communities.

- Ensure the sex and age disaggregation of data on hunger and malnutrition and provide support to regional and national strategies and programmes through intersectional gender and age analyses. This should be done in a manner that explores intrahousehold dynamics and roles in food security and nutrition, and addresses hunger and malnutrition through a lifecycle approach.

- Engage women, men, girls, and boys through social behavioural communication change initiatives that seek to engage all groups equitably utilizing gender transformative approaches that change stereotypical gender roles associated with food security and nutrition and acknowledge the valuable contributions of women and girls to food security, food production, preparation, and distribution.

- Address the disproportionate impacts of climate change on the food security and resilience of women and girls and promote gender equality and climate resilience in interventions related to the development of food systems.

- Strive for equitable access to safe WASH services, especially in rural and conflict/emergency settings and ensure adequate resources for effective implementation.

- Address the gender impact of climate change through gender responsive National Adaptation Plans that builds on relevant evidence, engage women and girls in the development process, maintain health and education services and secure economic and empowering opportunities for women and girls in WASH sector.

- Promote health literacy and nutrition and WASH education to improve the nutritional status of women and girls, households and communities, by ensuring that fathers and mothers are equally targeted by programmes and initiatives.

Situational Analysis of Women and Girls in the MENA and Arab States Region: Pillar 1 Health and Wellbeing Key Messages and Recommendations

OVERVIEW

The region has made significant progress on improving key general health indicators and strides are made to align national priorities with the SDGs agenda, however, emergencies and conflict settings continue to have significant health impacts on populations and are stilling and reverting progress. Conflicts are also the main drivers for food insecurity and malnutrition within the region. Non-communicable diseases have replaced nutritional disorders and communicable diseases as major causes of women's death and disability. The region has made significant progress on improving key general health indicators including lowering maternal and under-5 mortality, decreasing disease burden, and increasing life expectancy. 14 of the 21 countries have reached the SDG indicator of reducing maternal deaths to less than 70 per 100,000 and female life expectancy at birth increased in all countries (from an average of 68 years in 1995 to 71.31 years in 2019). However, Sudan, Djibouti, and Yemen remained above global estimate for U5 Mortality.

Continue fostering a rights-based and people-centred approach to health and focus on the four essential elements of the right to health: availability, accessibility, acceptability and quality.

POLICY GAPS

The right to health has been adopted into domestic or constitutional laws in most countries of the region, and governments throughout the region have made institutional changes and begun to align national priorities with the SDGs, including launching voluntary national reviews. There is lack of dedicated mental health legislation in 50% of the countries within the region, and a lack of national policies and plans in 30% of the countries which indicates that a large proportion of women are likely left without prevention and response services. Securing adequate and appropriate sexual and reproductive health care for every woman and adolescent girl hinges on the realization of reproductive rights, which are often overlooked. Barriers to SRHR are present in laws, policies including codes related to sale, procurement, or facilitation of contraception, and laws related to child marriage and FGM practices. While all countries in the region have signed the Convention on the Rights of Persons with Disabilities, operationalization and implementation of this instrument is very limited.

Addressing the health disparities and inequities through addressing the social determinants of health and focus on 'whole-of-society' approach that's ensures the engagement of women in decision making in reference to health service provision and accountability.

SYSTEM BARRIERS

Health services remain fragmented and often supply driven; most health systems continue to focus largely on curative health services instead of primary and preventative care and pay little attention to the social determinants of health. While advancements have been made regarding safe motherhood programmes, lack of integration between maternal and neonatal health remains a major challenge and services related to maternal health, health family planning, and the prevention and treatment of sexually transmitted infections and HIV/AIDS are not fully integrated within primary health care. Issues of human resources, supplies, public-private divisions, verticalization of health programmes and the lack of universal health coverage are sited as major barriers to SRHR in the region. The region also characterized by limited mental health services, inadequate antiretroviral treatment (reaching 38% of those in need), and low priority of screening for reproductive cancers which is practiced at a limited scale in the public sector.

Ensure that services provision includes the dimensions of universal health coverage in terms of better access to services with focus on access in rural areas and innovative telemedicine approaches and securing equitable access to health information, in addition to financial protection to those most vulnerable including women and girls

NORMS

There is little consistent, robust data on the issue of norms and practices relating to health care decisions and information and access to services within the region. However, data from some countries indicate limited levels of autonomy in decisions about women and girls own health (between 9.4% and 40% of decisions regarding a woman's own health are made by the woman herself). Stigma and discrimination limit access to and utilization of services for mental health issues, HIV testing, and menstrual health needs. Knowledge of HIV prevention remains extremely low with marked contrast between males and females. Discriminatory sociocultural norms affect women's control over assets and resources, as well as their decision-making power within households, communities and institutions, thus comprising their socioeconomic empowerment, their food security and their nutrition.

Build gender and adolescent-responsive health systems, to provide quality non-discriminatory and integrated youth-friendly health services with an adolescent and gender-competent workforce.

ACCESS INEQUALITY

53% of people in the region had access to basic health services below the global (population weighted) coverage of 64%. Access to health is especially inequal for rural women, women in conflicts and emergencies, as well as people living with disabilities (50% cannot afford health care). Long travel distances, lack of female health providers and concerns about entering health-care facilities alone, are among the underlying norms that affect access and utilization. Across the region, access of young people, particularly unmarried young people to SRHR services, remain limited. Lack of financial resources is another major barrier, where public health insurance usually covers only between 30 and 40% of the population; women from the wealthiest quintile between 46% and 62% more likely to deliver in a health facility than those from the poorest wealth quintile.

Ensure essential services are provided to vulnerable populations including women's and girls in fragile countries in the region and those of humanitarian complex settings including maintaining these services amid the current COVID-19 preparedness and response.

MENTAL HEALTH

The region has experienced a steady increase in mental health disorders. Within the region 33% of women felt stressed to a point where ´everything seemed like a hassle either ´often' or 'most of the time' and anxiety disorders and depressions is highly prevalent amongst girls 10 -19 years. Female youth in crisis-affected areas of the region exhibited a higher prevalence of mental health issues than male and refugees with disabilities were twice as likely to report psychological distress than refugees without. COVID-19 pandemic introduced additional mental health strains (and associated strains on services) in all countries. Mental health services are extremely limited within the region, with intra-regional disparity in dedicated human resources and the number of mental hospitals (per 1000,000 population) is higher than global median in only three countries. Women and girls face major barriers in accessing services, programming, and information. Approximately 70% of NGO-run shelters in the region follow the practice of not accommodating women with mental health issues and cultural stigma around mental health often prevents both access to services and effective treatment.

Advance mental health legislations and policies and expand access and quality of available medical, mental health and psychosocial support services, including to address violence against women and girls

SEXUAL AND REPRODUCTIVE HEALTH PROGRESS

Reduction in maternal mortality outperforms the global average; decreased from 238 (2000) to 156 (2015) per 100,000 live births, compared to a world average of 216 and the region is yet to reach the goal for lifetime risk of maternal death among 15 years and plus females. 13 of the 21 countries have reached at least 90% skilled birth attendance (Yemen and Somalia report levels below 75%) and roughly 78% of ever married women aged 15-49 reported having their reproductive needs for family planning satisfied with modern methods. Antenatal care is lower in rural and poor areas; estimated 65% of women receive postnatal care. However, in similar areas in the LDC subregion women are most likely to receive no postnatal care at all. Abortion, especially unsafe abortion, is a neglected public health topic despite two in five pregnancies being unplanned, of which one half ending in abortion. Qatar and Tunisia have CSE in schools, with other countries (Djibouti, Egypt, Jordan and Syria) providing some form of sexuality education outside the school context.

Ensure provision of integrated benefit packages which deliver services including the whole continuum of care at all ages with focus on maternal health, family planning, and the prevention and treatment of sexually transmitted infections, HIV/AIDS and GBV services, and strengthen cross-sectoral coordination to improve efficiency including aadvocating for comprehensive sexuality education in education – both in formal and non-formal settings.

ADOLESCENT HEALTH

Data and evidence on adolescent health continues to be a gap throughout the region. Collective violence is among top five causes of death and anxiety disorders and depressions are among the top five causes of DALYs among young girls 10 -19 years. Across the region, young people, particularly unmarried young people, remain highly neglected populations in terms of access to SRHR services and education. Reluctance to teach sexuality has meant that young people often rely on the internet or peers for information, which may be inaccurate. In conflict-affected countries, younger females (15 – 29) are less likely to have their family planning needs met than older cohorts. Given the increasing trends in child marriage, the prevention of unintended pregnancies and reduction of adolescent childbearing is crucial to the health and well-being of these young women. Women and girls affected by VAWG are growing in the region, adolescent girls in emergency contexts raise concerns of sexual abuse and exploitation particularly for those with disabilities.

Address insufficient data on adolescent health and nutrition by prioritizing key health indicators, allocating adequate resources to relevant quantitative and qualitative research gaps, and enhancing effective data management with focus on sex and age disaggregation.

PHYSICAL ACTIVITY AND NON-COMMUNICABLE DISEASES

While the region has witnessed a decrease in DALYs for causes such as diarrhoea and respiratory infections in recent years, ischaemic heart disease, major depressive disorders and diabetes have become more widespread. Unhealthy diets – along with physical inactivity – are key contributors to the burden of non-communicable disease in the region where several countries demonstrate highest rates of physical inactivity, obesity, and diabetes in the world (26.9% of men and 43.5% of women). Adolescents perform poorly in engaging in adequate physical activity, this is true globally but is worse in the region with a rate of 87% (84.3% boys and 89.9% girls).

Address the major increase in non-communicable diseases by ensuring gender-responsive research, policies as well as adequate access to training facilities.

COVID-19

Restrictions on movement and social distancing measures have limited households' access to work, regular income, remittances, markets, schools and healthcare in the region. Lower income/savings depletion and decreased government capacity to respond to a second and third wave may worsen poverty and inequality, and lead to deterioration of household food security while increasing people's health needs.

Ensure essential services are provided to vulnerable populations including women's and girls in fragile countries in the region and those of humanitarian complex settings including maintaining these services amid the current COVID-19 preparedness and response.

Situational Analysis of Women and Girls in the MENA and Arab States Region: Pillar 1 Food Security, Nutrition and WASH Key Messages and Recommendations

OVERVIEW

The triple burden of malnutrition (undernutrition, overweight or obesity, and micronutrient deficiencies), is clearly visible among women and girls in the region, particularly in countries affected by protracted crises such as Yemen and Syria. 11% of the population reported that they experience severe food insecurity, which is estimated to be 56 million people. Cross-cutting issues of conflict and climate change also impact food security and nutrition status. There is a specific gender dimension to food security and nutrition, vulnerable women and girls experience a greater risk of malnutrition than men, and more girls die of malnutrition than boys. Across the region, and particularly in countries affected by conflict, female-headed households are the most susceptible to food insecurity and the most likely to resort to negative coping mechanisms that increases their protection and security risks.

Address existing social and economic barriers to women's food security and nutrition by ensuring their equal entitlements, access to and control over assets, resources and services (financial and non-financial), and by enhancing their access to decent employment, livelihood opportunities, and social protection. Special attention should be dedicated to support women and girls in conflict-affected areas, women refugees and IDPs.

POLICY GAPS

Governments within the region have established laws and policies to address food insecurity and nutrition. While analyses around laws and policies influencing food security specifically are lacking, a range of policy statements and recommendations have been made over the past decade addressing key issues around nutrition. 89% of countries in the region have nutrition policy, 53% reporting policies relating infant and young child nutrition, and 17% had costed operational plans. Other examples of laws and policies include fortifying staple foods with micronutrients, micronutrient supplements, promoting exclusive breastfeeding and school feeding. The lack of policy coherence and sectoral coordination, coupled with limited institutional capacities, also prevents the formulation and implementation of gender-responsive food security and nutrition policies. While limited implementation, 17 countries in the region put some of the provisions of the International Code of Marketing of Breastmilk Substitutes into law. At national level, several countries have recognized the right to water in their constitutions; 13 countries ratified the Arab Charter of Human Rights which refers to the right to water and sanitation. Women's inadequate access to land remains an obstacle for improvement of both food security, agricultural productivity and access to water.

Allocate adequate resources for the adoption of gender-transformative approaches in food security and nutrition-related policies and programmes, to tackle the discriminatory social norms and gender roles that limit women's control over income and assets, and their decision-making power within households and communities.

SYSTEM BARRIERS

Supplementation and food fortification was implemented widely across the region. 21 countries are implementing vitamin and mineral supplementation for pregnant women (iron and folic acid), while 8 eight countries report provision of supplements to women of reproductive age (folic acid and iron) and 16 report the provision of supplements to children (vitamin A, iron, micronutrient powder, zinc and iodine). 16 countries report fortification of salt, 12 countries report fortification of wheat flour, six report fortification of oil, and one country reports fortifications of sugar. 17 countries had some coverage of wheat flour fortified with iron and folic acid, which is mandatory in 11 countries. There is limitation in the sex and age disaggregated data on hunger and food insecurity in the world and in the region.

Ensure the sex and age disaggregation of data on hunger and malnutrition and provide support to regional and national strategies and programmes through intersectional gender and age analyses. This should be done in a manner that explores intrahousehold dynamics and roles in food security and nutrition, and addresses hunger and malnutrition through a lifecycle approach.

NORMS

Roles and responsibilities associated with food security, nutrition and water management largely fall on the shoulders of women and girls in the region due to gender social norms. Women and girls gendered responsibility for household's water collection can involve long walks that expose them to protection and security risks. The lack of engagement of men and boys in food preparation exacerbates women and girls' unpaid domestic chores and restricts women. Limited knowledge about what constitutes appropriate complementary feeding, often results in poorer nutritional outcomes for women and their children. In terms of dietary intake, the region features a marked gender gap detrimental to girls and women. Girls in Yemen often have the least access to food at mealtimes due to cultural norms that determine who within a family eats first. In the South Darfur region of Sudan a mistaken belief is prevalent stating that male infants needed to be fed solid foods starting at three months, as opposed to six months for female infants. Lack of physical activity and mobility in public spaces due in part to cultural norms that constrain women's and girls' movement outside the house and de-emphasize the importance of physical education for girls in school contribute to the high rates of obesity and overweight status in women in the region.

Engage women, men, girls, and boys through social behavioural communication change initiatives that seek to engage all groups equitably utilizing gender transformative approaches that change stereotypical gender roles associated with food security and nutrition and acknowledge the valuable contributions of women and girls to food security, food production, preparation, and distribution.

AT RISK GROUPS

Most individuals who experience hunger in the MENA region are located in the five countries currently in conflict; Iraq, Libya, Syria, Sudan, and Yemen. Individuals living in poverty are more likely to have insufficient water and sanitation facilities and are at greater risk of experiencing food insecurity, hunger, and have a lower nutrition status as their economic access to food is compromised. Employment in agriculture sector accounts for 1/3 of total female employment in the region mainly through informal work sectors. As such, water scarcity jeopardizes women and adolescent girl's income opportunity, amplifying economic vulnerability while also risking food insecurity. Mothers with a low level of education and a low income are more likely to have stunted children due to their limited knowledge and capacity to obtain food that will provide a diverse and nutritious diet.

Enhance the access of rural women to and control of agricultural assets (land, in particular) and facilitate their exposure and uptake of nutrition-sensitive agricultural practices and technologies through targeted and accessible capacity building programmes.

FOOD SECURITY

There is a specific gender dimension to food security and nutrition. Despite the key roles women play in food systems, they tend to experience a greater risk of food insecurity than men, and more girls die of malnutrition than boys. Across the region, and particularly in countries affected by conflict, female-headed households, rural and refugee women, and women living with a disability are the most susceptible to food insecurity and the most likely to resort to negative coping mechanisms.

Address existing social and economic barriers to women's food security and nutrition by ensuring their equal entitlements, access to and control over assets, resources and services (financial and non-financial), and by enhancing their access to decent employment and social protection. Special attention should be dedicated to support women and girls in conflict-affected areas, women refugees and IDPs, whose access to resources and services is particularly compromised.

NUTRITION PROGRESS

Slightly less than 25% of the countries of the region have a high or very high prevalence of stunting in children under 5 years of age. Undernourishment prevalence in the region stand at 13.2%. Rates are double that of the world average for developed countries. In conflict affected countries (27.7%) rates are five times higher than non-conflict countries and higher than least developed countries at the global level. In Syria, the prevalence of malnutrition among pregnant and lactating women more than doubled. Although undernourishment rates in the region are decreasing, prevalence of undernourishment began increasing in conflict-affected countries, and children still suffer high rates of iron and vitamin A deficiency and inadequate iodine status. Every country in the region has either moderate or severe rates of anaemia in women of reproductive age ranging from 23% In Kuwait to as high as around 79% in Yemen. The region is the second most obese region in the world, with 19.5% among adults (14.9% men and 24.3% women), and 8.2% among children 5-19 years (8.3% boys, 8.1% girls). Prevalence for timely breastfeeding initiation and exclusive breastfeeding for six months stand at 34% and 20.5% respectively. For both indicators, the region remains below the global average of 40%. Caesarean section and first-time motherhood correlated with reduced prevalence, while rooming-in and successful breast-feeding experience increased prevalence. Children from the poorest quintile are 1.6 times more likely to be breastfed at two years of age than children from the wealthiest quintile. Lack of knowledge and skilled support for mothers in conflict affected countries led to reduced rates.

Promote health literacy and nutrition and WASH education to improve the nutritional status of women and girls, households and communities, by ensuring that fathers and mothers are equally targeted by programmes and initiatives.

LACK OF EQUITABLE ACCESS TO WASH

Equitable access to safe Water, Sanitation and Hygiene (WASH) services has not been met in the region. These access issues are exacerbated in very impoverished and/or conflict-affected countries, and more generally there are gaps in access to services between rural and urban communities throughout the region. In Bahrain, Kuwait and Qatar 100% of the population have access to basic drinking water services while Djibouti (76%) , Somalia (52%), Sudan (60%), Yemen (64%) and Morrocco (87%) have constrained access. Lack of access to WASH services at schools for women and girls may lead to their missing school or dropping out altogether due to inappropriate security and hygiene in relation to menstrual health management needs. 1 in 5 schools in the region does not have access to hygiene services in school, a range of 74% to 83% have access to basic drinking water in schools and a range of 79% to 87% have access to basic sanitation in schools. In terms of safe places within the region, there is a lack of comprehensive usable data on WASH in health facilities, suggesting that countries do not systematically track the availability or quality.

Strive for equitable access to safe WASH services, especially in rural and conflict/emergency settings and ensure adequate resources for effective implementation. maintain health and education services and secure economic and empowering opportunities for women and girls in WASH sector.

EMERGENCY AND CLIMATE CHANGE

During crisis situations, gender-based water insecurity is amplified, especially for refugee or internally displaced women and girls who face major barriers in access to basic services that are essential to their and their families' health and well-being. In addition to accessing basic services, women-headed households experience financial burdens that further limit their abilities to purchase water. WASH interventions being delivered to women and children in conflict settings in low-income and middle-income countries revealed gaps in the current evidence on WASH intervention delivery in conflict settings, suggesting that the WASH needs of women and children have not or are not being sufficiently considered in the humanitarian response in many conflict settings. The MENA region is the most water scarce region in the world, including 15 of the most water-scarce countries worldwide. Climate change, recurrent droughts and scarceness of natural resources combined with recent years conflicts and humanitarian crisis is putting extreme pressure on WASH service provision impacting the most vulnerable populations, especially women and girls. Water scarcity can amplify domestic work burden on women and girls at both household and community level.

Address the disproportionate impacts of climate change on the food security and resilience of women and girls and promote gender equality and climate resilience in interventions related to the development of food systems.

Situation of Health and Wellbeing – Key Highlights

POLICIES/ LEGISLATIVE

The right to health has been adopted into domestic or constitutional law in many countries.

All countries in the region have signed the Convention on the Rights of Persons with Disabilities but implementation is still limited

Lack of dedicated mental health legislation in 50% of countries within the region and a lack of national policies and plans in 30% of the countries

Barriers to SRHR are present in laws and policies and prevent access to knowledge and services that contribute to equitable lives

All of the 21 countries adopted the ICPD Programme of Action in 1994

SYSTEMS/ INSTITUTIONS

Mental health services are extremely limited

Lack of data on MHH due to sociocultural norms and stigma

Limited access to health services including MHH (rural, adolescent girls, disability and emergency setting)

Limited access to postnatal services
Lack of integration between maternal and neonatal health

Health services are often focused on curative health services instead of primary and preventative care
Public health insurance covers only between 30-40% of the population

STD's and HIV/AIDS not fully integrated within primary health care

Countries have undertaken efforts to scale up sexualit education (Qatar and Tunisia)

NORMS

Limited levels of autonomy in decisions about women and girls own health

Increased care burden on women and girls due to gendered expectations

Sociocultural norms affects women's and girls' nutritional status as well as child feeding

Declining level of physical activity

Stigmatization and discrimination for mental health issues and support

Abortion, especially unsafe abortion, is a neglected public health topic

EMERGENCY SETTINGS

Gender-based water and food insecurity is amplified during crisis, especially for refugee or internally displaced women. Women may face major barriers in access to basic services that are essential to their and their families' health and well-being

ISSUES

- Antenatal care is lower in rural and poor areas; estimated 65% of women receive postnatal care
- 50 million girls are being cut
  - **Reduce of and infant mortality and MMR (14 of 21 countries have achieved SDG indicator of 70 per 100,000 live births)**
- 1 in 5 girls are married
  - 13 of the 21 countries reached 90% skilled birth attendance (Yemen and Somalia below 75%)
- Irregular use of contraceptive amongst unmarried women and girls
  - Adolescent girls and unmarried young women access to SRHR is limited
- Limited access to MHH
- Lack of access to information, female health providers and concerns about entering health-care facilities alone
  - Adolescents physical activity is worse than global rates (84.3% boys and 89.9% girls)
- Evidence on adolescent health continues to be a gap throughout the region
- Increase of non-communicable diseases
  - Prevalence of obesity and diabetes among the highest worldwide
  - Anxiety disorders and depressions are among the top five causes of DALYs among young girls 10-19 years.
- MH and PSS have been exacerbated by the COVID-19 pandemic
  - 1 in 3 women in the region experience extreme levels of stress
    - Refugees with disabilities twice as likely to report psychological stress
- 70% of NGO-run shelters do not accommodate women with mental health issues.
  - 53% of people in the region had access to basic health services
- Only 46% of NGO services for PSS only accommodate elderly women.
- SRHR is minimally addressed in elderly time
- Inadequate antiretroviral treatment (reaching 38% of those in need)

Situation of Food Insecurity and WASH – Key Highlights

LEGISLATION/ POLICIES

The Arab Charter of Human Rights refers to the right to water and sanitation services under articles 38 and 39

No data available regarding existing laws and policies on food security

The lack of policy coherence and sectoral coordination prevents the formulation and implementation of gender-responsive food security and nutrition policies

89% of countries in the region have a comprehensive or topic-specific nutrition policy

79% of countries have a comprehensive nutrition policy that aims to address all forms of malnutrition

Several states have recognized the right to water in their constitutions

SYSTEMS/ INSTITUTIONS

Women's inadequate access to land remains an obstacle for improvement of both food security and agricultural productivity

Limitations in qualitative and quantitative disaggregated data for food security

Agriculture sector accounts for 1/3 of total female employment, mainly through informal work sectors

1 in 5 schools in the region does not have access to hygiene services in school

Equitable access to WASH services has not been met in the region (MHH, household responsibilities)

Limited consideration of WASH needs of women and children in the humanitarian response

74%-83% have access to basic drinking water in schools and a 79%-87% have access to basic sanitation in schools

17 countries had some coverage of wheat flour fortified with iron and folic acid, which is mandatory in 11 countries

16 countries report fortification of salt, 12 countries report fortification of wheat flour, six report fortification of oil, and one country reports fortifications of sugar

16 report the provision of supplements to children (vitamin A, iron, micronutrient powder, zinc and iodine

SOCIAL NORMS

The triple burden of malnutrition is clearly visible among women and girls, particularly in countries affected by protracted crises

Sociocultural norms affects women's and girls' nutritional status as well as child feeding

Lack of WASH services at schools leads to missing school and school-drop-out

Gendered expectations and female burden of water management

Water scarcity amplify domestic work burden on women and girls at both household and community level

Girls have less access to food at mealtimes due to cultural norms that determine who within a family eats first

EMERGENCY SETTINGS

Climate change, recurrent droughts and scarceness of natural resources combined with recent years conflicts and humanitarian crisis is putting extreme pressure on WASH service provision impacting the most vulnerable populations, especially women and girls. Water scarcity can amplify domestic work burden on women and girls at both household and community level

ISSUES

- Inadequate dietary intake
  - Breastfeeding initiation and exclusive breastfeeding for six months stand at 34% and 20.5%
- The region is the most water scarce region in the world, including 15 of the most water-scarce countries worldwide
- Slightly less 25% of the countries have a high or very high prevalence of stunting in children under 5 years
  - Children from the poorest quintile are 1.6 times more likely to be breastfed at two years of age
- Every country in the region has either moderate or severe rates of anaemia in women of reproductive age (23% Kuwait to 79% Yemen)
- Women-headed households experience financial burdens that further limit their abilities to purchase water
- 11% of the population reported that they experience severe food insecurity
  - Highest level in Iraq, Libya, Syria, Sudan, and Yemen
  - Eight countries report provision of supplements to women of reproductive age
- Female-headed households are the most susceptible to food insecurity
  - Prevalence of undernourishment and obesity stood at 13.2% and 28%, respectively
  - 21 countries are implementing vitamin and mineral supplementation for pregnant women
- Roles and responsibilities associated with food security and nutrition largely fall on the shoulders of women and girls
  - Women-headed households experience financial burdens that limit abilities to purchase water

GENERAL HEALTH

Overview

The WHO Constitution (1946) envisages '… the highest attainable standard of health as a fundamental right of every human being.' This recognition of health as a human right creates a legal obligation on states to ensure access to timely, acceptable, and affordable health care of appropriate quality as well as to provide for the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health-related information and education, and gender equality. In many countries, the right to health has been adopted into domestic or constitutional law.159 Tracking the realisation of this right to health is an integral part ofa range of international human rights mechanisms.

Governments throughout the region have joined the global community in committing to the 2030 Agenda for Sustainable Development and efforts to achieve the Sustainable Development Goals (SDGs) are on the rise across the region. To illustrate, states have made institutional changes and have begun to align national priorities with the SDGs, including launching voluntary national reviews.[160] Included in the SDGs is Global Target 3.8 which states 'achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all'.[161] An analysis by the World Health Organization (WHO) in 2018 estimated that 53 per cent of people in the region had access to basic health services – below

Table 1.1:
Universal Health Coverage Index

ESCWA Category	Country	Index Score
GCC	Qatar	77
	Oman	72
	UAE	63
	Bahrain	72
	Saudi Arabia	68
	Kuwait	77
Maghreb	Tunisia	65
	Algeria	-
	Morocco	65
	Libya	63
Mashreq	Lebanon	68
	Iran	65
	Syria	60
	Jordan	70
	Palestine	60
	Egypt	68
	Iraq	63
LDC	Djibouti	47
	Yemen	39
	Sudan	43
	Somalia	22

Source: World Health Organization

159 WHO, Human rights and health, Key Facts, 2017.
160 ESCWA, Arab Sustainable Development Report 2020, 2020
161 Universal health coverage means that all people and communities can use health services they need, of sufficient quality to be effective, without facing financial hardship.

Table 1.2:
Life expectancy at birth (years)

ESCWA Category	Country	Female	Male
GCC	Qatar	81.74	78.83
	Oman	79.91	75.65
	UAE	79.01	76.97
	Bahrain	78.14	76.19
	Saudi Arabia	76.49	73.67
	Kuwait	76.36	74.58
Maghreb	Tunisia	78.35	74.30
	Algeria	77.74	75.31
	Morocco	77.44	74.95
	Libya	75.62	69.67
Mashreq	Lebanon	80.79	77.03
	Iran	77.44	75.22
	Syria	77.42	65.41
	Jordan	76.05	72.63
	Palestine	75.45	72.11
	Egypt[162]	73.97	69.45
	Iraq	72.32	68.28
LDC	Djibouti	68.02	64.00
	Yemen	67.79	64.41
	Sudan	66.71	63.09
	Somalia	58.42	55.07

Source: United Nations Population Division

the global (population weighted) coverage of 64 per cent. However, projections show that a regional population weighted coverage of 60 per cent could be achieved by 2023 if WHO recommendations are implemented. [163]

The WHO analyses combined multiple indicators on health coverage to capture coverage by individual and population-based health services and give a composite score for each country (see Table 1.1). This provides a useful overall measure of country performance

A 2020 Economic and Social Commission for West Asia (ESCWA) report[164] on the status of the SDGs in the Arab region noted 'significant improvement in key health indicators in the Arab region, including lower maternal and under-five mortality.'

In 2016, ESCWA reported[165] that increasing life expectancy and decreasing maternal and child mortality rates reflected 'a commendable record' in the region when it comes to women's health, making it one of the key areas of success in the implementation of the Beijing Declaration and Platform for Action. The report noted that female life expectancy at birth had increased in all countries of the Arab region, rising from an average of 68 years in 1995 to an average of 72.5 years in 2015. 2019 data from WHO indicates that female life expectancy at birth in the Eastern Mediterranean is 71.31 years.[166]

However, the 2020 ESCWA SDG report noted that levels of health and well-being remain significantly uneven within and between countries, with health services fragmented and often supply-driven, and access to universal health coverage varying widely within and among countries and social groups. Most health systems continue to focus largely on curative health services instead of primary and

162 See Also Egypt in Figures 2020.
https://www.capmas.gov.eg/Pages/Publications.aspx?page_id=5104&Year=23602
163 WHO, 'Advancing universal health coverage', 2018
164 ESCWA, Arab Sustainable Development Report 2020, 2020.
165 ESCWA, Against Wind and Tides: A Review of the Status of Women and Gender Equality in the Arab Region (Beijing +20), 2016.
166 WHO, Data Base: Global Health Observatory- Life Expectancy at Birth.

preventative care and pay little attention to the social determinants of health.[167]

Reduction in maternal mortality, while outperforming the global average[168], has not seen as strong progress as other indicators - only three countries in the region had achieved the Millennium Development Goal (MDG) of reducing the Maternal Mortality Ratio (MMR) by three quarters between 1990 and 2015: Iran, Lebanon and Libya, with Saudi Arabia, UAE and Kuwait very close to meeting the target (albeit with already-low MMR). Algeria, while not achieving the MDG target, almost halved maternal mortality between 1999 and 2014 (from 117 to 64) per 100.000 life births.[169]

The Disability-Adjusted Life Year (DALY) is a quantitative way to present the burden of disease and ill-health among a given population. The calculation aggregates a range of health-related measures (life-expectancy, illness, disease, disability, accidents, time/age) to express the cumulative number of years of life lost. One DALY can be thought of as one lost year of 'healthy' life.[170]

According to WHO data, the MENA and Arab States region has, on average, experienced a positive trend of decreasing disease burden, with the steepest gains being made by countries in the LDC region (Somalia, Yemen, Sudan, Djibouti - albeit mitigated in Yemen since the commencement of conflict there in 2014). This mirrors global reductions in DALYs over the same time period, with lesser-developed countries (notably in Africa) exhibiting the largest declines. Other countries in the region, notably Morocco, Egypt, Iraq, Iran and Tunisia[171] have also seen smaller but still definite decreases in the aggregate burden of disease. However, some countries have seen increases in DALYs directly coinciding with the onset of conflicts, specifically Syria, Yemen, Somalia and Sudan. Similar trends are observed with respect to specific health indicators. For example, in Syria, which had seen a steady trend of decreases in maternal mortality between 1990 and 2010, the rate has increased to 2016 from approximately 50/100,000 to 70/100,000.[172]

The below table presents a sex-and-age disaggregated measure of DALYs for the year 2017 for the entire region. The burden for males is typically higher in all age groups and is concentrated in the older and younger age categories, reflecting the higher levels of morbidity and mortality associated with age cohorts at the beginning (<5) and end (>50) of life.

Table 1.3:
DALYs across MENA and Arab States countries for 2017 (per 100,000 people)

Sex	Aged under 5	Aged 5-14	Aged 15-49	Aged 50-69	Aged 70+
Male	56,635	9,849	22,306	53,704	111,802
Female	50,773	9,104	19,314	42,407	87,986

Source: WHO DALY Estimates (2017)

167 ESCWA, Arab Sustainable Development Report 2020, 2020.
168 The Arab region's average maternal mortality rate has decreased from 238 (2000) to 156 (2015) per 100,000 live births, compared to a world average of 216 per 100,000 live births in 2015.
169 UNICEF, Progress for Children with Equity in the Middle East and North Africa, 2016.
170 See WHO, Data Base: Global Health Observatory- Global Health Estimates: Life expectancy and leading causes of death and disability.
171 Data from Lancet- Institutes of Health Metrics and Evaluation, Global Burden of Disease, 2020.
172 Progress for Children with Equity in the Middle East and North Africa, UNICEF, 2016

Non-communicable diseases have replaced nutritional disorders and communicable diseases as major causes of women's death and disability. While the region has witnessed a decrease in DALYs for causes such as diarrhoea and respiratory infections in recent years, ischaemic heart disease, major depressive disorders and diabetes have become more widespread. This epidemiological transition reflects the demographic shift due to increased life expectancy and the nutrition transition.[173] A key additional factor (particularly influencing the presence of non-communicable diseases) is the declining level of physical activity - a common phenomenon as wealth increases. Several countries in the region have the highest rates of physical inactivity, obesity, and diabetes in the world.[174]

Finally, emergencies, conflict or civil unrest are one of the critical determinants of health in this region. Ongoing conflicts in Yemen, Sudan, Syria and Iraq, as well as the effects of these, and previous conflicts, in surrounding countries, continue to have significant health impacts on populations, and disproportionately on women and girls. In 2017, almost 85 per cent of the conflict-related casualties globally resulted from conflict in the countries of Syria, Afghanistan, Iraq, Yemen and Somalia.[175]

COMMUNICABLE DISEASES AND NON-COMMUNICABLE DISEASES

The leading causes of death worldwide and in the MENA and Arab States Region are noncommunicable diseases (NCDs). Within the region, NCDs accounted for 74 per cent of all deaths in 2015 compared to 70 per cent of deaths globally. Communicable diseases comprise infectious diseases such as tuberculosis and measles, while non-communicable diseases are mostly chronic diseases such as cardiovascular diseases, cancers, and diabetes.

Epidemics of communicable diseases follow predictable patterns, spreading across vulnerable population sectors by disease carrying agents or vectors. However, modern social, cultural, ethnic and socio-economic patterns can also influence the prevalence of health risk behaviours such as smoking, unbalanced nutrition, physical inactivity, and excess alcohol use. These are some of the determinants of non-communicable disease and many experts now argue that the intersection of the above patterns with chronic diseases means that they are actually also communicable.[176] However, the terms provide a useful comparison between diseases that are more determined by lifestyle factors and those caused or transmitted by an independent vector.

WHO data on communicable and non-communicable diseases illustrate clear gender-specific risk factors, and major disparities in location and age. In every Arab sub-region, females are at a higher proportion of death by both communicable and non-communicable diseases. Men are more at risk from death by injuries. With respect to non-communicable diseases, three myths contribute to their neglect among women:

- A persistent view that health-related issues of importance to women are defined through their reproductive capacity.
- The misperception that non-communicable diseases, especially cardiovascular diseases, primarily are diseases of men.
- The myth that non-communicable diseases in women are an issue only in high-income countries and a result of lifestyle choices.[177]

The chart below highlights the distribution of deaths by causes by both types of disease across all countries in the region compared with the global

173 Nasreddine, Lara M., et al. Nutritional status and dietary intakes of children amid the nutrition transition: the case of the Eastern Mediterranean Region, Nutrition Research 57 (2018): 12-27 5.
174 FAO, IFAD, UNICEF, WFP and WHO, Regional Overview of Food Security and Nutrition in the Near East and North Africa 2019 – Rethinking food systems for healthy diets and improved nutrition, 2020.
175 Dupuy, Kendra & Siri Aas Rustad, Trends in Armed Conflict, 1946–2017, Conflict Trends, 5. Oslo, 2018.
176 Ackland M, Choi BCK, Puska P, Rethinking the terms non-communicable disease and chronic disease, Journal of Epidemiology & Community Health 2003,
177 WHO, Data Base: Global Health Observatory- On the Prevention and Control of NCDs.

totals (for 2016), highlighting the increased mortality resulting from NCDs overall. Women in the region have a higher likelihood than the global average of dying from a communicable disease (26.8 per cent vs. 20.7 per cent) and from injury.

On a country-by-country level, as with other indicators, significant disparities exist due to the many social, cultural, economic and other factors at play (presented in the table below). Among adults, Somali females are the country population most at risk of death from communicable diseases, followed by Djibouti. Women in the UAE and Bahrain experience the highest risk of death from non-communicable diseases in the region, followed by Egypt.

Chart 1.1:
Cause of death: Non-communicable vs communicable disease (all ages)

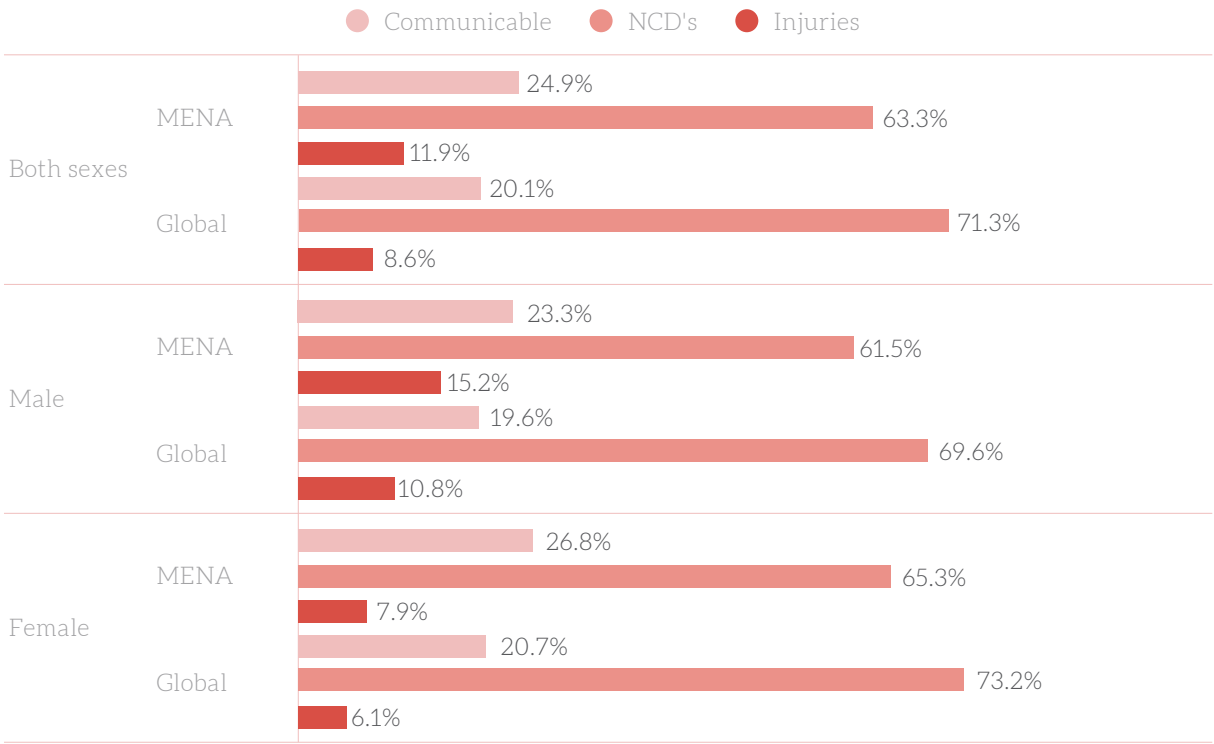


Table 1.4:
Cause of death by communicable and non-communicable diseases

Communicable diseases (per cent of relevant age group)						Non-communicable diseases (per cent of relevant age group)					
Region	Country	Sex/Age				Region	Country	Sex/Age			
		Female		Male				Female		Male	
		15-34	35-59	15-34	35-59			15-34	35-59	15-34	35-59
GCC	Oman	16.7	8.4	8	7.3	GCC	UAE	66.8	90.7	39.8	77.2
	Kuwait	14.7	9.6	2.7	6.5		Bahrain	64.9	90	41.5	78.2
	Saudi Arabia	12.5	7.7	3.7	5.1		Qatar	53	88.7	21.1	66.9
	Bahrain	11.1	4.5	5.4	4.9		Oman	49.9	81.3	29.3	69.6
	Qatar	9.5	2.8	3.2	2.5		Kuwait	49.9	79.5	33	72.7
	UAE	7.3	2.6	4.9	3.2		Saudi Arabia	44.2	75.3	19.7	61.7
Maghreb	Algeria	24.5	8.2	5.3	5.7	Maghreb	Morocco	52	85.4	29.5	74.9
	Morocco	21.4	6.8	8.7	7.4		Tunisia	52.5	84.7	27.1	77.8
	Tunisia	18.9	6.3	5	4.3		Algeria	49.1	82.4	26.4	70.4
	Libya	8	5.7	2.3	4.8		Libya	39.3	76.6	13.5	57.7
Mashreq	Egypt	18.6	4.2	9.7	4	Mashreq	Egypt	58.6	91.8	42.3	85.5
	Jordan	14.9	5.1	2.9	2.9		Lebanon	57.5	89.6	28.9	82
	Lebanon	11.7	3.9	2.8	2.2		Jordan	49.4	84.1	26.8	79.3
	Iran	9.3	5.1	5.5	9.8		Iran	46.6	83.2	26.1	67
	Iraq	8.3	4.6	1.3	2.9		Iraq	21.9	66.1	8	49.7
	Syria	3.2	2.1	0.4	1		Syria	12	50.3	5	35.9
LDC	Somalia	68.5	47.1	41	42.9	LDC	Yemen	41.2	77.8	28.1	71.5
	Djibouti	58.3	47	40.6	40.6		Sudan	41.8	74.8	28.3	67.5
	Sudan	37.9	18.7	15.2	12.8		Djibouti	26.6	46.8	31.1	48.4
	Yemen	31.7	13.7	8.2	6.8		Somalia	15.2	44.4	18.3	38.8

Source: WHO Global Health Estimates

UNDER 5 MORTALITY

A 2016 report from UNICEF on progress for children in MENA[178] noted that under-five mortality rate had 'more than halved on average' between 1990 and 2015, with nine countries meeting the SDG target (of reducing U5 mortality by two-thirds by 2015) and another five close to doing so.

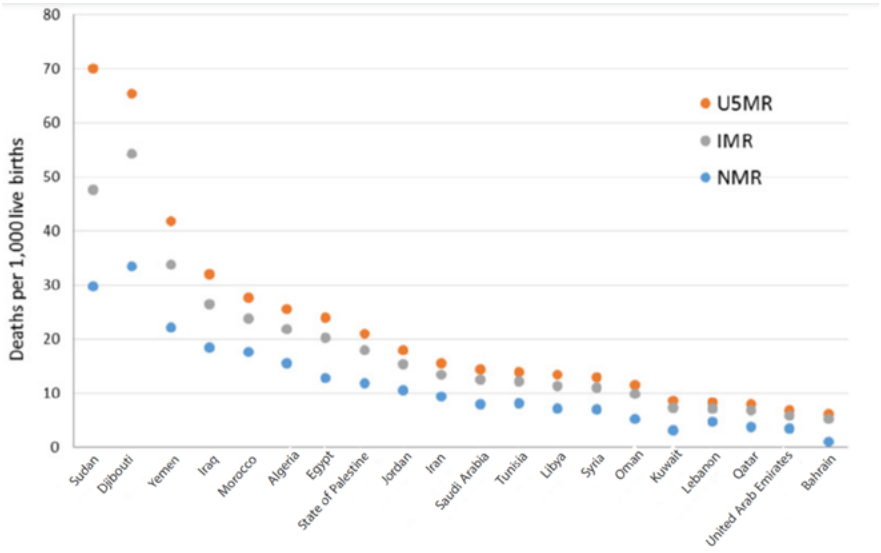
The MENA and Arab States region as a whole has demonstrated a consistent trend of decreasing under-five mortality. The United Nations Inter-agency Group for Child Mortality Estimation (IGME) has estimated the 2019 rate at 21.8 for the region, considerably under global under-five mortality rate of 37.65 deaths per 1,000 live births.[179]

Data presented in the figure below (2015 data) indicate that significantly above-average rates of under-five, neonatal and infant mortality are seen in Sudan and Djibouti, and to a lesser extent, Yemen. All three of these countries are above the global estimate.

178 UNICEF, Progress for Children with Equity in the Middle East and North Africa, 2016.
179 UN Inter-agency Group for Child Mortality Estimation, Global data for 2018.

More recent estimates from IGME place the 2019 under-five mortality rates for Sudan at 58.41 per thousand live births, for Djibouti at 57.49 and Yemen at 58.36. The latter country, in particular, is the only country in the region that has shown a significant increase in under-five mortality in the past decade (up from 55.2 in 2011).

Figure 1.1:
Neonatal-, infant-, and under-five mortality rates by country, 2015



Notes: NMW = Deaths 0-28 days from birth; IMR = deaths 0-364 days from birth; USMR = deaths 0-4 years of age from birth. Ranking of countries by total under-five mortality rates.
Source: UNICEF, WHO, World Bank Group, United Nations. Estimates generated by the UN Inter-agency Group for Child Mortality Estimation (IGME) in 2015. http://www.childmortality.org.

Socio-cultural Norms/Practices

DECISION-MAKING POWER

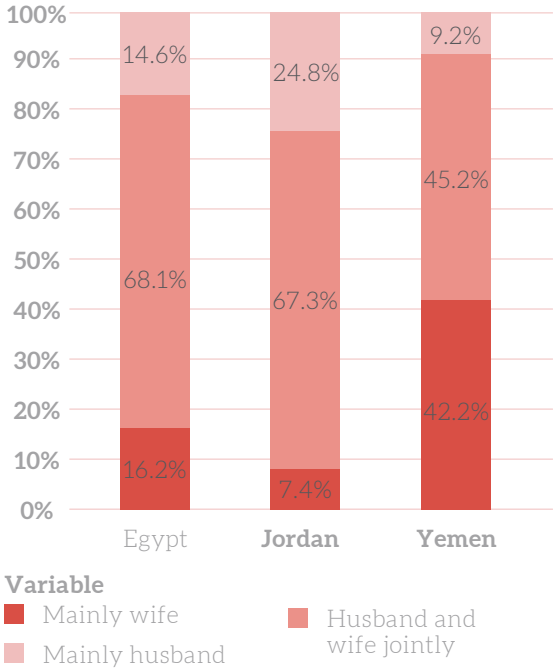
Despite legislation and polices that guarantee a level of autonomy in decision making, surveys conducted in Arab States suggest that women have limited levels of autonomy when it comes to decisions about their health. For example, 36.6 per cent of Yemeni women interviewed in a 2013 demographic and health surveys stressed the problem of needing the informal permission of male relatives to access health care. This contrasts with Jordan, where 67.3 per cent of women said they had full autonomy over decisions that affected them, including health care.[180] According to data on ever married women from the Demographic and Health Survey (DHS) surveys in Egypt, Jordan, and Yemen, between 9.4 per cent and 40.0 per cent of decisions regarding a woman's own health are made by herself. Between 11 per cent and 42.2 per cent of decisions are made by the husband.

Table 1.7 presents data on decision-making among married women for Jordan, Egypt and Yemen. It shows the dominance of patriarchy in Yemen, and higher levels of autonomy experienced by women in Jordan. In Egypt, the dominant mode of decision making is jointly between husband and wife and increased autonomy is correlated with increasing levels of education, urban living and higher household income.[181]

A specific SDG indicator under this is *5.6.1: Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care*. The data for this indicator are collected via DHS reports, which are available only Jordan (2017), Egypt (2015) and Yemen (2013). Results for the three countries on the specific component of the indicator relating to decisions on use of contraception (in the

Figure 1.2:
Healthcare Decision Making

This image depicts the percentage of currently-married women for whom the decision maker about healtcare is mainly the specified actor (%).



Source: Demographic and Health Survey (DHS). Egypt DHS (2014), Yemen DHS (2013), Jordan DHS (2018). Accessed through the WB API.

Table 1.7:
Women's Decision-making on Health issues

Country	Own decision (%)	Joint decision (with husband) (%)
Egypt (2014)	23	75
Yemen (2013) (health care only)	9.4	45.2
Jordan (2017)	8.4	85

Source: Demographic and Health Survey.

180 Demographic and Health Survey, Jordan, 2017.
181 Demographic and Health Survey, Egypt, 2014

case of Yemen only questions on decisions around general health care were asked) are as follows:

In contrast to the level of anecdotal and qualitative data, there is little consistent, robust and comparable data available on the issue of norms and practices relating to health care decisions, information and access to services within the region. For example, many stakeholders have dedicated resources to addressing perceived stigma or lack of facilities around menstruation and menstrual hygiene,[182] but there is a paucity of global or regional quantitative data on the specifics of the challenges in relation to socio-cultural norms and practices and in relation to stigma.

SMOKING

Smoking of tobacco (not counting other uses) in the region, at 19.8 per cent of the total ≥ 15-year-old population of the region – 82 million smokers in all – is slightly less than the global average of 21.9 per cent.[183] By 2020, the WHO estimates there will be 94 million smokers in the region. Smoking amongst children 13-15 in the MENA and Arab States region is, at 4.5 per cent (7.0/1.9 per cent boys/girls), lower than the global average of 6.8 per cent (9.3/4.2 per centboys/girls).[184]

The global age-standardized prevalence of tobacco smoking has decreased steadily since 2000. WHO estimates that smoking rates decreased by 6.7 per cent globally between 2000 and 2015. However, this overall trend is not seen in the MENA and Arab States region, where the trends appear to be flat or even increasing.[185] WHO projections suggest that 36.2 per cent of the ≥ 15 population will smoke by 2025 if tobacco control efforts are not implemented, 13 per cent below the WHO target for the time period.[187]

Table 1.8:
WHO age-standardized estimated prevalence of smoking among those aged 15 years or more (current tobacco smokers)[186]

		Male (%)	Female (%)	Total (%)	Data Year
GCC	UAE	29.1	0.6	14.8	2017
	Bahrain	33.8	4.0	18.8	2017
	Qatar	25.5	0.7	13.1	2017
	Oman	15.2	0.3	7.8	2017
	Kuwait	36.5	2.2	19.3	2017
	Saudi Arabia	24.0	1.3	12.7	2017
Maghreb	Morocco	27.4	1.1	14.2	2017
	Tunisia	43.8	2.0	22.9	2017
	Algeria	28.4	0.9	14.7	2017
	Libya	n/a	n/a	25.1	2009
Mashreq	Egypt	42.3	0.4	21.4	2017
	Lebanon	39.0	25.4	32.2	2017
	Jordan	49.6	5.7	29.0	2007
	Iran	20.3	1.5	10.9	2017
	Iraq	34.8	2.6	18.7	2017
	Syria	48.0	8.9	24.7	2003
LDC	Yemen	27.3	6.3	16.8	2017
	Sudan	17.1	0.7	9.6	2016
	Djibouti	18.0	2.0	n/a	2012
	Somalia	n/a	n/a	n/a	n/a

Table 1.8 provides estimated country-specific data on smoking among those ≥ 15. Men smoke at much higher rates (33.9 per cent) than women (2.3 per cent) in the region. Outliers include Lebanon, where 26.9 per cent of women smoke. This is

182 For example, see UNICEF, MENSTRUAL HYGIENE MANAGEMENT "MHM" PROGRAMME ENABLES GIRLS TO REACH THEIR FULL POTENTIAL, 2019.
183 Age-standardized prevalence of tobacco smoking among persons 15 years and older (per cent), by WHO region, 2016.
184 World Health Organization, Global report on trends in prevalence of tobacco smoking 2000-2025, 2nd ed. 2018.
185 Ibid.
186 Appendix X to the WHO Report on the Global Tobacco Epidemic, 2019.
187 Ibid.

much higher than the world average of women who smoke of 6.4 per cent.[188]

Countries with the highest rates of smoking are Jordan (49.6 per cent), Syria (48 per cent) and Tunisia (43.8 per cent),although lack of recent data for Jordan and Syria (2007 and 2003, respectively) means that those rates are not accurate.

Accurate policy setting in the region is hampered by lack of data on smoking prevalence- some countries have not completed surveys for a decade or more.

The lack of data and limited tobacco control efforts in the region means that none of the countries in the region are likely to achieve the Framework Convention on Tobacco Control target of a 30 per cent reduction in smoking prevalence by 2025, with two likely to see an *increase*, nine not likely to see any change, and only three likely to see any decrease in prevalence (the remaining countries did not have adequate data on which to base projections).[189]

PHYSICAL ACTIVITY

Inadequate physical activity is a leading risk factor for a range of chronic illnesses such as cardiovascular disease, cancer and diabetes, and premature death worldwide.[190] Conversely, undertaking physical activity has significant health benefits and contributes to preventing a range of non-communicable diseases. Sufficient physical activity for adults is defined as a minimum of 150 minutes of moderate physical activity, or at least 75 minutes of vigorous physical activity per week, or any combination of the two.

According to the WHO, globally in 2016, 23 per cent of men and 32 per cent of adult women were insufficiently physically active. In the MENA and Arab States region, rates substantially exceeded the global average: 26.9 per cent of men and 43.5 per cent of women. This rise in physical inactivity is due to the growing sedentary nature of many forms of work, changing modes of transportation, and increasing urbanization.

Adolescents perform particularly poorly in engaging in adequate physical activity. This is true globally, with 81 per cent of adolescents aged 11-17 not undertaking sufficient activity (77.6 per cent boys; 84.7 per cent girls), and is worse in the MENA and Arab States region with a rate of 87 per cent (84.3 per cent boys; 89.9 per cent girls). This is likely a high contributor toward health problems later in life.

On a country basis, for adults by far the worst performing country in the region, and also in the world, is Kuwait, with 67 per cent (61.3 per centM/74.6 per centF) performing insufficient physical exercise, although adolescents in Kuwait are closer to the global average. Adults in Saudi Arabia and Iraq (predominantly women) are also particularly poor performers, occupying the second and third positions on the global ranking of insufficient physical activity, respectively. Among adolescents, Sudan is one of the worst globally, with girls in Egypt similarly poorly engaged in physical activity. For both adults and adolescents, males invariably outperform females in the level of activity engaged in, indicating that the negative outcomes associated with inadequate physical activity will accrue more amongst women than men.

188 World Health Organization, Report on the Global Tobacco Epidemic, 2019.
189 Global report on trends in prevalence of tobacco smoking 2000-2025, 2nd ed. World Health Organization; 2018.
190 All data in this section from World Health Organization, 2020. Accessed at https://www.who.int/news-room/fact-sheets/detail/physical-activity and https://www.who.int/gho/ncd/risk_factors/physical_activity/en/

Figure 1.3:
Prevalence in Insufficient Physical Activity Amoong Adults and Adolescents

This indicator shows the percentage of school going adolescents and adults age 18 and older who are estimated by the WHO to not meet the WHO recommendations on physical activity for health, i.e., doing less than 60 minutes of moderate to vigorous intensity physical activity daily.

Services, Programming and Information

Despite progress in the quantity and quality of health services available to women and girls living in the region over the past decades, they continue to face many barriers in obtaining necessary care. Some of the most frequently cited obstacles in the research include long travel distances to health-care facilities and challenges related to transportation, as well as a lack of female health providers and concerns about entering health-care facilities alone (see Table 1.9, below). Aggregate statistics on access to health care can conceal significant differences in coverage at the sub-national level. In the Midlands region of Yemen, for example, about 80 per cent of women report having access to health care, while in the Northern region of the country less than 25 per cent of women report having such access.[191] Young people, particularly unmarried young people, remain highly neglected populations in terms of access to SRH services and education in the region.[192]

Lack of financial resources is another major barrier. Indeed, public health insurance in the region usually covers only between 30 and 40 per cent of the population, leaving the remaining individuals or their employers to subscribe to private insurance schemes. For example, according to a national survey conducted in 2010, only 45 per cent of Lebanese women could afford regular medical visits and medication when they did not receive health insurance benefits through their work. This is indicative of the extent to which women may be at greater risk from limited social security coverage, as the regional female participation in the formal labour market is as low as 23 per cent.[193]

Out-of-pocket health expenditures for all people (not specifically women) are usually high in the region (see Figure 1.4, below), with the exception of some countries that provide free health care for their citizens, most notably those in the GCC subregion. Stagnating or declining state investment in the health sector has exacerbated this problem in some cases. On average, countries in the region spend 2.97 per cent of their GDPs on health, in contrast with 3.53 per cent globally.[194] This is of particular concern, as deficiencies in health care and social programmes may result in an increased burden on women, who usually assume the

Table 1.9:
Perceived challenges in accessing health care, as identified by women aged 15–49 who reported serious problems in accessing health care for themselves when they are sick, in selected countries (data 2013-2015).[195]

Country	Getting money for treatment (%)	Distance to health facility (%)	Using means of transportation (%)	Not wanting to go alone (%)	No female provider available (%)
Egypt	10.5	18.2	20.9	31.3	28.9
Jordan	22.5	26.4	28.6	28.8	29.5
Yemen	56.1	58.8	-	80.2	62.9

Source: Against Wind and Tides: A Review of the Status of Women and Gender Equality in the Arab Region (Beijing +20), ESCWA 2016

191 ESCWA, Against Wind and Tides: A Review of the Status of Women and Gender Equality in the Arab Region (Beijing +20), 2016.
192 Regional Report: Sexual and Reproductive Health Laws and Policies in Selected Arab Countries, UNFPA, 2016
193 ESCWA, Against Wind and Tides: A Review of the Status of Women and Gender Equality in the Arab Region (Beijing +20), 2016.
194 World Health Organization, Global Health Observatory Data Repository.
195 ESCWA, Against Wind and Tides: A Review of the Status of Women and Gender Equality in the Arab Region (Beijing +20), 2016.

responsibility of caring for relatives.[196] Illustratively, available data suggests that between 60 per cent and 97 per cent of people in LDC countries are at risk of a catastrophic expenditure for surgical care (i.e. >40 per cent of household income remaining after subsistence needs) , in comparison to a global average of 28.1 per cent in 2017.[197]

There is great disparity within the region regarding out-of-pocket expenditures on health care, ranging from 5.9 per cent in Oman to 81.0 per cent in Yemen.

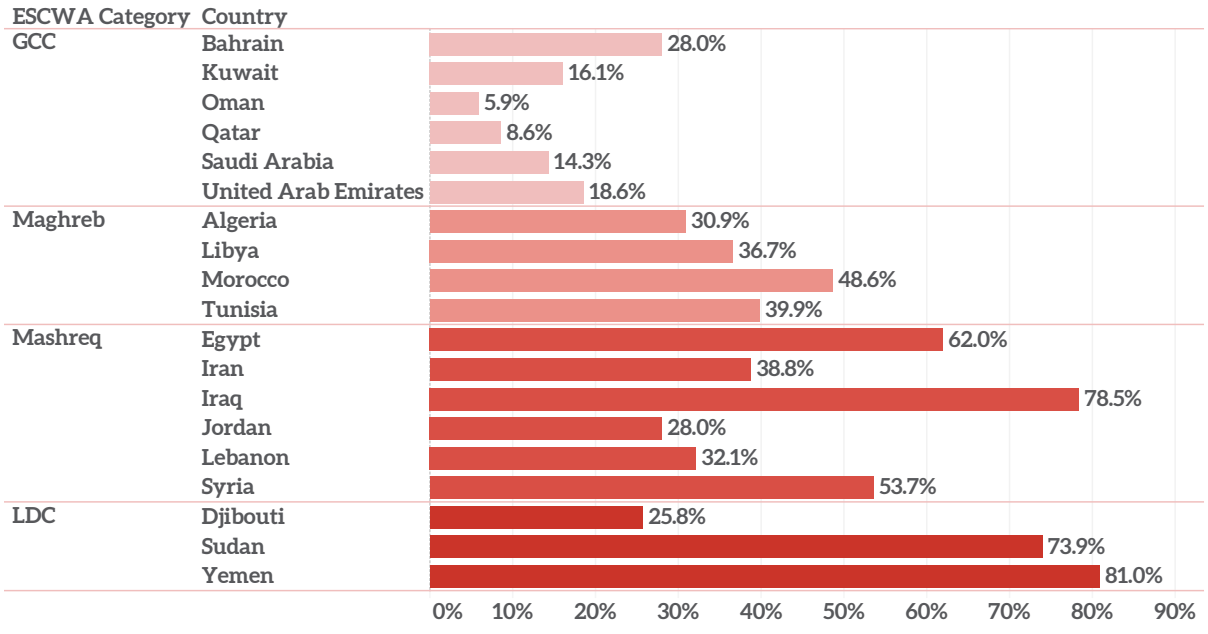
VACCINATIONS AND IMMUNIZATION COVERAGE

Immunization coverage for the major to vaccine preventable diseases ranges from 37 per cent in Somalia (for BCG) to 99 per cent in the GCC countries.

All countries in the region report high immunization coverage for HepB3, BCG, DPT1 and DpPT3, with over 90 per cent coverage rates across the region. Areas that fall short of the 90 per cent immunization coverage mark for these common diseases are Iraq, Syria, Djibouti, Somalia, Sudan, and Yemen.

Figure 1.4:
Out of Pocket Expenditures on Healthcare

This graph shows the percentage of current healthcare expenditures that are out of pocket.



Source: WHO Global Health Expenditure Database

196 ESCWA, Against Wind and Tides: A Review of the Status of Women and Gender Equality in the Arab Region (Beijing +20), 2016.
197 World Bank Data. Accessed at https://data.worldbank.org/indicator/SH.SGR.CRSK.ZS
198 See also: National Survey on Population and Health 2018 for more numbers on Morocco.

Table 1.10:
Immunization coverage among 1-year-olds ()

ESCWA	Country (%)	HepB3 (%)	BCG (%)	DPT1 (%)	DPT3 (%)	MCV1 (%)	MCV2 (%)
GCC	Bahrain	99	-	-	99	99	99
	Kuwait	99	99	99	99	99	99
	Oman	99	99	99	99	99	99
	Qatar	98	99	99	98	99	95
	Saudi Arabia	97	98	96	96	98	97
	UAE	99	95	99	99	99	99
Maghreb	Algeria	91	99	96	91	80	77
	Libya	97	99	98	97	97	96
	Morocco[193]	99	99	99	99	99	99
	Tunisia	97	92	98	97	96	99
Mashreq	Egypt	95	95	96	95	94	94
	Iran	99	99	99	99	99	98
	Iraq	84	95	92	84	83	81
	Jordan	96	94	98	96	97	96
	Lebanon	80	-	-	83	82	63
	Syria	47	79	67	47	63	54
LDC	Djibouti	84	93	91	84	86	81
	Somalia	42	37	52	42	46	-
	Sudan	93	88	97	93	88	72
	Yemen	65	64	75	65	64	46

Source: WHO Global Health Observatory (2018)

DISABILITY

Access of women and girls with disabilities to health care typically presents significant challenges, exacerbated by a lack or absence of services. While all countries in the region have signed the Convention on the Rights of Persons with Disabilities, operationalization and implementation of this instrument is very limited. Over 100 million people (15 per cent of the population) in the WHO Eastern Mediterranean Region are living with some form of disability.[199] Data from the 2011 WHO World report on disability highlighted that 50 per cent of people with disability cannot afford health care and face challenges that impede their access to those services.[200] These challenges vary between income levels, rural and urban communities and countries with poor resources, rich, and developing, developed, industrial, and agricultural countries.[201] In a number of Arab countries, disability caused by conflict, occupation and terrorist operations is reported to be increasing.[202]

Further, anecdotal evidence indicates substantial gaps in non-mainstream health services, such as rehabilitation/physical/occupational therapy, assistive devices (hearing aids, wheelchairs, glasses etc.), specialist medications as well as surgical interventions which are not provided systemically by the Ministries of Health or covered by health insurance providers.

Rural vs. urban areas

The Arab Multidimensional Poverty Index shows that health services are generally lower in rural areas, reflecting high spatial inequality whereby acute poverty and poverty is more prevalent in rural areas. Therefore, rural women have lower access to health care than urban counterparts.[203]

HUMANITARIAN AND CONFLICT-AFFECTED AREAS

In many countries of the region, armed conflicts have had an unprecedented impact on women and girls' access to health care services, threatening their lives and undermining decades-long investments. In Syria, a 2015 WHO assessment found that only 43 per cent of public hospitals were fully functioning. Thirty-two percent were considered partially operational with shortages in equipment, supplies, or staff, while the remaining 25 per cent were not functioning at all. In addition, 22 per cent of health care facilities in that country was deemed inaccessible.

In Gaza, health infrastructure has been seriously affected by Israel's frequent military operations. At least 15 out of 32 hospitals in that area were damaged during the July-August 2014 war, putting additional strain on remaining health facilities. Moreover, years of blockade have led to a chronic shortage of essential medical supplies and delays in patients accessing hospitals on the other side of military checkpoints.[204]

Due to the conflict in Yemen that started in 2015, the health infrastructure in Yemen was brought to the point of collapse. As of 2019, only 51 per cent of health facilities in the country were fully functional. The majority of the Yemeni population had limited access to health services as a result of the harsh economic conditions, which impacts their ability to seek health services. This is compounded by high transport costs, poor road infrastructure and insecurity, roadblocks and advancing frontlines.[205]

199 WHO, 2020. Accessed at http://www.emro.who.int/entity/violence-injuries-disability/index.html#
200 WHO, 'Violence, injuries and disability' 2020. Accessed at http://www.emro.who.int/entity/violence-injuries-disability/index.html#
201 Arab Multidimensional Poverty Report, 2017
202 Ibid.
203 Ibid.
204 ESCWA, Against Wind and Tides: A Review of the Status of Women and Gender Equality in the Arab Region (Beijing +20), 2016.
205 WHO, 2020: https://www.who.int/bulletinvolumes/93/10/15- 021015/en/

COVID-19 PANDEMIC IMPACT

The 2020 pandemic caused by the coronavirus disease 2019 (COVID-19) has affected the region severely, given that many of its countries are directly or indirectly impacted by complex humanitarian emergencies, with fragile health systems vulnerable to suboptimal disease surveillance, preparedness and response capacities.

The virus, which entered its pandemic phase in March 2020, had reached all 22 countries of the region by early May. By late 2020, more than four million cases had been recorded across the region, with over 100,000 deaths. The hardest hit country in the region has been Iran, with more than 1.1 million cases and over 50,000 deaths recorded as of December 2020.[206]

The pandemic has had a major impact on the countries health system capacity to maintain and continue delivery of essential health services. With the increase in the demand for care of COVID-19 patients, it has been critical to maintain preventive and curative services for the most vulnerable populations including women and girls. Countries had to achieve the optimal balance between pandemic preparedness and response and provision of essential services including most importantly sexual and reproductive health in addition to psychological and mental health support.

While countries in the region reacted to the pandemic with swift and rigorous measures to avoid the spread of the virus, the measures have had a large impact on socio-economic outputs that that will aggravate existing economic and humanitarian challenges. Specific health-related impacts are:[207]

- Increases in food prices has led to the proportion of households consuming inadequate diets reaching the highest levels in the past five years (Sudan, Yemen, Syria and Lebanon).
- A decrease in global oil prices and demand hampered health responses and is leading to reduced health budget (, Iraq and Libya).
- Restrictions on movement and social distancing measures have limited households' access to work, regular income, remittances, markets, schools and health care (all countries).
- Lower income/savings depletion and decreased government capacity to respond to a second wave may worsen poverty and inequality, and lead to deterioration of household food security while increasing people's health needs.

206 Johns Hopkins Coronavirus Resource Center, COVID-19 Dashboard by the Center for Systems Science and Engineering, 2020.
207 World Food Programme, Vulnerability Analysis and Mapping Food Security Analysis, Impact of COVID-19 in the Middle East, North Africa, Central Asia, and Eastern Europe, Update #7, 2020.

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT[208]

OVERVIEW

The right to the health is protected under both international human rights law and international humanitarian law. The most comprehensive article regarding the right to health is found in the International Covenant on Economic, Social and Cultural Rights wherein States Parties recognize 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.[209] Yet data show that women and girls throughout the region face major barriers in accessing mental health services, programming, and information. While many women throughout the region suffer from depression and stress, cultural stigma around mental health often prevents both access to services and effective treatment. Further, the lack of dedicated mental health legislation in half of the countries within the region and a lack of national policies and plans in 30 per cent of the countries may indicate that a large proportion of women are likely left without prevention and response services.[210] Overall, there is a lack of psychosocial support across the region.[211]

Besides this, humanitarian crises including natural disasters, man-made emergencies (e.g. armed conflicts), and complex emergencies (i.e. a combination of natural and man-made factors) can weigh heavily on affected populations and lead to significant, oftentimes consequential psychosocial suffering. These crises have been exacerbated by the COVID-19 pandemic, as well as introducing mental health strains (and associated strains on services) in all countries. Already scarce outpatient and community mental health services have been most affected. Mental health prevention and promotion programmes felt the most severe impacts at a time when countries need them the most. Although global advocacy for mental health inclusion in COVID-19 responses has resulted in better integration into plans, multisectoral co-ordination platforms and regular data collection, there is still a gap in the financial and human resources allocated to integrate mental health into the emergency response, which constitutes a significant challenge and a barrier to the continuity of services.[212]

According to Arab Barometer, women experience stress more frequently than men within the region. When women and men throughout the region[213] were asked how often in the past six months they had felt so stressed that everything seemed to be a hassle, women were more likely to answer ´sometimes´, ´often´, and ´most of the time´ than their male counterparts. Specifically, 33 per cent of women express that they felt stressed to a point where ´everything seemed like a hassle´ either ´often' or 'most of the time' in the region.

208 Defined as any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat a mental disorder. Source: Inter-Agency Standing Committee (IASC), IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 2007.
209 UN General Assembly, International Covenant on Economic, Social and Cultural Rights, 16 December 1966.
210 Dalacoura, Katerina, Middle East and North Africa Regional Architecture: Mapping Geopolitical Shifts, Regional order and Domestic Transformations, Women and Gender in the Middle East and North Africa: Mapping the Field and Addressing Policy Dilemmas at the post-2011 Juncture, 2019.
211 UN Women, Accountability for Sexual Violence in Conflict: Identifying Gaps in Theory and Practice of National Jurisdictions in the Arab Region, 2018.
212 World Health Organization, The impact of COVID-19 on mental, neurological and substance use services: results of a rapid assessment, 2020.
213 Countries included: Algeria, Iraq, Egypt, Jordan, Kuwait, Lebanon, Libya, Morocco, State of Palestine, Sudan, Tunisia, Yemen.

Table 1.11:
Distribution of Stress Frequency

Variable: In the past six months, how often did you feel so stressed that everything seemed to be a hassle?

Results: Chi-square test shows significant differences in stress frequency between ESCWA group respondents.

	Maghreb		GCC		LDC		Mashreq		Whole Region	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Never	20.99	17.07	33.52	28.01	32.26	30.07	18.15	13.42	22.65	18.4
Sometimes	43	47.07	55.92	59.79	41.81	43.69	47.85	48.03	46.21	48.23
Often	20.33	18.88	9.7	11.14	18.62	19.68	23.47	27.5	20.38	21.99
Most of the Time	15.67	16.98	0.86	1.05	7.31	6.56	10.53	11.05	10.76	11.38

Source: Arab Barometer Wave V

Table 1.12:
Distribution of Depression Frequency

Variable: In the past six months, how often did you feel so depressed that nothing could cheer you up?

Results: Chi-square test shows significant differences in depression frequency between ESCWA group respondents.

*This question was not asked to participants from GCC

	Maghreb		LDC		Mashreq		Whole Region*	
	Male	Female	Male	Female	Male	Female	Male	Female
Never	36.8	32.61	39.96	38.52	27.46	21.94	32.81	28.42
Sometimes	38.7	39.78	39.67	38.62	42.29	42.54	40.58	40.92
Often	13.45	14.88	14.3	15.77	20.67	25.14	17.06	19.96
Most of the Time	11.06	12.74	6.07	7.08	9.58	10.38	9.54	10.71

Source: Arab Barometer, Wave V

Table 1.13:
Stand-alone Laws and Policy Plans for Mental Health

ESCWA Category	Country	Law	Policy or Plan	ESCWA Category	Country	Law	Policy or Plan
GCC	Bahrain		●	Mashreq	Egypt	●	●
	Kuwait				Iran	●	●
	Oman		●		Iraq	●	●
	Qatar	●	●		Jordan		●
	Saudi Arabia	●	●		Lebanon	●	●
	UAE	●	●		Syria		●
Maghreb	Algeria	●		LDC	Djibouti		
	Libya				Somalia		
	Morocco	●	●		Sudan	●	●
	Tunisia		●		Yemen		

Source: World Health Organization, Global Health Observatory (accessed 2019)

Women in the Mashreq and Maghreb regions are most likely to experience extreme levels of stress, with 38.5 per cent in the Mashreq and 35.9 per cent in the Maghreb experiencing high levels of stress (reporting to experience high stress levels to the point where everything seemed to be a hassle 'often' or 'most of the time'). Women in the Maghreb exhibit the highest stress levels ('most of the time' they feel so stressed that everything seemed to be a hassle) at 17.0 per cent, more than 5 per cent higher than women in any other subregion.

Similarly, women report higher levels of depression than men in the region as a whole. When women and men throughout the region[214] were asked how often in the past six months they had felt so depressed that nothing could cheer you up, women were more likely to answer 'sometimes', 'often', and 'most of the time' than their male counterparts.

DALY figures for mental health indicate that men are more affected by mental and substance abuse disorders, while women are much more affected by anxiety disorders. For example, in Iran, anxiety disorders were estimated by the WHO as 310.43 DALY, while men only recorded 188.96. Women are more affected by anxiety than men in every country in the region.

While the region exhibits the lowest female suicide mortality rate for females (ages 15-29 and 30-49) in the world, the within region differences in suicide mortality rates are worth noting. For example, while fewer than one female per 100,000 people per year commits suicide in the United Arab Emirates, females in Yemen are committing suicide approximately 8 to 10 times more often.[215] The contributing factors to suicide risk are complex, however, documentation suggests that living in a conflict-affected area can lead to circumstances of increased insecurity and violence, thus increasing the prevalence of depression, anxiety and post-traumatic stress, which may overwhelm one's normal coping ability.[216],[217] While men aged 30-49 are more likely to commit suicide than their younger counterparts (age 15-29), the opposite is true for females in several countries, where deaths by suicide are generally higher among young adults (15-29) than adults (30-49).

214 Countries included: Algeria, Iraq, Egypt, Jordan, Kuwait, Lebanon, Libya, Morocco, State of Palestine, Sudan, Tunisia, Yemen.
215 WHO Global Health Estimates.
216 International Medical Corps and UNICEF, Mental Health Psychosocial and Child Protection for Syrian Adolescent Refugees in Jordan, 2014.
217 ESCWA, Against Wind and Tides: A Review of the Status of Women and Gender Equality in the Arab Region (Beijing +20), 2016.

Conflict andhumanitarian situations often have an adverse effect on the mental health and psychosocial well-being of the population. Adolescents are especially affected by these situations as these hardships occur during a time in their lives where they are developing their identifies and roles in their families and communities.[218] As an example, evidence from the State of Palestine indicate that 47 per cent of Palestinian girls ages 6 to 12 displayed emotional and/or behavioural disorders and that women are experiencing high rates of anxiety and depression.[219]

In Syria, individuals with pre-existing mental health conditions are even more vulnerable and significant numbers of Syrians are experienced increasing levels of emotional disorders (e.g. depression, prolonged grief disorder, and post-traumatic stress disorder).[220] A study in 2014 found that Syrian refugees with disabilities were twice as likely to report psychological distress than refugees without disabilities, and that refugees with disabilities experience greater obstacles in accessing services, support, and justice.[221]

LAWS AND POLICIES

Regionally, half of the countries have a dedicated mental health legislation regarding mental health, however, when broken down by subregions, greater contrasts are exhibited. For example, one out of four of LDCs and two thirds of countries from the Mashreq have stand-alone laws regarding mental health.

A majority of countries in the region (70 per cent) have an officially approved mental health policy or plan in place. The GCC and Mashreq subregions exhibit the highest percentages of countries with mental health policies and plans at 100 per cent and 83 per cent, respectively.

SOCIO-CULTURAL NORMS AND PRACTICES

A systematic literature review of nearly 100 reports related to mental health in the region confirmed that female youth in crisis-affected areas exhibit a higher prevalence of mental health issues than their male counterparts. Interestingly, while boys are equally (or more often) exposed to traumatic situations – due in part to the socio-cultural norms and standards that allow boys to spend more time outside of the house than girls – girls experience a higher prevalence of conditions such as post-traumatic stress disorder, depression, anxiety, and other psychological symptoms.[222]

Research also reveals that the practice of female genital mutilation and female circumcision (FGM/C) can negatively affect the emotional well-being of girls and women throughout their lifecycle. A majority of women who have been subjected to the harmful practice of FGM/C have reported mental health issues and emotional disorders due to the procedure, with many FGM/C survivors reporting severe depression, anxiety, and post-traumatic stress disorders.[223]

In conflict-affected areas, girls are the first to be taken out of school and limits are placed on their mobility due to security reasons. As education is halted and there is increased confinement, families begin to perceive their girls as becoming financial burdens. In turn, this leads to limits in access to psychosocial support and other protection services.[224]

SERVICES, PROGRAMMING AND INFORMATION

Mental health services are extremely limited even though the region has experienced a steady increase in mental health disorders.[225] A survey of NGO-run shelters in the region – which often provide some

218 International medical Corps and UNICEF, Mental Health Psychosocial and Child Protection for Syrian Adolescent Refugees in Jordan, 2014.
219 ESCWA, Social and Economic Situation of Palestinian Women and Girls (July 2016 – June 2018), 2019.
220 Avis, Qilliam, The impact of protracted crises on attitudes and aspirations, 2016.
221 UNHCR, Sexual and Gender-based Violence Prevention and Response in Refugee Situations in the Middle East and North Africa, 2015.
222 Fehling, M., et al., Youth in crisis in the Middle East and North Africa: a systematic literature review and focused landscape analysis, Eastern Mediterranean Health Journal, Vol. 21 No. 12, 2015.
223 UNFPA Arab States Regional Office, Female Genital Mutilation and Population Movements within and from the Arab Region, 2018.
224 UNFPA, UNICEF, et al., Child marriage in humanitarian settings: Spotlight on the situation in the Arab region. N.d.
225 ESCWA, Against Wind and Tides: A Review of the Status of Women and Gender Equality in the Arab Region (Beijing +20), 2016.

psychosocial support services – revealed that of shelters surveyed, only 46 per cent accommodate elderly women over the age of 65, 69 per cent accommodate unaccompanied girls under 18 years of age, 31 per cent accommodate women with mental health problems, 62 per cent accommodate women with physical disabilities, 54 per cent accommodate migrant workers, and 70 per cent accommodate women refugees. Approximately 70 per cent of NGO-run shelters in the region follow the practice of not accommodating women with mental health issues. This is a major issue as there is a direct link between intimate partner violence (of which women are most affected) and psychological trauma, and stress and mental health problems. Therefore, it is contradictory to prevent women from gaining access to the services they require due to their mental health problems – problems they have sustained as a direct consequence of experiencing violence.[226]

Survey findings concluded that shelters in Lebanon had the least amount of restrictions regarding who can access the shelters while Yemen had the most restrictions. The same survey revealed that in 2017, shelters in Algeria, Lebanon, and Tunisia were forced to turn women away due to lack of resources or because they did not meet criteria for the specific shelter.[227] Limited access for women with specific needs is a major concern within the region – providing specialised support for women with moderate or severe mental health requirements necessitate additional expertise and resources which place additional burden on shelters' often limitedresources.[228]

Data regarding government expenditure on mental health is scant. Out of the 21 countries in the region, six countries report government expenditures on mental hospitals as a percentage of total government expenditures on mental health. Lebanon leads the region, at 5 per cent of the mental health budget spent on mental hospitals, followed by Saudi Arabia (4 per cent), Bahrain (3.2 per cent), Qatar (.6 per cent), Egypt (.5 per cent), and Syria (.2 per cent).[229]

Moreover, mental health human resources vary widely within the region. Some countries, like Bahrain and Iran, exceed the global median[230] in every mental health workforce category for which data are available. Other countries like Iraq, Syria, and Yemen have between zero and 1.2 staff per 100,000 population.

At a subregional level, the GCC has the highest rates of mental health nurses, psychiatrists, and social workers. The Mashreq has the highest rates of psychologists within the region. When aggregated at the subregional level, the GCC and the Mashreq exceed the global median for mental health nurses and psychologists; the GCC exceeds the global median for psychiatrists; and all four subregions meet or exceed the global median for social workers focusing on mental health.

In addition to human resources dedicated to mental health, the region also exhibits great disparities regarding facilities focused on treating mental health issues. The number of mental hospitals (per 1000,000 population) is higher than the global median of .06[231] in only three of 16 countries in the region for which data are available.[232]

The number of beds dedicated to mental health per 100,000 population varies greatly by facility type and subregion, however, differences are more noticeable at the country level within each subregion (see Figure 1.5, below). Only the Mashreq (11.7) exceeds the global median rate for the number of beds in mental hospitals per 100,000 population (11.3).[233]

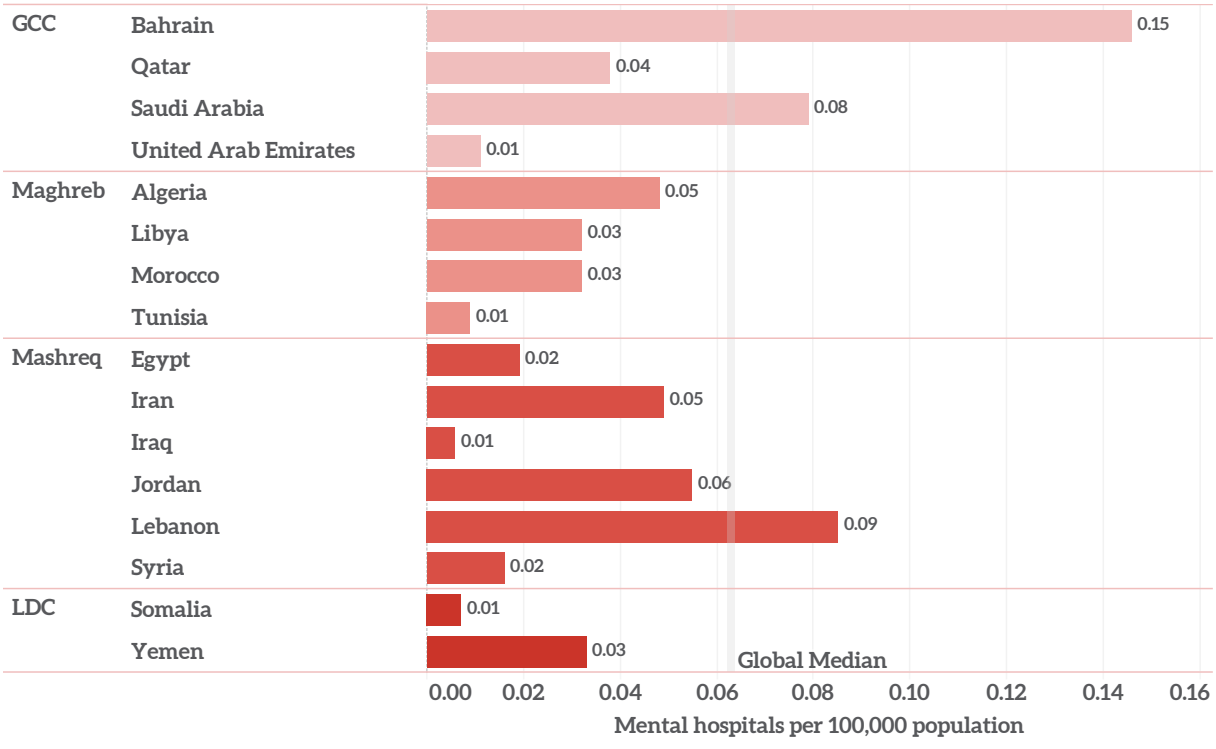
226 ESCWA, UNFPA, ABAAD, WAVE. Shelters for Women Survivors of Violence: Availability and Accessibility in the Arab Region, 2019.
227 Ibid.
228 Ibid.
229 WHO, Global Health Observatory. Data from 2015- 2017: Bahrain (2017), Egypt (2016), Lebanon (2015), Qatar (2016), Saudi Arabia (2016), and Syria (2016). Accessed at: https://www.who.int/data/gho/data/indicators/indicator-details/GHO/government-expenditures-on-mental-hospitals-as-a-percentage-of-total-government-expenditures-on-mental-health-(-)
230 Global data: mental health nurses, 3.49; psychiatrists, 1.27; psychologists, .88; social workers, .33 (per 100,000 population). See World Health Organization's Global Health Observatory.
231 World Health Organization, Mental Health Atlas 2017, 2018.
232 Data from multiple years: 2015: Lebanon; 2016: Algeria, Egypt, Jordan, Libya, Morocco, Qatar, Saudi Arabia, Syria, UAE, and Yemen; 2017: Bahrain, Iran, Iraq, Somalia, and Tunisia.
233 World Health Organization, Mental Health Atlas 2017, 2018.

Figure 1.4:
Mental Health Human Resources
This graph shows the rate of mental health nurses, psychiatrists, psychologists and social workers per 100,000 population.

	Bahrain	Egypt	Iran	Iraq	Jordan	Lebanon	Morocco	Oman	Qatar	Saudi Arabia	Sudan	Syria	Tunisia	U.A.E.	Yemen
Mental Health Nurses	27.9	4.8	9.5	1.2	3.3	3.1	2.5	3.0	9.9	10.7		1.1	0.2	4.4	0.3
Psychiatrists	5.5	1.6	2.0	0.3	1.1	1.2	0.8	1.7	2.7	1.3	0.1	0.4		1.6	0.2
Psychologists	1.2	0.3	5.2	0.1	1.3	3.3	0.6	0.8	1.4	2.0		1.1	0.0	0.8	0.4
Social Workers	1.5	0.4	1.5	0.1	0.2	1.3	0.6		0.1	4.0	0.6	0.8		0.4	0.1

Source: World Health Organization, Global Health Observatory

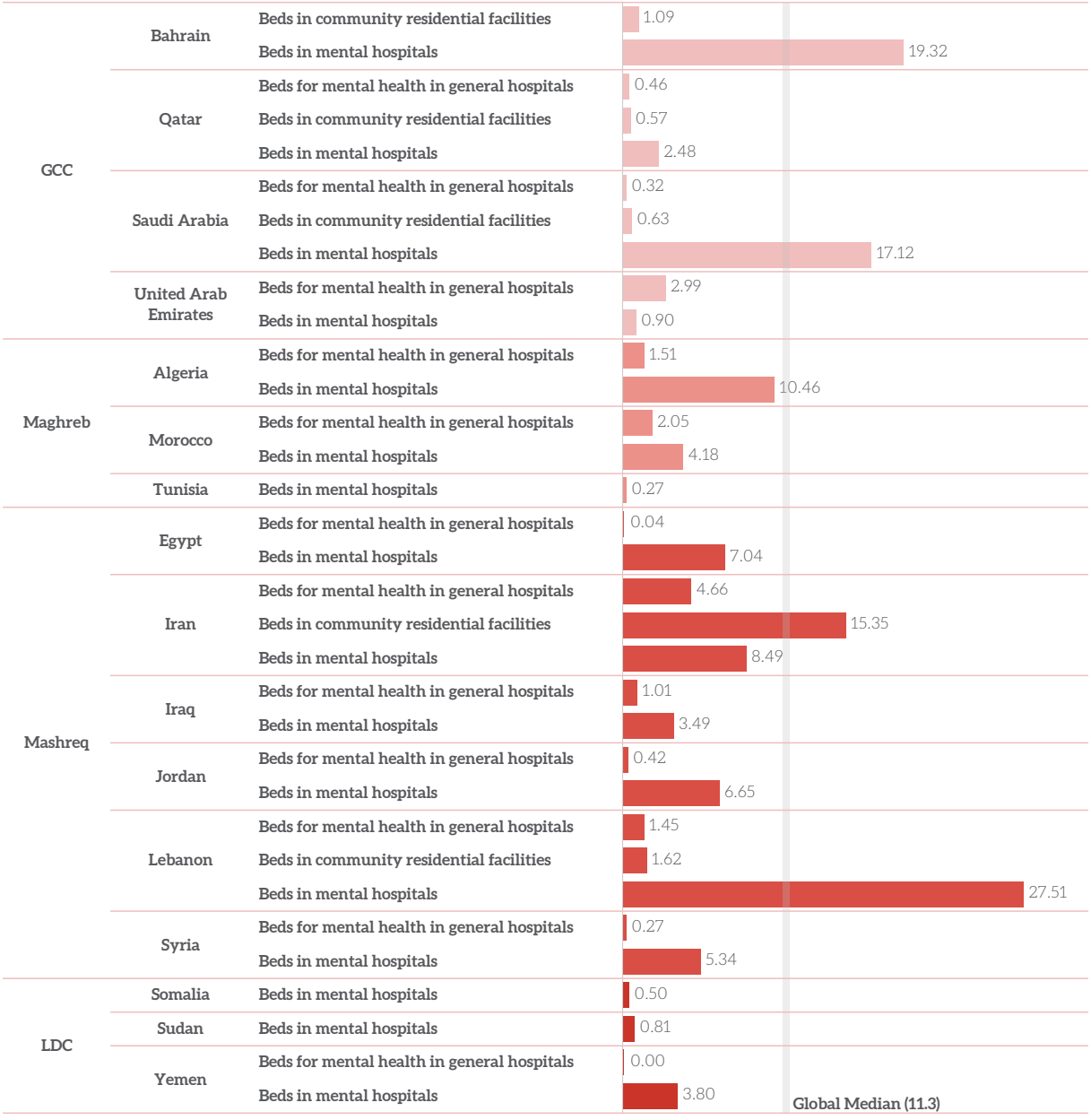
Figure 1.5:
Mental Hospitals (per 100,000 population)



Source: World Health Organization, Global Health Observatory

Figure 1.6:
Beds Dedicated to Mental Health

This graph shows the rate of beds per 100,000 population dedicated to mental health. Missing areas signifies no data from the country for that variable.



Source: World Health Organization, Global Health Observatory

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

OVERVIEW

Sexual and Reproductive Health and Rights (SRHR), sometimes referred to as Sexual and Reproductive Health and Reproductive Rights (SRHRR), is central to both health and development and impacts the health and well-being of women and girls throughout their lifecycle. While progress regarding SRHR has taken place over the past decade throughout the region, gains have been mixed both between and within countries. Further, progress is hindered by discrimination against women and girls, weak political commitments, and inadequate resources paired with a reluctance to address issues of sexuality openly and comprehensively.[234]

For all individuals to live healthy and satisfying lives and to achieve their full potential, their SRHR must be fulfilled and respected.[235]

Box 1.1: Working definitions of topics included under SRHR/SRHRR

- **Sexual health** is a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, along with the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the reproductive rights of all persons must be respected, protected, and fulfilled.[236]

- **Sexuality** is a central aspect of being human throughout life; it encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles, and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors.[237]

- **Reproductive health** is a state of complete physical, mental, and social well-being and not merely the absence of disease of infirmity, in all matters relating to the reproductive system and to its functions and processes. It implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. [238]

236 See working definition here: https://www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/.
237 See working definition here: https://www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/.
238 Beijing Declaration and Platform for Action, The Fourth World Conference on Women, 1995.

234 Starrs, Ann M, et al, Accelerate progress – sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission, 2018.
235 Ibid.

- **Reproductive rights** include the right of all men and women to be informed about and have access to safe, effective, affordable, and acceptable methods of family planning of their choice along with other methods of their choice for regulation of fertility that are not against the law and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and that will provide couples with the best chance of having a healthy infant.
- **Reproductive health care** is the constellation of methods, techniques, and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and STIs.[239]
- **SRH services** include general SRH information, family planning, safe abortion (where abortion is legal) and post-abortion care (regardless of legality of abortion), antenatal care, safe delivery care, and postnatal care, STI prevention and treatment, and treatment and prevention of non-sexually transmitted reproductive tract infections and other diseases and disorders (e.g. cancer, endometriosis).

239 UNFPA, Report of the International Conference on Population and Development, Cairo, 5-13 September 1994, 1995, A/CONF.171/13/Rev.1, Available at: https://www.refworld.org/docid/4a54bc080.html.

Ensuring that SRHR are met for all women and girls in the region requires that norms and practices embedded in society are challenged and confronted. Barriers to SRHR are present in laws, policies, and the economy worldwide, and prevent women and girls from gaining access to knowledge and services that contribute to healthy and equitable lives for women and girls at all stages of their lifecycle. Securing adequate and appropriate sexual and reproductive health care for every woman and adolescent girl hinges on the realisation of reproductive rights, which are often overlooked.[240] These barriers are not unique to the region and are present throughout the globe, however, the MENA and Arab States region presents a particularly challenging operating environment as SRHR is a culturally sensitive topic for many societies in the region, especially within the context of the ongoing conflicts and fragilities. For example, a reluctance to teach sexuality has meant that young people often rely on the internet or peers for information, and this may be inaccurate. Furthermore, a prevalent tendency among socially conservative societies of the region to only consider SRHR in the context of marriage means that unmarried adolescents, men and women, face social barriers in raising issues concerning their SRH with health-care providers.[241]

The SDGs include a range of key indicators specific to the health aspect of SRHR. Such indicators are in the areas of:

- Contraception
- SRH service availability
- Knowledge about SRHR
- Adolescent fertility
- Quality of SRH care, including respect for rights
- Prevention of STIs
- Availability of abortion services

240 ibid.
241 ESCWA, Arab Sustainable Development Report 2020, 2020.

Individual national and regional data on these areas (where available) is presented below. Overall, however, there is a regional lack of a rights-based approach to SRHR, despite commitments to and efforts to comply with the range of global instruments noted above. Countries in the region still face challenges in granting access to sexual and reproductive health care for all, without discrimination based on sex, nationality, displacement status or marital status. Services related to maternal health, family planning, and the prevention and treatment of sexually transmitted infections and HIV/AIDS are not fully integrated within primary health care. Accessibility and quality vary across countries, among social classes and from urban to rural areas. Cultural barriers significantly prevent women and couples from deciding freely and responsibly on their sexual and reproductive health, including family planning.[242]

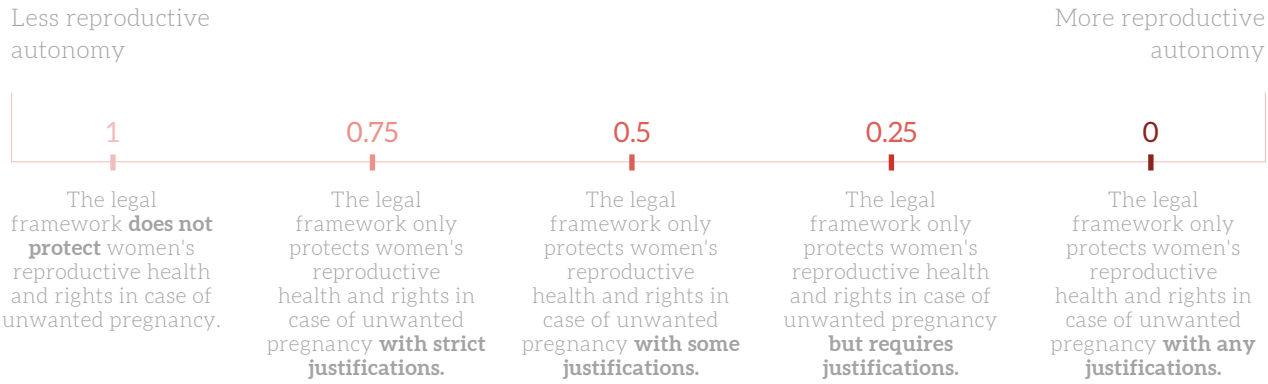
Similarly, legal frameworks do not reflect a rights-based approach that promotes well-informed individual choices, and often stipulate exemptions from the legal age to marry, forcing young girls into marriage and early pregnancy.

LAWS AND POLICIES

Supportive legal and regulatory environments are key determinants of the availability, accessibility, and quality of SRHR.

In 1994, the International Conference on Population and Development (ICPD) brought together 179 countries to declare that sexual and reproductive health and rights are human rights and are a precondition for women's empowerment and equality. The ICPD Programme of Action called for universal access to comprehensive reproductive health care (including voluntary family planning; safe pregnancy and childbirth services; prevention and treatment of sexually transmitted infections; information and counselling on sexuality; and the elimination of harmful practices against women and girls such as female genital mutilation and forced marriage) and recognized that both reproductive health and women's empowerment are interconnected. The ICPD Programme of Action is guided by 15 principles that reaffirm that 'the path to sustainable development is through the equitable achievement of dignity and human rights, good health, security

Figure 1.8:
SIGI Reproductive Autonomy Scale



242 Ibid.

of place and mobility and achievements secured through good governance and accountabilities'.[243]

As a whole, the ICPD Programme of Action[244] sets out to:

- Provide universal access to family planning and sexual and reproductive health services and reproductive rights;
- Deliver gender equality, empowerment of women and equal access to education for girls;
- Address the individual, social and economic impact of urbanization and migration;
- Support sustainable development and address environmental issues associated with population changes.

All of the countries included in this analysis adopted the ICPD Programme of Action in 1994, however, Djibouti, Egypt, Iran, Jordan, Kuwait, Libya, Syria, UAE, and Yemen made statements and reservations for the record regarding the ICPD Programme of Action.

Aside from Djibouti, Jordan, and Lebanon, all countries included in the situational analysis have constitutions that guarantee the right to health care; however, none of the countries specifically reference reproductive health care or family planning.[245]

A recent study regarding the status of and gaps in policies for sexual and reproductive health across 11 countries[246] in the MENA and Arab States region revealed that all countries except the UAE and Saudi Arabia have specific family planning strategies/policies/plans in their health plans.[247]

Some countries have eliminated restrictions on access to family planning and are committed to ensuring access to family planning methods (Egypt, Jordan, Morocco, Tunisia, and Syria) through national-level family planning strategies and other mechanisms. To illustrate, Tunisia has had a long history of family planning programmes and policies, dating back to its first family planning programme in 1964 and continuing with the establishment of the National Office of Family Planning (*Office National de Planification Familial*) in 1973. Over the decades, the implementation of family planning activities in Tunisia has transformed into a core element of a comprehensive sexual and reproductive health and rights strategy that prioritizes women's rights.[248]

Egypt, Jordan, Lebanon, Syria, and Tunisia have instituted national programmes and strategies specifically related to addressing HIV. However, legal barriers reportedly still exist which prevent optimization of HIV prevention and treatments in these countries.[249]

The OECD Development Centre's Social Institutions & Gender Index (SIGI)[250] scores reproductive autonomy from '0' to '1' based on whether the legal framework in a country protects women's reproductive health and rights.

Per the 2019 SIGI coding framework, 17 of the 21 countries received a score of .75 on the category 'legal framework on reproductive rights', meaning that the legal framework only protects women's reproductive health and rights in case of unwanted pregnancy with strict justifications. [251]

A majority of the countries in the region allow for abortion under certain circumstances, whether through the penal code, fatwa, ministerial regulation, or presidential decree. These circumstances include

243 UNFPA, The Five Themes of Population & Development, N.d.
244 UNFPA, The International Conference on Population and Development.
245 English language constitutions for each country were taken from Constitute at https://www.constituteproject.org.
246 These 11 countries were: Algeria, Egypt, Jordan, Lebanon, Morocco, State of Palestine, Saudi Arabia, Sudan, Syria, Tunisia, and UAE. All countries under the referenced study are also included in in the forthcoming situational analysis.
247 UNFPA and the Middle East and North Africa Health Policy Form, Regional Report, Sexual and Reproductive Health Laws and Policies in Selected Arab Countries, 2016.
248 Ibid.
249 Ibid.
250 See: https://www.genderindex.org/.
251 See SIGI datasheets for Algeria, Bahrain, Djibouti, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Qatar, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, UAE, West Bank and Gaza Strip (Palestine), and Yemen. Available at: https://www.genderindex.org/country-profiles/.

rape or incest, mental or physical health of the pregnant woman, foetal impairments, and, in the case of Djibouti, undefined 'therapeutic' reasons. In Bahrain and Tunisia, a broad range of reasons for acquiring a legal abortion exist. In Bahrain, Penal Code 20 March 1976 (Sections 321-323) allows for abortion to save the mother's life, to protect her physical and mental health, in the case of rape or incest, foetal malformations, and socio-economic problems. In Tunisia, under the Penal Code 2012 Article 214, women are freely permitted to seek an abortion, however, the procedure must be carried out during the first three months by legally licensed medical doctor in a hospital, health facility, or licensed clinic. After the first three months of pregnancy, an abortion may be performed if there is a risk to the mother's health (including if mental well-being would be impaired by continuing the pregnancy) or a risk that the unborn child will 'suffer' from a disability or serious illness. More restrictive environments are present in Iraq, Lebanon, Libya, Oman, Somalia, Syria, and Yemen where abortion is only legal if the life of the mother is at risk or to save the mother's life.[252]

Within the region, criminal codes in some countries can be an obstacle to accessing and using certain family planning methods. For example, Article 523 and Article 524 of Syria's Criminal Code prohibits the advertisement, promotion, sale, procurement, or facilitation of contraception or contraceptive use.[253]

In Egypt, a ministerial decree in 2012 stated that Syrian refugees in Egypt have access to public primary health care services which include maternal health. Under this decree, Syrian refugee women and girls are able to receive care.[254]

Laws and policies that affect SRHR but are related to harmful practices (e.g. child marriage, FGM/C) are discussed under Pillar 3: Freedom from Violence and Discrimination.

SOCIO-CULTURAL NORMS AND PRACTICES

Throughout the region, taboos around sexuality often prevent discussions and information sharing about SRHR.[255] This reticence translates into difficulties in obtaining information regarding SRHR and can reinforce misconceptions, stereotypes, and misinformation on SRHR-related topics.

Decision making regarding SRHR

While the 1995 Beijing Declaration and Platform for Action affirms that 'the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment', many women in the region do not control decision making regarding their health care, including sexual and reproductive health care. Women's access to and decision making regarding sexual and reproductive health in the region is sometimes at odds with socio-cultural norms (e.g., gender disparities, taboos, and SRHR services that are heavily weighted in favour of married individuals) and the state's pronatalist objectives.[256]

It is important to note that decision making abilities are likely to depend on many factors such as location, education, and income level, however, available data indicate limited levels of women's autonomy regarding sexual relations, contraceptive use and health care.

Data regarding the proportion of women aged 15-49 years[257] who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care[258] is limited in the region. Publicly available data on this indicator is only available for Jordan, which was reported by the United Nations Global SDG Database as having 84.2 per cent of women make their own decisions regarding sexual relations, 90 per cent reproductive

252 See also SIGI, Social Institutions & Gender Index Country Profiles 2019.
253 UNFPA and the Middle East and North Africa Health Policy Form, Regional Report, Sexual and Reproductive Health Laws and Policies in Selected Arab Countries, 2016.
254 UNHCR, In Search of Solutions: Addressing Statelessness in the Middle East and North Africa, 2016.
255 UNICEF MENA Regional Office in collaboration with the International Center for Research on Women (ICRW), Child Marriage in the Middle East and North Africa, 2017.
256 ESCWA, Against Wind and Tides: A Review of the Status of Women and Gender Equality in the Arab Region (Beijing +20), 2016.
257 The generally accepted definition for women of reproductive age. See https://apps.who.int/iris/bitstream/handle/10665/43185/924156315X_eng.pdf.
258 Indicator definition: Proportion of women ages 15-49 years (married or in union) who make their own decision on all three selected areas i.e. can say no to sexual intercourse with their husband or partner if they do not want; decide on use of contraception; and decide on their own health care.

health care, 95.3 per cent regarding contraceptive use.[259] According to data published by the United Nations Population fund, based on Demographic and Health Surveys, 72.6 per cent of women in Jordan answer 'yes' to all three questions.[260]

While comprehensive data related to sexual and reproductive health indicators (e.g. related to the 14 SDG Global Targets under the categories noted at the start of this section) are unavailable for multiple countries, data regarding decision making of married women in three countries (Egypt, Jordan, and Yemen) for health care more generally reveal that married women do not usually make health decisions on their own (between 9.4 per cent and 40.0 per cent of decisions regarding a woman's own health are made by the woman herself). Health decisions, including those related to sexual and reproductive health, for between 11 per cent and 42.2 per cent of married women are made solely by the woman's husband.

Data on decision making regarding sexual relations is similarly lacking for the region. The percentage of women ages 15-49 who believe a man would be justified in beating his wife if she refused sex is at 19.9 per cent Egypt and 32.4 per cent in Yemen.[261]

SERVICES, PROGRAMMING AND INFORMATION

While many countries in the region have taken steps to improve SRHR coverage, significant inequities and disparities remain. In some cases, these inequities and disparities have increased in recent years, specifically for countries that have been impacted by crises.[262] Still, evidence shows that educated women more readily access SRH services than women with lower levels of education or no education.[263] Studies by Handicap International in Algeria, Morocco and Tunisia concerning persons with disabilities found that the type and quality of services is a major shortcoming and emphasized that health care systems often overlook the reproductive needs of women with disabilities.[264]

A recent regional study involving 11 countries[265] in the MENA and Arab States region revealed that several barriers to the achievement of SRHR relate to how the health system functions. The report cited issues of human resources and supplies, public-private divisions, the verticalization of health programmes, and the lack of universal health coverage as major barriers to SRHR. Furthermore, the study noted the need for better integration of SRHR-related services with other existing services, for example those related to mental health and non-communicable diseases. By increasing linkages, health systems would be able to take advantage of women's and adolescent girls' contacts within the health system to increase prevention and treatment opportunities. Moreover, ensuring continuity of care throughout the lifecycle of the woman would increase the inclusion of marginalised groups

Only women who provide a 'yes' answer to all three components are considered as women who 'make her own decisions regarding sexual relations, contraceptive use, and reproductive health care'.

259 United Nations SDG Global Database 5.6.1: Proportion of women (per cent of women aged 15-49) who: make their own informed decisions regarding sexual relations, who make their own informed decisions regarding reproductive health care, who make their own informed decisions regarding contraceptive use. Available at https://unstats.un.org/sdgs/indicators/database/.

260 A 'yes' answer to all three components is considered as women who 'make her own decisions regarding sexual relations, contraceptive use, and reproductive health care'.

261 Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), and UNICEF. Accessed through the World Bank API.

262 UNFPA, Regional Interventions Action Plan for Arab States 2018-2021, no date.

263 UNICEF MENA Regional Office in collaboration with the International Center for Research on Women (ICRW), Child Marriage in the Middle East and North Africa, 2017.

264 ESCWA, Strengthening Social Protection for Persons with Disabilities in Arab Countries, 2017.

265 These 11 countries were: Algeria, Egypt, Jordan, Lebanon, Morocco, State of Palestine, Saudi Arabia, Sudan, Syria, Tunisia, and UAE. All countries under the referenced study are also included in in the forthcoming situational analysis.

including adolescent and young women, unmarried women, and post-menopausal women.[266]

Comprehensive Sexuality Education

In order for individuals to make informed decisions and protect their health, access to accurate information regarding SRHR is essential. The ICPD specifically recommends that countries provide scientifically accurate and Comprehensive Sexuality Education (CSE) programmes both within and outside of schools.

However, the holistic approach addressing the cognitive, emotional, physical and social aspects of sexuality endorsed by the ICPD is perceived in the region as 'fostering promiscuous or immoral behaviour, and abstinence only sexuality education is therefore preferred'.[267]

While there is considerable work to be done to achieve the ICPD commitments, several countries in the region have undertaken efforts to scale up sexuality education. For example, the Ministry of Education and Higher Education and the Ministry of Public Health in Lebanon approved a decree in 2010 to introduce a school-based reproductive health education and gender curriculum, but it has yet to be widely implemented in schools. The Ministry of Health in the State of Palestine has also taken steps to carry out the ICPD recommendations by conducting comprehensive sexuality education programmes within and outside of schools that include information on contraceptive acquisition and use.[268] Jordan and Tunisia have also made good progress in recent years in institutionalising CSE.

However, other countries are not exhibiting significant progress in CSE. United Nations Educational, Scientific and Cultural Organization (UNESCO) data reveals that only 3.1 per cent of lower secondary schools in the State of Palestine offer life-skills-based sexuality education. UNESCO reports that while Bahrain, Oman, Qatar, and Saudi Arabia (have 100 per cent coverage of secondary schools providing life-skills-based sexuality education, it noted a negligible percentage of schools in Algeria and Egypt.[269]

Findings from a study that included 11 countries in the region[270] concluded that none of the countries reported implementing CSE—even where curricula regarding SRHR existed, teachers were not sufficiently trained and implementation was weak.[271]

Data published by UNFPA in 2020[272] indicate that only two countries: Qatar and Tunisia, have CSE in schools, with other countries (Djibouti, Egypt, Jordan and Syria) providing some form of sexuality education outside a school context. The following table, drawn from the UNFPA findings, summarises country progress towards CSE as of 2020:

266 UNFPA and the Middle East and North Africa Health Policy Form, Regional Report, Sexual and Reproductive Health Laws and Policies in Selected Arab Countries, 2016.
267 UNFPA Arab States Regional Office, between 3eib* and Marriage: Navigating Comprehensive Sexuality Education in the Arab Region, 2020.
268 UNFPA and the Middle East and North Africa Health Policy Form, Regional Report, Sexual and Reproductive Health Laws and Policies in Selected Arab Countries, 2016.
269 UNESCO Institute for Statistics, Sustainable Development Goal 4.7.2.
270 Algeria, Egypt, Jordan, Lebanon, Morocco, State of Palestine, Saudi Arabia, Sudan, Syria, Tunisia, and the United Arab Emirates.
271 UNFPA and the Middle East and North Africa Health Policy Form, Regional Report, Sexual and Reproductive Health Laws and Policies in Selected Arab Countries, 2016.
272 UNFPA Arab States Regional Office, between 3eib* and Marriage: Navigating Comprehensive Sexuality Education in the Arab Region, 2020.

Table 1.14:
Progress towards comprehensive sexuality education[273]

Country	In-school curriculum	School topics taught	Non-school topics taught
Bahrain	No	Human body & development	No info
Kuwait	No	No info	No info
Oman	No	Violence and Staying Safe	No info
Qatar	Yes	Values, Rights, Cultures & Sexuality; Human Body & Development; Sexual & Reproductive Health	Y-PEER Peer-education training
Saudi Arabia	No	No info	Human Body and Development
UAE	No	No info	No info
Algeria	No	Human body & development	No info
Libya	No	No info	No info
Morocco	Yes	Human body & development, Sexual Education	
Tunisia	Yes	To be agreed	Relationships; Values, Rights, Cultures & Sexuality; Understanding Gender; Violence and Staying Safe; Skills for Health and Wellbeing; Human Body and Development; Sexuality and Sexual Behaviour; Sexual and Reproductive Health
Egypt	No	No info	Violence and Staying Safe; Skills for Health and Wellbeing; Human Body and Development; Sexuality and Sexual Behaviour Sexual and Reproductive Health
Iran	No info	No info	No info
Iraq	No	No info	Human Body and Development
Jordan			Relationships; Values, Rights, Cultures & Sexuality; Understanding Gender; Violence and Staying Safe; Skills for Health and Wellbeing; Human Body and Development; Sexuality and Sexual Behaviour; Sexual and Reproductive Health
Lebanon	No	Human Body & Development	Understanding Gender; Violence and Staying Safe; Human Body and Development; Sexuality and Sexual Behaviour; Sexual and Reproductive Health
Syria	No	No info	Violence and Staying Safe; Human Body and Development; Sexual and Reproductive Health
State of Palestine	No	No info	No info
Djibouti	No	No info	Violence and Staying Safe; Human Body and Development; Reproduction; Sexual and Reproductive Health
Somalia	No	Relationships; Human Body & Development	Human Body & Development
Sudan	No	Human Body & Development	Violence and Staying Safe; Human Body & Development
Yemen	No	No info	No info

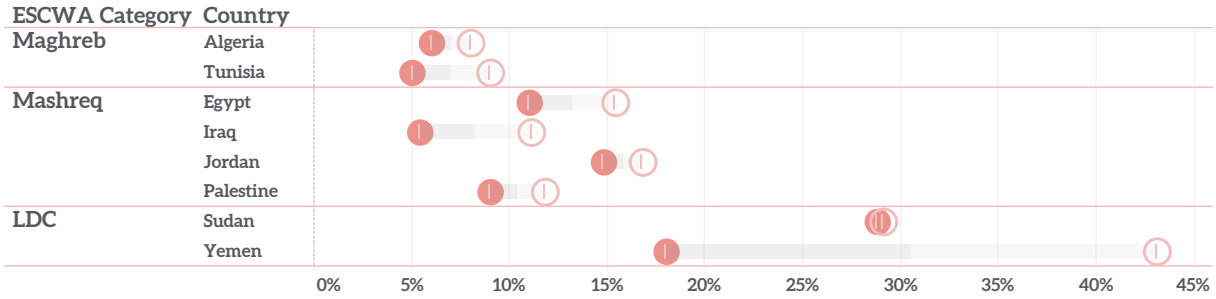
273 Ibid.

Family Planning

While family planning services have increased their coverage within the region, these often serve married women and contraceptive use amongst unmarried women and girls remain irregular or unknown.[274] There is also a disturbing trend in unmet family planning needs in conflict-affected countries. In these countries, younger women (ages 15 – 29) are less likely to have their family planning needs met than older cohorts. Given that protracted conflicts have caused the average age of first marriage to decrease, these younger women without access to contraceptives may be forced to have larger families than desired.[275] The prevention of unintended pregnancies and reduction of adolescent childbearing is crucial to the health and well-being of these young women. Prevention through universal access to sexual and reproductive health care is vitally important, especially in conflict-affected countries where socio-economic conditions deteriorate, for example in relation to the COVID-19 pandemic which has significantly impacted on the socio-economic status of many people (discussed above).[276]

Findings from a study that included 11 countries in the region[277] determined that married youth are typically non-users of family planning. Furthermore, the study showed that countries do not offer full access to family planning services for persons with disabilities or for minorities.[278]

Figure 1.9:
Unmet Need for Family Planning (%), by Household Wealth
This figure shows the percentage of currently married women who are in need of family planning for spacing, limiting, or both.



Source: MICS and DHS Surveys, as compiled by the World Bank. Accessed through API.

274 UNICEF MENA Regional Office in collaboration with the International Center for Research on Women (ICRW), Child Marriage in the Middle East and North Africa, 2017.
275 ESCWA, The Sustainable Development Goals in an Arab Region Affected by Conflict, Monitoring the Sustainable Development Goals with Household Survey Microdata, 2018.
276 ESCWA, The Sustainable Development Goals in an Arab Region Affected by Conflict, Monitoring the Sustainable Development Goals with Household Survey Microdata, 2018.
277 Algeria, Egypt, Jordan, Lebanon, Morocco, State of Palestine, the Kingdom of Saudi Arabia, Sudan, Syria, Tunisia, and the United Arab Emirates.
278 UNFPA and the Middle East and North Africa Health Policy Form, Regional Report, Sexual and Reproductive Health Laws and Policies in Selected Arab Countries, 2016.

Data suggest that unmet needs for family planning is inversely related to household wealth in all countries in the region, with Yemen exhibiting the strongest positive association between unmet need and household wealth. In Yemen, 43 per cent of married women in the poorest wealth quintile report having unmet needs for family planning, compared to 18 per cent of the wealthiest quintile.

Roughly 78 per cent of ever married women aged 15-49 who were married or in a union[279] in the region have reported having their reproductive needs for family planning satisfied with modern methods.[280] The highest among all women in the region is Egypt, where nearly 80 per cent of women report having their needs met by modern methods. The lowest is Libya, where only 24 per cent of women reported that their needs were met by modern methods.[281]

Furthermore, survey data collected by the Pan Arab Project for Family Health (PAPFAM) and Demographic Health Surveys (DHS) found that religion was not cited a major preventing factor for women seeking family planning services. Illustratively, in Syria, only 3 per cent of women who were not using or intending to use contraception cited religious prohibition as the main reason. In Yemen, less than 3 per cent of women with unmet need for family planning and who were not intending to use a contraceptive method cited religious prohibition as the main reason for not seeking contraception.[282]

Safe Abortion (where legal) and Post-abortion Care (regardless of legality)

Mentioned above, abortion is legal in at least some (albeit varying) circumstances in all but four countries of the region. Where legal, abortion should always be safe, and the ICPD Programme of Action stipulates that women should always have access to quality post-abortion care regardless of whether abortion is legal in the country.[283]

Thus, within the region, abortion —especially unsafe abortion[284]— is a neglected public health topic.[285] While the use of a range of family planning methods have increased in the region, unplanned pregnancies ending in abortions have remained nearly unchanged. Data suggest that two in five pregnancies in the region are unplanned with one-half of unplanned pregnancies ending in abortion.[286] Maternal mortality due to unsafe abortion is one of the most easily preventable causes of maternal mortality, however, women often do not seek post-abortion care in the region due to perceived risk (e.g. fear of abuse, ill treatment, legal reprisal) or a lack of awareness for the need or the availability of services.[287]

Research on abortion in the region is rare and when carried out, is often performed on a small scale. Examples of evidence from recent studies include:

- Estimates from Northern Africa suggest that nearly two million abortions were performed each year between 2010 and 2014. Of those, only 29 per cent were considered 'safe' and 44 per cent were considered 'least safe' meaning that they were performed by untrained individuals in a substandard medical setting.

279 Both formal (i.e. marriages) and informal unions are covered under this indicator. Informal unions are generally defined as those in which a couple lives together for some time, intends to have a lasting relationship, but for which there has been no formal civil or religious ceremony (i.e. cohabitation).
280 WHO Data Repository, Women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods (per cent). 2010-2018. Notably missing data from Somalia, Djibouti, Bahrain, Saudi Arabia, Syria, State of Palestine, or the UAE.
281 WHO Data Repository, Women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods (per cent) Year 2010-2018 only. See Egypt and Libya. For definition of 'married or in-union'. See: https://apps.who.int/gho/data/view.xgswcah.30-meta.
282 Roudi-Fahimi, Farzaneh, et al., Women's Need for Family Planning in Arab Countries, UNFPA, 2012.
283 Key Actions for Further Implementation of the Program of Action of the International Conference on Population and Development, U.N. GAOR, 21st Special Sess., June 30-July 3, 1999, para. 63, U.N. Doc. A/S-21/5/Add.1 (1999); ICPD Programme of Action, supra note 9, paras. 7.24 & 8.25.
284 Unsafe abortion is defined as a procedure for terminating a pregnancy carried out by individuals lacking the necessary training or performed in an environment not conforming to minimal medical standards, or both. Source: WHO.
285 UNFPA Arab States Regional Office, Prevention of unsafe abortion in the Arab states, 2018.
286 Guttmacher Institute, Adding It Up: Investing in Contraception and Maternal and Newborn Health, 2017—Estimation Methodology, Tables 6 and 7, 2017.
287 UNFPA Arab States Regional Office, Prevention of unsafe abortion in the Arab states, 2018.

This figure is more than three times higher than the global average for 'least safe' abortions at 14percent[288]

- A study conducted by the Palestinian Family Planning and Protection Association in four rural and urban areas of Hebron Governorate revealed that more than 70 per cent of women had at least one abortion (11 per cent induced and 66 per cent spontaneous). Of the induced abortions, 68 per cent of women did so secretly without anyone's knowledge. [289]

Examples of states taking action to address unsafe abortion are also rare. As previously discussed, Tunisia is the only country in the region that allows abortion on demand while all other countries criminalize abortion except under certain legal grounds including to preserve the mother's life or health or avoid foetal impairment. Evidence from Morocco suggests that abortion is common and a debate regarding legislative reform took place in 2015. The King of Morocco requested that the Department of Justice and Islamic Affairs and the National Council for Human Rights conduct a study regarding liberalizing abortion laws in the country. Their recommendations were ratified by the King of Morocco and broadened the conditions under which abortion is allowed to include health conditions of the woman (including mental health) and cases of rape, incest and congenital malformations. [290]

Post-abortion care throughout the region is inadequate due to the illegality of abortion in a majority of countries. While some countries report safe illegal abortions by private doctors, access to these safe but illegal abortions presents a situation of inequity as only those who can afford to pay a private doctor to perform the procedure are able to access safe abortion.

Antenatal Care, Safe Delivery Care, and Postnatal Care

Antenatal care

Antenatal care is lower in rural areas of some countries in the region, with rural women in Iraq and Sudan reporting statistically significant lower access to care. In some countries, it appears that efforts to increase antenatal care coverage have

Table 1.15:
Antenatal Care Coverage: (in two or three years preceding the survey)

			One Visit		Four Visits	
Country	**Year**	**Source**	**Urban**	**Rural**	**Urban**	**Rural**
Algeria	2012	MICS	93.6	91.3	72.3	59.5
Egypt	2014	DHS	93.1	90.5	88.1	81.9
Iraq	2011	MICS	83.3	66.1	54.0	40.5
Jordan	2012	DHS	99.1	99.1	94.5	93.1
Sudan	2014	MICS	90.8	74.9	71.8	43.2

Source: World Health Observatory Data Repository

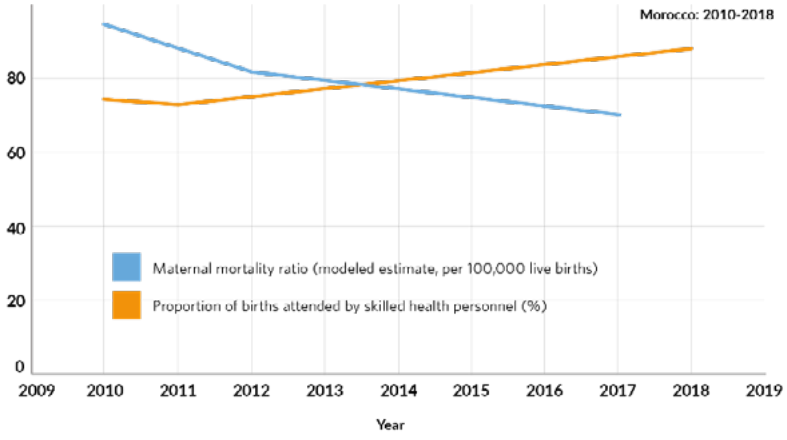
288 Guttmacher institute, Abortion Worldwide 2017: Uneven Progress and Unequal Access, 2017.
289 UNFPA and Middle East and North Africa Health Policy Forum, Addressing unintended pregnancy in the Arab region, 2018.
290 Miller, Bryn, Morocco Liberalizes Abortion Laws, Amends Penal Code, Morocco World News, 2016.

succeeded in bridging the gap between rural and urban areas. Jordan in particular reports excellent coverage in both rural and urban areas. Similarly, Egypt and Algeria report non-significant differences in access between rural and urban women. (See Table 1.15.)

Maternal Mortality Ratio (MMR)

Overall, the MMR[291] is trending downward in the region, likely as a result of efforts to improve antenatal health care and health care in general. According to data collected and modelled by the World Bank, 14 of the 21 countries have reached the Sustainable Development Goal of reducing maternal deaths to less than 70 per 100,000 live births. After weighting for population, the region as a whole is yet to reach the goal, with an estimated 123.5 deaths per 100,000 live births. However, the disparity between countries is highlighted heavily in this indicator, with Somalia reaching over 800 maternal deaths per 100,000 live births while the UAE was reported only three for the same figure. Egypt and Iran's large populations and relatively low MMR reduce the weighted regional average considerably. Good progress has been noted in individual countries, despite not yet reaching MDG/SDG targets (e.g. Algeria).[292]

The lifetime risk of maternal death is the probability that a 15-year-old female will die from complications of pregnancy or childbirth over her lifetime; it takes into account both the maternal mortality ratio and the total fertility rate (average number of births per woman during her reproductive years). The region contains substantial differences for this indicator, ranging from 1 in 20 in Somalia to only 1 in 17,900 in the UAE. After weighting for population, the region as a whole is yet to reach the goal, with an estimated 123.5 deaths per 100,000 live births. However, the disparity between countries is highlighted heavily in this indicator, with Somalia reaching over 800 maternal deaths per 100,000 live births while the UAE was reported only three for the same figure. Egypt and Iran's large populations and relatively low MMR reduce the weighted regional average considerably.



291 The MMR is defined as the number of maternal deaths during a given time period per 100,000 live births during the same time period. All data utilized in calculating the MMR was collected from the World Bank World Development Indicators database, which collects and models data from the WHO, UNICEF, UNFPA, World Bank Group, and the United Nations Population Division. Trends in Maternal Mortality: 2000 to 2017. Geneva, World Health Organization, 2019. Weighting was performed using standard weighting techniques utilizing fertility totals on women and girls aged 15-49 as published by UN DESA/Population Division.

292 See World Bank modelled data on MMR, here: https://data.worldbank.org/indicator/SH.STA.MMRT.

293 World Bank World Development Indicators database: per cent births attended by skilled health personnel: Morocco.

Table 1.16:
Lifetime Risk of Maternal Death, 2017
The probability that a 15-year-old female will die eventually from a maternal cause assuming current levels of fertility and mortality, taking account competing causes of death.

GCC	United Arab Emirates	17,900
	Qatar	5,000
	Kuwait	4,200
	Bahrain	3,000
	Saudi Arabia	2,300
	Oman	1,600
Maghreb	Algeria	270
	Morocco	560
	Libya	590
	Tunisia	970
Mashreq	Iran	2,600
	Lebanon	1,600
	Syria	1,000
	State of Palestine	880
	Egypt	730
	Jordan	730
	Iraq	320
LDC	Yemen	150
	Djibouti	140
	Sudan	75
	Somalia	20

Source: WHO, UNICEF, UNFPA, World Bank Group, and the United Nations Population Division, 'Trends in Maternal Mortality, 2019'.

Proportion of Births Attended by Skilled Health Personnel [294]

Available data from 2010-2018 indicate that 13 of the 21 countries in the region have reached a rate of at least 90 per cent of all births being attended by a skilled health person, with all countries except Yemen and Somalia[295] having over 75 per cent of all births attended by a skilled health person. Regionally, around 76 per cent of all births are attended by skilled health personnel.[296] Countries with ongoing conflicts were found to have rapidly declining rates, for example in Syria where the crisis has caused birth attendance by skilled professionals to decline by as much as 24.25 per cent between 2011 and 2013., Similarly, access to skilled attendance during birth has been extremely curtailed due to the ongoing conflict.[297]

Notably, maternal mortality is clearly inversely related to the percentage of births attended by skilled personnel: as the percentage of births attended by skilled personnel rises, the MMR is reduced. For instance, Morocco has reduced their MMR from 153 in 2010 to 121 in 2015. This success can likely be partially attributed to the efforts of skilled attendants at birth – whose attendance increased from 74.1 per cent in 2010 to 86.6 per cent in 2018.[298] The latest National Population and Health Survey in 2018 indicates that MMR decreased from 112 deaths per 100,000 live births (2009-2010) to 72.6 (2015-2016), a 35 per cent reduction.

Place of delivery

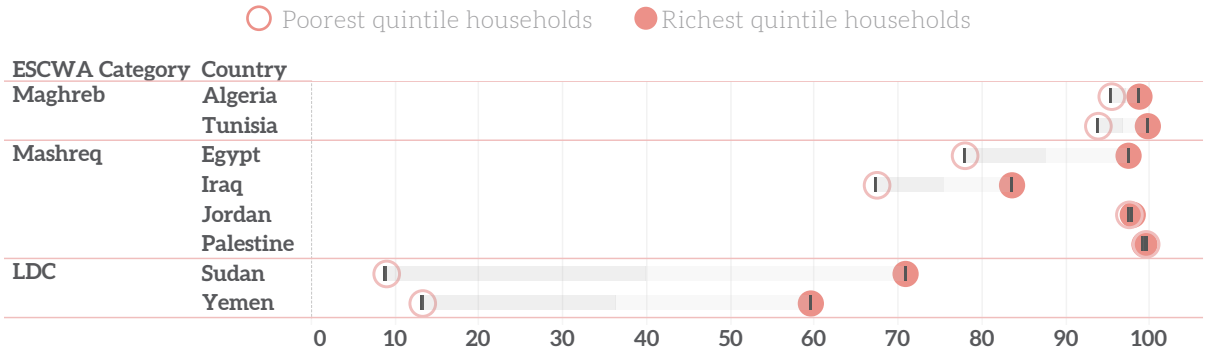
Data from DHS and MICS indicate that women in the region from the poorest wealth quintile have less access to health facilities across the region. This correlation between household wealth and access to health facilities for birth is exhibited most in the LDCs, with women from the wealthiest quintile between 46 per cent and 62 per cent more likely to deliver in a health facility than those from the poorest wealth quintile.

UNICEF data on the subject similarly exposes existing gaps between access to health facilities, which is pronounced in the LDC subregion (and lesser so in the Maghreb/Mashreq subregion). In the LDC subregion, data from Sudan and Yemen in 2014 indicate that women in urban areas are over twice as likely to give birth in a health facility than women in rural areas.[299]

294 Relevant SDG target: 3.1: Reduce maternal mortality.
295 World Bank World Development Indicators database: per cent births attended by skilled health personnel: Somalia, 9 per cent 2009.
296 UNFPA estimate, does not include Iran.
297 UNICEF, Yemen: Parenting in a War Zone: Children Dying in Their First Days, 2019.
298 World Bank World Development Indicators database: per cent births attended by skilled health personnel: Morocco. See also: UNFPA.الأمم صحة 23 November 2015: Accessed at https://arabstates.unfpa.org/ar/node/22510.
299 Based on data published by UNICEF in Yemen and Sudan. In Yemen, only 22.6 per cent births in rural areas occur in health facility, compared to 49.1 per cent in urban areas. Similar trends are observed in Sudan.

Figure 1.12:
Place of Delivery

This figure shows the percentage of live births in the three years prior to the survey which took place at a health facility. Wealth Quintiles in this figure show the wealthiest 20% of households and the poorest 20% of households in each country with data displayed.



Source: MICS and DHS Surveys, as compiled by the World Bank. Accessed through API.

Caesarean Section Rates

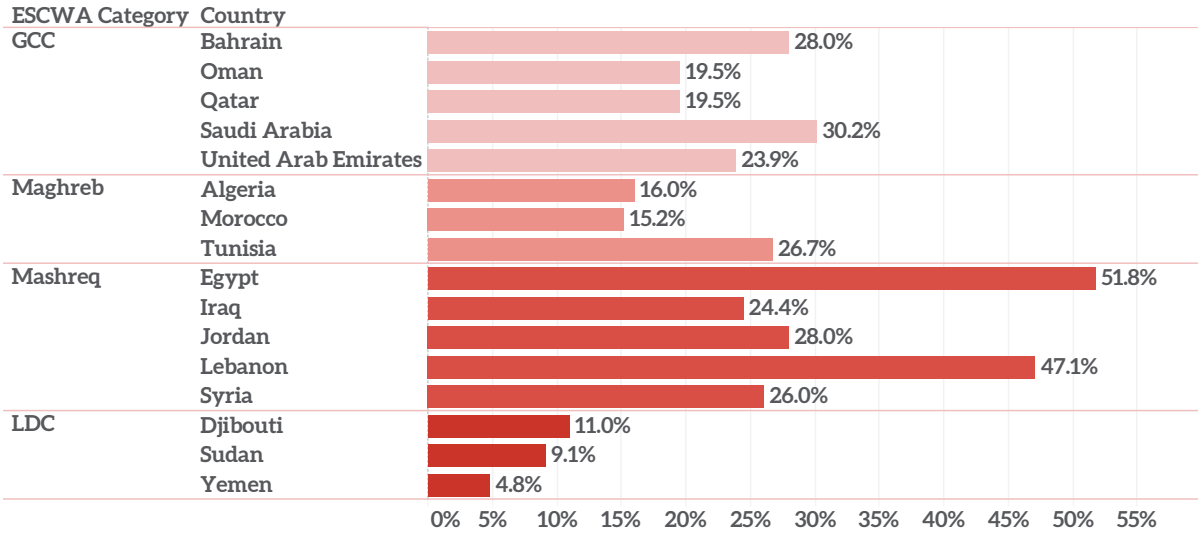
While there is no ideal rate for caesarean deliveries the international community generally agrees that 1) a rate of less than 1-2 per cent is likely to indicate a lack of emergency obstetric care and may be associated with excess maternal mortality and 2) a rate of 15 per cent for caesarean sections should be considered the threshold that should not be exceeded (according to a World Health Organization's statement).[300]

Caesarean section rates vary greatly within the region, ranging from 4.8 per cent in Yemen to 51.8 per cent in Egypt (all data from 2015). The exceptionally high rate in Egypt may be partly caused by FGM prevalence (87.2 per cent[301]) and obesity (36 per cent[302]) – two circumstances that are known to cause complications during childbirth and necessitate caesarean sections[303] as well as socio-economic aspects determining access to private or public health facilities – however, data does not allow for this analysis.

300 Cavallaro, Francesca L., et al., Trends in caesarean delivery by country and wealth quintile: cross-sectional surveys in southern Asia and sub-Saharan Africa, Bulletin of the World Health Organization, 2013.
301 WHO, Global Health Observatory, 2015.
302 ESCWA, Arab Society, a compendium of Social Statistics (Issue No. 12), 2016.
303 A large body of research is dedicated to investigating the effects of FGM and obesity on caesarean section rates. See, for example: Banks, Emily, et. al., Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries, Lancet, 2006. Australian National University. Female Genital Mutilation Affects Births: Study, ScienceDaily. 2006. Varol, N., et. al., Obstetric outcomes for women with female genital mutilation at an Australian hospital, 2006-2012: a descriptive study, BMC Pregnancy Childbirth, 2016. Machado, Lovina SM, Cesarean Section in Morbidly Obese Parturients: Practical Implications and Complications, North American Journal of Medical Sciences, 2012.

Figure 1.13:
Caesarean Births

This figure shows the percentage of births by caesarean section among all live births in a given time period. The percentage of births by caesarean section is an indicator of access to and use of emergency health care during childbirth.



Source: WHO Global Health Observatory

Postnatal Care

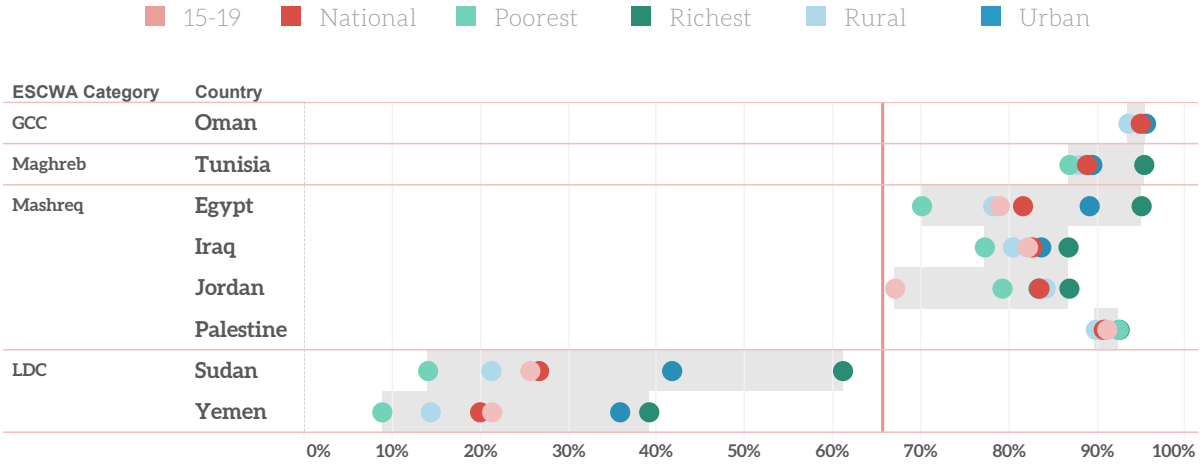
While advancements have been made regarding safe motherhood programmes in the region, lack of integration between maternal and neonatal health remains a major challenge. In turn, this challenge contributes to the neglect of the postnatal period and the low utilization of postnatal care.[304]

Household survey data published by UNICEF gives evidence that access to postnatal care is affected by household wealth and location. As illustrated by the graph below,[305] women from poor, rural households especially in the LDC subregion are most likely to receive no postnatal care at all, in contrast to other regions where at least 65 per cent of women even in the poor, rural areas of the country receive postnatal care.

304 UNFPA and the Middle East and North Africa Health Policy Form, Regional Report, Sexual and Reproductive Health Laws and Policies in Selected Arab Countries, 2016.
305 Egypt (2014), Iraq (2018), Jordan (2018), Oman (2014), Palestine (2014), Sudan (2014), Tunisia (2018), and Yemen (2013).

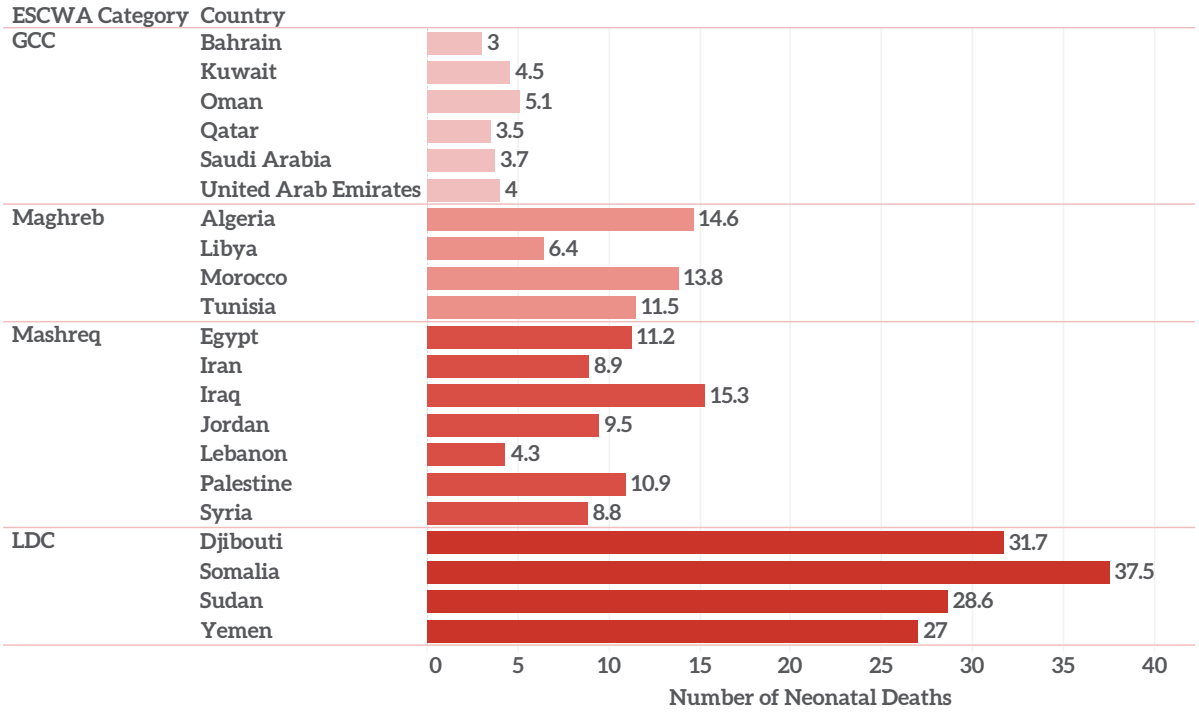
Figure 1.14:
Postnatal Care

This figure shows the percentage of women (age 15-49) who received postnatal care within 2 days of giving birth.



Source: Country-specific Demographic and Health (DHS), Multiple Indicator and Cluster (MICS), and other national surveys as published by UNICEF.

Figure 1.15:
Mortality rate, per 1000 live births



Source: United Nations Populations Division, World Population Prospects

Treatment and Prevention of STIs

HIV/AIDS

Table 1.17:
Estimated antiretroviral therapy coverage among people living with HIV

ESCWA Category	Country	per cent
GCC	Bahrain	..
	Kuwait	62
	Oman	41
	Qatar	..
	Saudi Arabia	..
	UAE	..
Maghreb	Algeria	81
	Libya	44
	Morocco	..
	Tunisia	..
Mashreq	Egypt	31
	Iran[306]	20
	Jordan	..
	Lebanon	..
	State of Palestine	..
	Syria	20
LDC	Djibouti	30
	Sudan	15
	Somalia	30
	Yemen	21

Source: WHO Global Health Observatory

As of 2019, the Joint United Nations Programme on HIV and AIDS (UNAIDS) estimated that 240,000 people in the region were living with HIV, representing less than 0.1 per cent adult prevalence.[307]

While the region exhibits the lowest HIV prevalence in the world, it is an area of increasing concern due to a 10 per cent increase in new infections and a 9 per cent increase in the number of annual AIDS-related deaths between 2010 and 2018.[308] Further, the region presents a high mortality (4.5 per cent) incidence among individuals living with HIV and a lack of knowledge concerning HIV spread. Around 8,000 people died of an AIDS-related illness in 2019. This is a result of very poor access to Antiretroviral Treatment (ART), with only 38 per cent of those needing ART having access – far below the global level of 59 per cent.[309]

Research also suggests that stigmas associated with the disease could be contributing to its rise in severalcountries.[310]

In 2018, members of key populations – sex workers, people who use drugs, gay men, other men who have sex with men, transgender individuals, and prisoners – comprised at least three quarters of new infections in the region. Stigma and discrimination related to HIV/AIDS can significantly interfere with the ability of individuals to access both testing and treatment services that, in turn, could prevent further transmission.[311] Furthermore, stigma and discrimination (both social and legal) marginalizes people living with HIV and can expose them to social or legal sanction. A multi-country survey revealed that more than 60 per cent of people aged 15-49 in Algeria and more than 70 per cent of people aged 15-49 in Egypt, Jordan, and Yemen stated that they would not buy vegetables from a shopkeeper who is living with HIV (a question used to assess discriminatory attitudes towards those with HIV).[312] More than 50 per cent of persons surveyed in Algeria reported being denied health services due to their HIV positive status.[313]

According to a report released by UNAIDS, 'Special efforts are needed to expand and improve the HIV testing and treatment programmes in the Islamic Republic of Iran and Sudan, which accounted for more than 60 per cent of the region's deaths from AIDS-related illness in 2017.'[314] Even though men living with HIV greatly outnumber women, new infections among women are on the rise. A study on HIV/AIDS trends in the region revealed that sex

306 UNAIDS 'AIDSinfo' estimates 25 per cent for Iran.
307 UNAIDS 'AIDSinfo' (accessed August 2020).
308 UNAIDS, Communities at the Centre: The response to HIV in the Middle East and North Africa, 2019.
309 Ibid.
310 UNAIDS, UNAIDS Data 2018, 2018. Pg 243.
311 UNAIDS, Power to the People, 2019.
312 UNAIDS, Miles to go: global AIDS update 2018, 2018.
313 Ibid.
314 UNAIDS, UNAIDS Data 2018, 2018. Pg 240.

within marriage was a major transmission pathway for women. For instance, three quarters of women living with HIV in Iran acquired the virus from their husbands, a majority of whom believe they had been infected through injecting drugs.[315]

According to the United Nations SDG Database, Djibouti has the highest rate of new infection cases in the region, with .64 new cases being reported per every 1000 in the uninfected population.[316] Research suggests that the populations most at risk in the region include people who inject drugs, sex workers, and clients of sex workers and other sexual partners.[317,318] Djibouti also exhibits the highest DALY for females due to HIV/AIDS in the region at 4,164.65 per 100,000. This figure is more than four times the amount of the second and third highest DALYs, Somalia and Sudan.[319]

Morocco, on the other hand, has reduced its new infection rate by 42 per cent between 2010 and 2018, partially attributed to the implementation of a human rights-based HIV prevention programme that targets individuals most affected by HIV.[320]

While not sex disaggregated, WHO data reveal large disparities in antiretroviral therapy coverage among people living with HIV. The three countries with the highest DALYs for females due to HIV/AIDS also exhibit very low antiretroviral therapy rates of between 15 per cent and 30 per cent.

A particularly underserved population of persons living with HIV is pregnant women. In 2017, around 5,200 women in the region living with HIV gave birth, yet only 1,100 received antiretroviral treatment, which prevents transmission to infants during pregnancy, childbirth and breastfeeding. As a result, around a quarter of pregnant women living with HIV transmitted HIV to their babies. Throughout the region, only 940 newborn children were tested for HIV before eight weeks of age.[321]

In Sudan, of the estimated 760 to 3,700 pregnant women who are living with HIV, only 5 per cent are estimated to have access to antiretroviral drugs which not only places the women at continued risk but also poses a risk to their children.[322]

Although recent data is limited Oman (using data from 2014), UAE, Iran and Morocco have relatively high testing rates for pregnant women, although none of these countries have coverage levels higher than 70 per cent. In contrast, Prevention of Mother-to-Child Transmission (PMTCT) programmes in Lebanon (2013 data) are undermined by a lack of testing services, expensive referral systems, lack of awareness about HIV and stigma.[323]

UNAIDS reports that between 2010 and 2017 the level of new infections among children 0-14 in the region remained stable. UNAIDS reported the highest reduction in new infections among children in Djibouti (44 per cent reduction from 2010-2017) due to the integration of PMTCT services into maternal and child health programmes.[324]

Knowledge of HIV prevention in the region remains extremely low with marked contrast between males and females in countries for which data are available. While knowledge for both sexes is low, females are less likely to correctly identify 1) two major ways of preventing the sexual transmission of HIV, 2) reject two most common local misconceptions about HIV transition, and 3) know that a healthy-looking person can have HIV.

Knowledge regarding HIV prevention in the region is dependent on many factors, however, the limited presence of comprehensive sexuality education contributes to this lack of knowledge.

315 Gökengina, D. et al., HIV/AIDS: trends in the Middle East and North Africa region', International Journal of Infectious Diseases, Vol 44, p.66-73, 2016.
316 United Nations SDG Global Database 3.3.1. Number of new HIV infections per 1,000 uninfected population, by sex and age (per 1,000 uninfected population).
317 UNAIDS, UNAIDS Data 2018, 2018. Pg 9.
318 Global SDG Indicators Database.
319 Institute for Health Metrics and Evaluation, University of Washington, GBD 2017, 2020.
320 UNAIDS, Update: A 30-year response to HIV in Morocco, 2018.
321 UNAIDS, Miles to go: global AIDS update 2018, 2018.
322 WHO Global Health Observatory.
323 UNAIDS 'AIDSinfo'.
324 UNAIDS, Ending AIDS: Progress towards 90-90-90 targets, 2017.

Table 1.18:
Knowledge about HIV
per cent of males and females aged 15-49 who can correctly identify at least two major ways of preventing the sexual transmission of HIV, and who can reject the two most common local misconceptions about HIV transmission and who know that a healthy-looking person can have HIV.

ESCWA Category	Country	Female (%)	Male (%)
GCC	Qatar	20.8	29.9
Maghreb	Tunisia	18.5	
	Algeria	9	
Mashreq	Egypt	6.1	9.7
	Jordan	12.9	
	State of Palestine	7.7	
	Iraq	3.5	
LDC	Sudan	8.9	

Source: Household surveys as compiled by UNICEF

Other STIs

While data for countries across the region on Sexually Transmitted Infections (STIs) such as syphilis, chlamydia, gonorrhoea and HPV are limited, some recent surveillance or meta-analysis data have been published.

Overall, a study by WHO of data between 2012 and 2016 (presented in Table 1.19, below) suggests that between 2012 to 2016, prevalence of these STIs was increasing in MENA, with a global decrease or no change being seen with respect to Chlamydia and Syphilis, respectively, in the same timeframe.[325]

Some specific data related to individual STIs is as follows:

Syphilis: Globally, in 2019, 1 per cent or more of antenatal care attendees in 38 of 78 reporting countries tested positive for syphilis. In these 78 reporting countries, an average of 3.2 per cent (range 1.1 per cent to 10.9 per cent) of antenatal care attendees tested positive for syphilis.[326] In comparison, the (limited) data available for countries in the region indicates that only three countries of six that provided data for 2018-2019 reported any incidence of syphilis among ANC attendees. Of these, Somalia, at 4.1 per cent, was the only above 1 per cent incidence.

Chlamydia: A 2019 meta-analysis of reports of chlamydia trachomatis prevalence in the region found that it is similar to other regions (at approximately 3 per cent of the general population, rising to approximately 13 per cent at high-risk populations), but was higher than expected given the sexually conservative norms of the region. High prevalence in infertility clinic attendees and in women with miscarriage suggests a potential role for Chlamydia in poor reproductive health outcomes in this region.[327]

Human papillomavirus (HPV): Countries in the region have given insufficient attention to the HPV vaccine. The vaccine is typically not subsidized nor is there a widespread effort to undertake public health campaigns to raise awareness and uptake.[328] The

325 Rowley, J., Vander Hoorn, S., Korenromp, E., Low, N., Unemo, M., Abu-Raddad, L. J., Chico, R. M., Smolak, A., Newman, L., Gottlieb, S., Thwin, S. S., Broutet, N., & Taylor, M. M. (2019). Chlamydia, gonorrhoea, trichomoniasis and syphilis: global prevalence and incidence estimates, 2016. Bulletin of the World Health Organization.
326 WHO Global Health Observatory.
327 Smolak, A, et al, Epidemiology of Chlamydia trachomatis in the Middle East and north Africa: a systematic review, meta-analysis, and meta-regression, The Lancet, Vol. 7, Issue 9, September 2019
328 UNFPA and the Middle East and North Africa Health Policy Form, Regional Report, Sexual and Reproductive Health Laws and Policies in Selected Arab Countries, 2016.

Table 1.19:
Comparison of 2012 and 2016 WHO regional prevalence estimates of chlamydia, gonorrhoea, and syphilis

	Chlamydia		Gonorrhoea		Syphilis	
Year	2012 (%)	2016 (%)	2012 (%)	2016 (%)	2012 (%)	2016 (%)
MENA Women	3.5	3.8	0.5	0.7	0.6	0.7
Global Women	4.2	3.8	0.8	0.9	0.5	0.5
MENA Men	2.7	3.0	0.4	0.6	0.6	0.7
Global Men	2.7	2.7	0.6	0.7	0.5	0.5

Source: Rowley, J., Vander Hoorn, S., Korenromp, E., Low, N., Unemo, M., Abu-Raddad, L. J., Chico, R. M., Smolak, A., Newman, L., Gottlieb, S., Thwin, S. S., Broutet, N., & Taylor, M. M., Chlamydia, gonorrhoea, trichomoniasis and syphilis: global prevalence and incidence estimates, 2016, Bulletin of the World Health Organization, 2019.

only countries in the region that have existing HPV vaccination programmes are Qatar and the UAE.[329] Data regarding the proportion of females who have received the recommended number of doses of HPV vaccine prior to age 15 is only available for the UAE which reports 28 per cent of girls in secondary schools are vaccinated against HPV.[330]

Prevention and Treatment of Non-sexually Transmitted Reproductive Tract Infections and Other Diseases and Disorders

Reproductive Cancers

Reproductive cancers are included in the reproductive health package of services in some countries (State of Palestine, Syria, and Morocco). In other countries, such as Lebanon, there have been public education campaigns to encourage mammography, however, screening for reproductive cancers is still a low priority and practiced at a limited scale in the public sector.[331] Bahrain, Djibouti, Iran, Lebanon, Qatar, Somalia, Syria, and the UAE have national cancer screening programmes for cervical cancer. Iran's national programme utilizes the HPV test and all others utilize the PAP smear test.[332] Lebanon's coverage of national cervical screening programme is estimated to be 'more than 50 per cent but less than 70 per cent'. Djibouti's national cervical screening programme estimates 10-50 per cent coverage. All other countries with national screening programmes (Bahrain, Iran, Qatar, Somalia, Syria, and the UAE) report less than 10 per centcoverage.[333]

Other Sexual and Reproductive Health Concerns

The sexual and reproductive health of women during and after menopause is important, however, findings from the region indicate that women's sexual and reproductive health during this time is minimally addressed through education, programmes, and services.[334] This research study found little data around non-sexually transmitted infections available specific to the region, and none more recent than the last 5-10 years, underscoring the level of neglect this area of women's health faces.

329 WHO Global Health Observatory; Management of NCDs Primary and secondary prevention of cancer.
330 Source: WHO estimates of Human papillomavirus immunization coverage 2010-2018.
331 UNFPA and the Middle East and North Africa Health Policy Form, Regional Report, Sexual and Reproductive Health Laws and Policies in Selected Arab Countries, 2016.
332 WHO Global Health Observatory; Management of NCDs Primary and secondary prevention of cancer.
333 WHO Global Health Observatory; Management of NCDs Primary and secondary prevention of cancer.
334 UNFPA and the Middle East and North Africa Health Policy Form, Regional Report, Sexual and Reproductive Health Laws and Policies in Selected Arab Countries, 2016.

FOOD SECURITY AND NUTRITION

Introduction

Food security and nutrition are interlinked but distinct concepts. Food security is defined as a 'situation that exists when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life'. Food security is defined by four dimensions: food availability, economic and physical access to food, food utilization, and stability over time.[335]

Food security is a prerequisite for nutrition security but does not necessarily guarantee optimal nutritional status. Unhealthy diets – along with physical inactivity – are key contributors to the burden of non-communicable disease (NCD) in the region. The WHO reports that, as of 2019, 53 per cent of women, 45 per cent of men and 8 per cent of school-age children or adolescents in the Eastern Mediterranean region are obese.[336]

Access to clean water, adequate sanitation, and health care are crucial components of food security and nutrition; without these components, nutritional diseases and infections become more common even in communities where individuals have adequate food consumption levels.[337] For example, undernutrition may not only result from insufficient food intake but rather unsanitary conditions which expose individuals to infections that lead to poor absorption and utilization of consumed nutrients.[338] Even persons who consume a healthy diet will be unable to fully benefit from their diet if they suffer from certain types of illnesses or live in unsanitary conditions that foster illnesses.[339]

Food security, nutrition, and poverty are deeply interrelated: individuals living in poverty are more likely to have insufficient water and sanitation facilities and are at greater risk of experiencing food insecurity, hunger, and have a lower nutrition status as their economic access to food is compromised. Experiencing food insecurity, hunger, or having suboptimal nutrition often leads to lower productivity that then traps individuals in a cycle of poverty. Both food security and nutrition affect women and girls at each stage of their lifecycle as well as their offspring.

As with many other developing countries or emerging economies, countries in the region are experiencing the so-called 'double-burden' of malnutrition, with growing food insecurity and high prevalence of undernutrition at the same time as high, and increasing, rates of overweight, obesity and diet-related non-communicable diseases. This phenomenon exposes many populations in the region to a nutrition transition - a shift from food insecurity and deprivation towards unhealthy diets and sedentary lifestyles.340

There is a specific gender dimension to food security and nutrition that is widely confirmed by established research and data. Worldwide, vulnerable women and girls experience a greater

335 FAO, IFAD, UNICEF, WFP and WHO, The State of Food Security and Nutrition in the World 2020. Transforming food systems for affordable healthy diets. Rome, FAO, 2020.
336 WHO, Strategy on nutrition for the Eastern Mediterranean Region 2020–2030, 2019
337 ESCWA, Arab Horizon 2030: Prospects for Enhancing Food Security in the Arab Region, 2017.
338 Ghattas, Hala, Food Security and Nutrition in the Context of the Global Nutrition Transition, FAO, 2014.
339 Ruel, Marie, Chapter Two, Food Security and Nutrition: Linkages and Complementarities, International Food Policy Research institute, n.d.
340 WHO, Strategy on nutrition for the Eastern Mediterranean Region 2020–2030, 2019

risk of malnutrition than men, and more girls die of malnutrition than boys.[341]

The cross-cutting issues of conflict and climate change also impact food security and nutrition status. Conflict directly impacts food production and access to markets as well as destroying livelihoods and decreasing government funding for social protection programmes. As food production and access is compromised, accessing necessary health care due to nutrition or other issues in conflict settings is increasingly difficult. Most individuals who experience hunger in the Middle East and North Africa region are located in the five countries currently in conflict – Iraq, Libya, Syria, Sudan, and Yemen.[342] Climate change makes planning for the future difficult as the presence of more intense droughts and warmer temperatures have begun to add stress to region's agricultural productivity and sustainability.[343]

Acknowledging the distinctions between these topics, but considering the interlinkages, this chapter presents laws and policies as they relate to food security and nutrition in one section.

Laws and Policies Related to Food Security and Nutrition

With respect to laws and policies governing food security and nutrition in the region, some progress has been noted in the available literature. However, analyses around laws and policies influencing food security specifically are lacking. A recent report by the Food and Agriculture Organization (FAO) and ESCWA states that reforming policies that produce food loss (e.g., non-targeted subsidies) may support food security, however, no data was available regarding existing laws and policies in the region and their impacts on food security.[344]

A range of policy statements and recommendations by relevant actors (e.g., WHO, FAO) made over the past decade have been aimed at addressing key issues around nutrition. For example, the WHO Regional strategy on nutrition 2010–2019 and plan of action was supplemented with four policy statements on key areas of nutritional concern [Type 2 diabetes/obesity (2016/2017), lowering fat intake/coronary heart disease incidence (2013), lowering salt intake/high blood pressure & stroke incidence (2013), implementation of the code of practice of marketing of breastmilk substitutes, Sharjah Declaration on Obesity Prevention (2018).[345]

This strategy has been succeeded by a 2019 strategy for 2020-2030 which notes that there is 'a growing body of evidence on the effectiveness, cost-effectiveness and feasibility of policy interventions to improve nutrition' but also notes 'an urgent need to translate this knowledge into action and to disseminate lessons from implementation on the ground'.[346]

While much of the policy changes needed remain at the level of regional-level commitments and/or recommendations by bodies such as the WHO, there have been some concrete achievements. For example, WHO reports that in 2016/17, 89 per cent of countries in the region have a comprehensive or topic-specific nutrition policy, with 79 per cent reporting having a comprehensive nutrition policy that aims to address all forms of malnutrition, and 53 per cent reporting policies relating to a specific aspect of nutrition, such as infant and young child nutrition.[347] Just over half (53 per cent) of these

341 FAO, Gender and Nutrition, No date.
342 FAO, Near East and North Africa, Regional Overview of Food Security and Hunger 2018.
343 ESCWA, Arab Horizon 2030: Prospects for Enhancing Food Security in the Arab Region, 2017.
344 ESCWA, Arab Horizon 2030: Prospects for Enhancing Food Security in the Arab Region, 2017.
345 See: http://www.emro.who.int/nutrition/strategy/.
346 WHO, Strategy on nutrition for the Eastern Mediterranean Region 2020–2030, 2019.
347 World Health Organization, Global nutrition policy review 2016-2017: country progress in creating enabling policy environments for promoting healthy diets and nutrition, 2018.

policies were developed between 2011 and 2014 and 18 per cent developed in 2015 or later; 17 per cent had costed operational plans and 86 per cent had a nutrition co-ordination mechanism.[348]

While governments within the region have established laws and policies to address food insecurity and nutrition, these laws and policies experience varying degrees of success. For instance, although undernourishment rates in the region are decreasing, children still suffer high rates of iron and vitamin A deficiency as well as adequate iodine status. Recent (2019) data from an interagency study indicates that salt iodization has been a more successful policy effort than fortification of food staples to reduce iron and Vitamin A deficiencies.[349]

Other examples of laws and policies aimed at addressing child and maternal malnutrition include fortifying staple foods with micronutrients, micronutrient supplements, promoting exclusive breastfeeding for the first six months of a child's life, and school feeding.[350] For example, the UAE is embracing recommendations of the WHO and UNICEF on infant and child feeding practices and is promoting breastfeeding as the ideal method of feeding infants and young children.

Table 1.20:
Legal status of the code of marketing of breastmilk substitutes 2020

ESCWA Category	Country	Year of Measure	Legal status of the Code
GCC	Bahrain	2018	Substantially aligned
	Kuwait	2014	Substantially aligned
	Oman[351]	1998	Some provisions included
	Qatar	-	No legal measures
	Saudi Arabia	2019	Substantially aligned
	UAE	2018	Substantially aligned
Maghreb	Algeria	2012	Some provisions included
	Libya	-	No legal measures
	Morocco	-	No legal measures
	Tunisia	1983	Moderately aligned
Mashreq	Egypt	2018	Some provisions included
	Iran	2010	Some provisions included
	Jordan	2015	Some provisions included
	Lebanon	2008	Substantially aligned
	State of Palestine	n/a	n/a
	Syria	2000	Moderately aligned
LDC	Djibouti	2010	Moderately aligned
	Sudan	2000	Some provisions included
	Somalia	-	No legal measures
	Yemen	2002	Moderately aligned

Source: World Health Organization

348 WHO, Strategy on nutrition for the Eastern Mediterranean Region 2020–2030, 2019.
349 FAO, IFAD, UNICEF, WFP and WHO, Regional Overview of Food Security and Nutrition in the Near East and North Africa 2019 – Rethinking food systems for healthy diets and improved nutrition, 2020.
350 FAO, IFAD, UNICEF, WFP and WHO, Regional Overview of Food Security and Nutrition in the Near East and North Africa 2019 – Rethinking food systems for healthy diets and improved nutrition, 2020.
351 See Ministerial Decree 74/2021 for updated codes on marketing of breastmilk substitutes in Oman.

The UAE infant feeding policy states that infants should be breastfed exclusively until six months of age. Furthermore, in 2014 the country's Federal National Council passed a draft clause in the child rights law to make breastfeeding mandatory for the first two years of an infant's life with the introduction of optimal complementary feeding at six months of age. However, a 2015 study found poor adherence to recommended or mandated infant feeding practices.[352]

Most countries in the region have taken some steps to regulate the marketing of breast-milk substitutes, with 17 countries having put some of the provisions of the International Code of Marketing of Breast-milk Substitutes into law. Of these, however, only six had fully implemented the provisions of the code with a further four implementing many of the code's provisions. Table 1.20 lists the status of individual countries regarding the code as of 2020.[353]

352 Gardner H. et al, Infant Feeding Practices of Emirati Women in the Rapidly Developing City of Abu Dhabi, United Arab Emirates. Int J Environ Res Public Health. 2015.
353 WHO, Marketing of Breast-milk Substitutes: National Implementation of the International Code- Status Report 2020, 2020.

FOOD SECURITY

Overview

Food insecurity is a complex problem and affected by many, often interconnected, issues including governance challenges, economic sanctions, a high dependency on food imports, conflict, civil unrest, and increasing vulnerability to climate change and natural disasters.[354] Due to gender roles and domestic expectations, women are often a critical determining factor on whether households are food secure. Studies show that men and women utilize resources differently and that women are more likely than men to protect the food security of their household when resources are under their control.[355]

Food insecurity is a serious concern in the region, and as of 2019, the main driver of food crises in the region[356] remained in conflict. Yemen remained the world's most acute food crisis in 2019 where the protracted conflict continues to disrupt economic activity, restrict access to services and markets, and damage infrastructure (including basic public services).[357] The number of acutely food-insecure people ranged from 15.9 million in Yemen to 0.3 million in Lebanon.

Data from 2016 reveals that, at the regional level, the prevalence of undernourishment and obesity stood at 12 per cent and 28 per cent, respectively. Additionally, 11 per cent of the population reported that they experience severe food insecurity. These figures are slightly higher than global averages, which are 11 per cent for undernourishment and 9 per cent for severe food insecurity.[358]

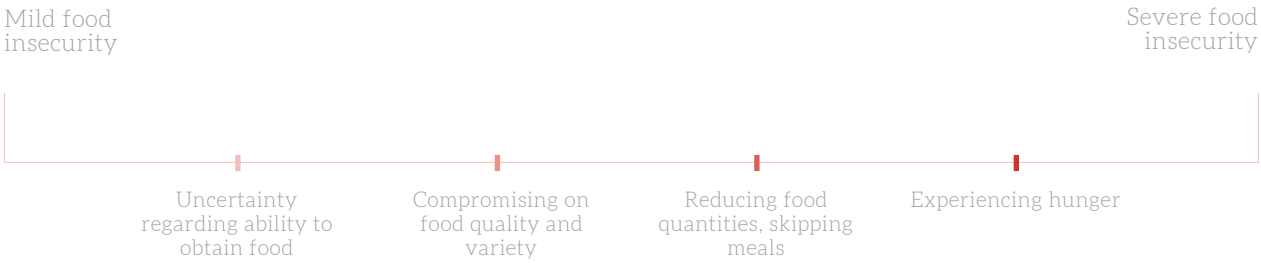
Table 1.21:
Number of acutely food-insecure people

Country	People (millions)
Yemen	15.9
Syria	6.6
Iraq	1.8
State of Palestine	1.7
Lebanon (Syrian Refugees)	0.3

Source: Global Report on Food Crises, 2020.

354 International Policy Centre for Inclusive Growth, Policy in Focus, Social Protection After the Arab Spring, The International Policy Centre for Inclusive Growth, Volume 14, Issue No. 3, 2017.
355 Ruel, Marie, Chapter Two, Food Security and Nutrition: Linkages and Complementarities, International Food Policy Research institute, n.d.
356 Note that the Global Report on Food Crises classifies the region as including Afghanistan, Bangladesh, Iraq, Lebanon, Myanmar, State of Palestine, Pakistan, Syria, Turkey, and Yemen. Therefore, regional figures from this study were not used as they are not representative of the region as defined by this situational analysis.
357 Global Network Against Food Crises and Food Security Information Network, 2020 Global Report on Food Crises, Joint Analysis for Better Decisions, 2020.
358 ESCWA, Tracking Food Security in the Arab Region, Executive Summary, 2019.

Figure 1.16:
Food insecurity severity along a continuous scale[359]



Food insecurity affects women and girls of all ages. While pregnant, food insecure women are more likely to experience iron-deficiency anemia, anxiety, depression, and excess weight gain; among children, food insecurity can negatively impact long-term physical, mental, and cognitive development; and food-insecure adults are more likely to have diabetes, high blood pressure, and experience hypertension.[360]

Table 1.22 presents a global picture of food insecurity as articulated in the 2019 Global Hunger Index (GHI).[361] The scores are a composite of four indicators – child wasting, stunting, mortality and undernourishment (insufficient calories). Any score under 10 is considered low in hunger severity; 10-20 moderate; and above 20 serious.

Five of the fourteen countries with available data are within the 'low' category of severity, with three in the serious category – although three of the seven countries without data (Libya, Somalia and Syria) are considered to be of significant concern. Yemen, at 45.9, has a level of hunger that is considered 'alarming' under this scale. The trend over time (between 2005 and 2019) is generally one of improvement among the majority of countries, with the exception of Yemen, although an increase has been seen in hunger since 2010 in Lebanon and Jordan.

The chart below presents a global picture of food security by country. Countries within the region are a mixture of 'good' and 'moderate' performers, with the exception of Syria and Yemen, with missing data from some key countries of concern (Somalia and Djibouti). This aligns well with the above data in Table 1.22

359 FAO, The Food Insecurity Experience Scale.
360 ESCWA, Arab Horizon 2030: Prospects for Enhancing Food Security in the Arab Region, 2017.
361 International Food Policy Research Institute (IFPRI), Concern Worldwide, and Welthungerhilfe (WHH), 2019 Global Hunger Index, 2019.

Table 1.22:
Global Hunger Index Scores of MENA Countries, 2010-19

ESCWA Category	Country	2005	2010	2019
GCC	Bahrain	n/a	n/a	n/a
	Kuwait	<5	<5	<5
	Qatar	n/a	n/a	n/a
	Saudi Arabia	13.7	9.2	8.5
	UAE	n/a	n/a	n/a
Maghreb	Algeria	12.9	10.6	10.3
	Libya	n/a	n/a	n/a
	Morocco	17.7	10/0	9.4
	Tunisia	8.6	7.9	6.2
Mashreq	Egypt	14.3	16.3	14.6
	Iran	9.4	8.2	7.9
	Iraq	24.8	23.8	18.7
	Jordan	8.7	8.3	10.5
	Lebanon	10.3	8.0	11.6
	Palestine	n/a	n/a	n/a
	Syria	n/a	n/a	n/a
LDC	Djibouti	43.9	36.6	30.9
	Sudan	-	-	32.8
	Somalia	n/a	n/a	n/a
	Yemen	41.7	34.5	45.9

Source: GHI Severity Scale, where 0 is the best score (no hunger) and 100 is the worst.

≤9.9: Low	10-19.9: Moderate	20-34.9: Serious	35+: Alarming

Socio-cultural Norms and Practices

Globally, on average, 43 per cent of the agricultural labour force in developing countries is women. Of these women, 79 per cent depend on agriculture as their primary source of livelihood.[362] Even though women make critical contributions to agriculture through production, processing, marketing, purchase and preparation of food, their land tenure rights are not secure in many countries within the region, nor do they exercise control over much of food production and management. Women's inadequate access to land and other productive resources and inputs remains a serious obstacle for improvement of both food security as well as agricultural productivity in the region.[363] For example, in Egypt, social norms frame women as 'helpers' to their families and husbands instead of as workers in their own right. Women are assumed not to contribute to agriculture or participate in irrigation, while recent research indicates that 43 per cent of women are employed in agriculture.[364] Between 2 per cent and 20 per cent of agricultural land (depending on the type) in Egypt is owned by women.[365]

Data on land ownership or control of agricultural land by gender in the region is sparse and unavailable for the timeframe under this situational analysis (2010-2019). However, latest data (between 1996 to 2005) from agricultural censuses compiled by the FAO on agricultural holders by gender indicate extremely low ownership and control of agricultural land by women (i.e. less than 10 per cent for the six countries for which data are available[366]).

It is important to note that laws based on some interpretations of shari'a provide a range of rights to property to Muslim women, for instance the right to acquire, hold, use, administer, inherit and sell property including land. These rights are not affected when a woman marries.[367] In many countries in the region, state laws enshrine property ownership rights for females. However, the interpretation and application of these rights on the ground is limited and precarious. Societal norms often condone dispossessing females of land and other property, leading to covert or overt violations of their rights. Males may coerce female relatives into relinquishing their land or other property or acquire and dispose of it without their knowledge.[368]

Thus, the lack of control of productive resources on the part of women in the region is likely to be an ongoing constraint to food security and have a range of negative consequences for women and girls.

NEGATIVE COPING STRATEGIES

Across the region, and particularly in countries affected by conflict, female-headed households are the most susceptible to food insecurity and the most likely to resort to negative coping mechanisms such as begging, unsustainable borrowing, distressed sale of assets, and demeaning and/or dangerous work. The available literature describes such issues across the region, particularly in the State of Palestine, Syria, Yemen and Libya. In the State of Palestine, female-headed households are 15 per cent more likely to be food-insecure than male-headed households.[369] Similarly, 17 per cent of Libyan female-headed households are considered food insecure, compared to 11 per cent of male-headed households.[370] In Libya, women are also generally the first to go without food so that their children and other relatives can eat, and are more likely to resort to emergency coping mechanisms. This includes work that can expose them to gender-

362 FAO, 'The future of food and agriculture – Trends and challenges', 2017.
363 ESCWA, Arab Horizon 2030: Prospects for Enhancing Food Security in the Arab Region, 2017.
364 Najjar, D. et al, Making Egyptian women's agricultural labor visible and improving their access to productive assets, 2019.
365 Ibid.
366 Algeria, Egypt, Iran, Jordan, Lebanon, Morocco, Saudi Arabia, and Tunisia.
367 UN-HABITAT, Islamic Principles and Land, 2011.
368 Kandeel, Amal, Let Justice be Done: Respect for Female Land Rights in the Middle East and North Africa, 2020.
369 United Nations Economic and Social Commission for Western Asia, Social and Economic Situation of Palestinian Women and Girls, Beirut, 2019, p. 15.
370 OCHA, Humanitarian Needs Overview 2019: Libya, 2019, p. 55

based violence and other serious risks to their safety and even their lives.[371]

In Yemen, food insecurity disproportionately affects Pregnant and Lactating Women (PLW) and their children, and women in general are more likely to be the first in a family to go hungry when food is scarce in order to uphold their traditional role as the food preparer for other family members.[372] To cope, some Yemeni women seek paid employment outside of the house while still performing their traditional domestic tasks, which can substantially increase their burden of work.[373] It is when these women are out searching for food and/or paid work in order to purchase food that they are greatest risk of abuse and other protection issues.[374] Most concerningly, there has been a rise in the child marriages in Yemen in 2017 and 2018 which the available literature has linked with food insecurity; parents may be more inclined to marry off their daughters at an earlier age in order to lessen the number of mouths they have to feed at home.[375]

Similarly, women- and child-headed households in Syria are more likely to resort to negative coping mechanisms when faced with food insecurity, such as purchasing food on credit.[376] Access issues are a primary reason for food insecurity for many Syrian women and girls; the conflict has made it difficult to access food supplies or aid.[377]

Services, Programming and Information

Data and analyses related to services and programming to foster food security in the region is sparse. There are, however, examples within the region of countries initiating social and welfare programmes specifically targeting women and girls to prevent food insecurity (as well as foster adequate nutrition). In Iran, for instance, the government sends food packages to pregnant and lactating women to avoid malnutrition during this critical period for both mothers and babies. This is one component of a special program housed under the Ministry of Health and Medical Education that focuses specifically on food security and nutrition of women and children.[378] In Algeria, the government is trying to promote women's increased economic activity in the agricultural sector as a means of promoting food security.[379]

371 Ibid, p. 37.
372 Peace Track, et al., Changes Ahead: Yemeni Women Map the Road to Peace, Women's International League for Peace and Freedom, 2019, p. 8 and 11.
373 Ibid. p. 6.
374 OCHA, Humanitarian Needs Overview 2019: Yemen, 2019, p. 24.
375 Ibid, p. 17 and 40.
376 OCHA, Humanitarian Needs Overview 2019: Syrian Arab Republic, 2019, p. 26, 65.
377 Ibid. p. 75.
378 The Vice Presidency for Women and Family Affairs, Iranian Women 25 Years after the Beijing Action Plan (Beijing+25), Office of International Affairs, Islamic Republic of Iran, 2019, p. 91 and 148.
379 People's Democratic Republic of Algeria, National Report on the Implementation the Beijing Platform for Action after 25 years (Beijing +25): Algeria, 2019, p. 9.

NUTRITION

Overview

The triple burden of malnutrition, consisting of undernutrition, being overweight or obesity, and micronutrient deficiencies, is clearly visible among women and girls in the region, with high rates of obesity existing alongside both acute and chronic undernutrition, particularly in countries affected by protracted crises such as Yemen and Syria. Undernourishment is especially high in conflict-affected countries (see Table 1.23, below).

Women, notably pregnant and lactating women and pregnant adolescents also have increased requirements for nutrients such as iron, calcium, folate, and vitamin A that are frequently not met. Knowledge of and adherence to Infant and Young Child Feeding (IYCF) practices, including breastfeeding, vary substantially both between and within countries in the region, with factors such as mother's education level, mother's age, mother's health, mother's employment status, place of delivery, and place of residence (i.e. urban versus rural) impacting children's nutritional status. Across the region, women and girls have the potential to benefit from national policies that focus on guaranteed maternity leave, behaviour change communication based on global nutrition standards, and incentives to improve women's access to, and utilization of key vitamins and minerals.

While improving access to, and consumption healthy, diversified diets is the best way to ensure adequate micronutrient intakes, where this is not being achieved there is a role for supplementation and food fortification. Research by the WHO found that supplementation and food fortification was implemented widely across the region.[380] Twenty-one countries are implementing vitamin and mineral supplementation for pregnant women (most commonly iron or iron and folic acid), while eight countries report provision of supplements to women of reproductive age (folic acid, iron) and 16 report in the provision of supplements to children (vitamin A, iron, micronutrient powder, zinc, iodine).[381] Sixteen countries report fortification of salt, while 12 report fortification of wheat flour and six report fortification of oil, and one country reports fortifications of sugar.[382] Iron and folic acid were the fortificants most commonly added to wheat flour. A specific regional assessment of wheat flour fortification in 2018 found that 17 countries had some coverage of wheat flour fortified with iron and folic acid, and that this was mandatory in 11 countries.[383] Despite this progress, a regional report on wheat flour fortification identified that further action was needed to expand coverage of wheat flour fortification and to ensure that it was effective.[384]

The region exhibits huge disparities related to undernourishment and food security. In non-conflict countries, undernourishment rates are approximately double that of the world average for developed countries. Conflict-affected countries, however, alarmingly report undernourishment at 27.7 per cent - more than five times that of non-conflict-affected countries in the region and an even higher prevalence than least developed countries at the global level.[385]

380 World Health Organization, Strategy on nutrition for the Eastern Mediterranean Region 2020–2030, 2019.
381 World Health Organization, Global nutrition policy review 2016-2017: country progress in creating enabling policy environments for promoting healthy diets and nutrition, 2018.
382 Ibid.
383 World Health Organization, Wheat flour fortification in the Eastern Mediterranean Region, 2019.
384 Ibid.
385 FAO, IFAD, UNICEF, WFP and WHO, Regional Overview of Food Security and Nutrition in the Near East and North Africa 2019 – Rethinking food systems for healthy diets and improved nutrition, 2020.

Table 1.23:
Hunger and Food Insecurity in Selected Sub-Regions of the Arab States, 3 Year Averages for 2016 - 2018

Category	Prevalence of undernourishment (%)	Prevalence of severe food security (%)	Prevalence of moderate or severe food insecurity (%)	Countries in category
ARAB STATES				
All Arab States	13.2	10.2	33.3	Algeria, Bahrain, Comoros, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Mauritania, Morocco, Oman, State of Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Syria, UAE, Tunisia, and Yemen.
BY CONFLICT/NON-CONFLICT				
Conflict countries	27.7	..	..	Iraq, Libya, Somalia, Syria, Sudan, and Yemen.
Non-conflict countries	5.4	8.9	32.1	Algeria, Bahrain, Comoros, Djibouti, Egypt, Jordan, Kuwait, Lebanon, Mauritania, Morocco, Oman, State of Palestine, Qatar, Saudi Arabia, Tunisia, and UAE.
GLOBAL COMPARISON FOR REGIONS OR CATEGORIES				
Least developed countries	23.6	22.4	52.5	
Developing regions	12.8	10.2	28.9	
Developed regions	<2.5	1.1	8.0	

Notes:
'.' signifies data unavailable. The FIES data are not available either because they were not collected, or governments did not make them available.
*Comoros and Mauritania were also included in the 'All Arab States' figure and Non-conflict Countries' figure but are not part of this situational analysis.
Source: FAO. FAOSTAT, 2019. As presented in FAO, IFAD, UNICEF, WFP and WHO, Regional Overview of Food Security and Nutrition in the Near East and North Africa 2019 – Rethinking food systems for healthy diets and improved nutrition, 2020.

Undernourishment in the region as a whole declined nearly continuously between 2000 and 2014, and a majority of the countries achieved the Millennium Development Goal (MDG) target of halving undernourishment between 1990 and 2015. However, the prevalence of undernourishment began increasing in conflict-affected countries and has erased much of the regional progress. Data related to undernourishment in conflict-affected countries are sparse and extensive data is only available for Iraq and Yemen. No data exists for Libya, Somalia, or Syria; however, experts assume that there are similar levels of undernourishment as the average of Iraq and Yemen. Estimates suggest that conflict-affected countries have had between four to five times higher prevalence of undernourishment than non-conflict-affected countries since 2004-2006.[386]

386 FAO, IFAD, UNICEF, WFP and WHO, Regional Overview of Food Security and Nutrition in the Near East and North Africa 2019 – Rethinking food systems for healthy diets and improved nutrition, 2020.

DIET

Table 1.24:
Percent of persons (18+ years) with obesity (BM1> 30) (Age-standardized estimate, 2016)

ESCWA Category	Country	Female (%)	Male (%)
GCC	Bahrain	36.8	25.5
	Kuwait	45.6	33.3
	Oman	33.7	22.9
	Qatar	43.1	32.5
	Saudi Arabia	42.3	30.8
	United Arab Emirates	41.0	27.5
Maghreb	Libya	34.9	19.9
	Morocco	39.6	25.0
	Tunisia	32.2	19.4
Mashreq	Egypt[387]	34.3	19.1
	Iraq	41.1	22.7
	Jordan	32.2	19.3
	Lebanon	37.0	23.4
	Syria	27.3	15.9
LDC	Sudan	9.6	3.6
	Yemen	19.4	9.1

Source: Global Health Observatory

Poor diet directly leads to a range of negative health outcomes, both in terms of under and overnutrition (see the Nutrition section for more detail). Overnutrition leading to obesity can contribute to a range of non-communicable diseases, such as cardiovascular diseases (mainly heart disease and stroke), diabetes, musculoskeletal disorders and some cancers.

The last few decades have seen increases in intake of energy-dense foods that are high in fat and sugars. Combined with a decrease in physical activity (see above), this has led to a global obesity epidemic. In 2016, worldwide more than 1.9 billion adults 18 years and older (39 per cent of men and 40 per cent of women) were overweight. Of these over 650 million (13 per cent of the world's adult population - 11 per cent of men and 15 per cent of women) were obese. The global prevalence of obesity nearly tripled between 1975 and 2016.[388]

The MENA and Arab States region is the second most obese region in the world. When analysed by per capita income, data suggest that there is a positive association between overweight and obesity prevalence and per capita income. The countries in the region with the lowest rates of overweight and obese populations are low or lower-middle-income countries (Djibouti, Somalia, Yemen).[389] Being overweigh or obese is of high prevalence in the GCC countries, with rates for women and girls consistently higher than men and boys across the region.

Overall, the rate of being overweight (BMI >25>30) for the region in 2016 was 46.5 per cent for adults (43.3 per cent male, 49.8 per cent women), and 20.5 per cent for children 5-19 years (20.2 per cent boys, 20.7 per cent girls). This is higher than the global average (39.1 per cent adults, 18.4 per cent children), but lower than Europe, the Americas and WesternPacific.[390]

The rate of obesity (BMI >30) for the region in 2016 was 19.5 per cent among adults (14.9 per cent men, 24.3 per cent women), and 8.2 per cent for children 5-19 years (8.3 per cent boys, 8.1 per cent girls). This is also higher than the global average (13.2 per cent for adults, 5.6 per cent for children), but lower than Europe and the Americas.

On a country basis, Qatar leads the region in obesity, with nearly half (47.8 per cent) of women qualifying as obese. Qatar is following closely by Kuwait, Bahrain and UAE, all with obesity rates among women above 40 per cent. Lesser-developed countries for which data is available (Sudan and

387 EHIS, 2012 indicated BMI>30 for age 15-59 is 50.3 per cent for women and 26.4 per cent for men in Egypt.
388 World Health Organization, Obesity Fact Sheet, April 2020, 2020.
389 FAO, IFAD, UNICEF, WFP and WHO, Regional Overview of Food Security and Nutrition in the Near East and North Africa 2019 – Rethinking food systems for healthy diets and improved nutrition, 2020.
390 WHO- Global Health Observatory.

Yemen) have much lower rates of overweight/obesity but face greater challenges related to under-nutrition.

A 2019 study of gender disparity in dietary intake noted that the MENA region features a marked gender gap detrimental to women. It also noted that the region has experienced a major increase in the prevalence of obesity and nutrition related non-communicable diseases with the prevalence of obesity and diabetes among the highest worldwide.[391]

Socio-cultural Norms and Practices

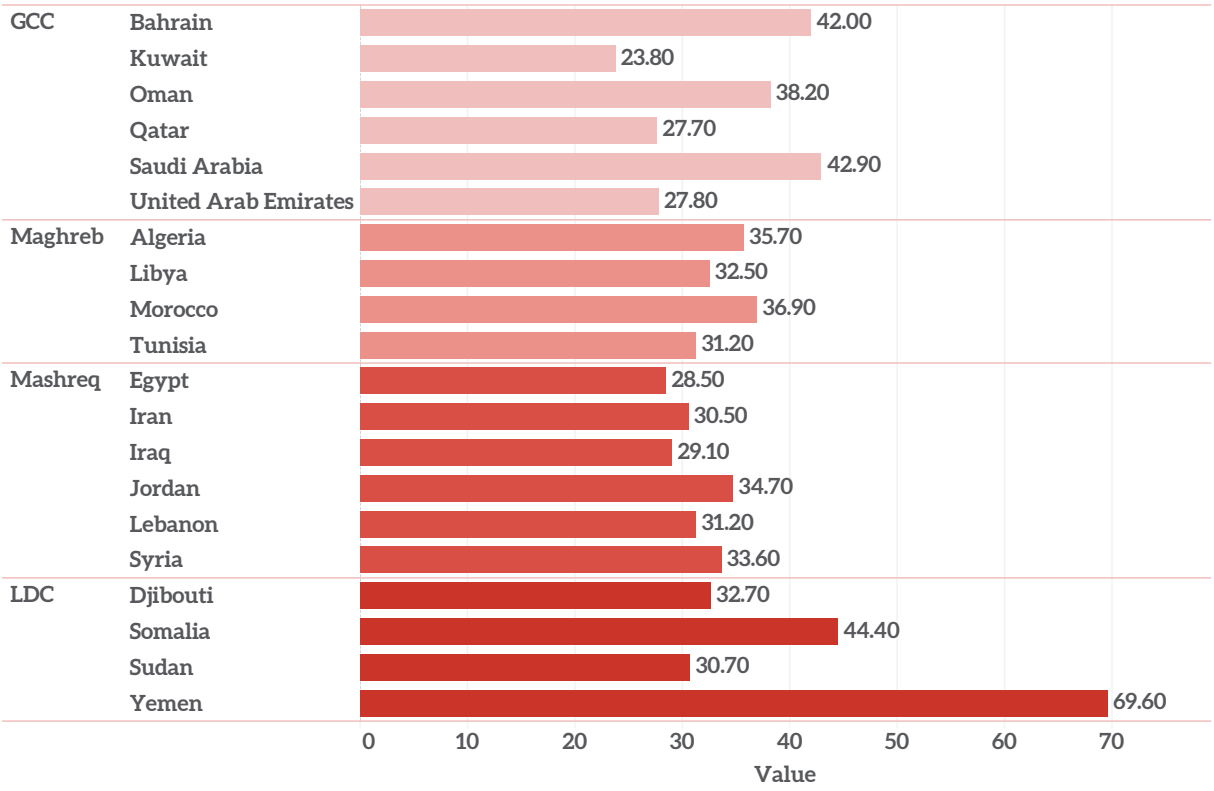
Socio-cultural norms and beliefs likely play some role in women's and girls' nutritional status in the region. A study in Tunisia, for example, found that women had an overall poorer quality diet than men in terms of the variety and adequacy of food.[392] Age, household size, and education levels were not significantly associated with nutrition levels, but the researchers did note cultural associations with sweets being considered as feminine and meat being masculine.[393] This association, even if subtle and subconscious, could partially explain women's insufficient levels of iron, which is an issue of concern for women of child-bearing age and children globally and particularly in the region. For example, in 2019, an estimated 28.4 per cent of non-pregnant women of reproductive age (aged 15-49) and 30.9 per cent among pregnant women in Iraq experience iron-deficiency anaemia; and in the State of Palestine, between 20 and 25 per cent of both boy and girl children have iron-deficiency anaemia.[394],[395] Yemen and Somalia have the region's highest prevalence of iron-deficiency anaemia, at 69.6 per cent and 44.4 per cent, respectively.[396] Iron-deficiency anaemia prevalence throughout the region is presented in Figure 1.17, below.

Since increased prevalence of anaemia among women of reproductive age indicates inadequate intake of micronutrients, anaemia is indicative of the food security situation.[397]

Cultural norms and practices also contribute to the high rates of obesity and overweight status in women in the region; throughout the region, women have nearly double the rates of obesity as men.398 In addition to diet, this can be attributed to women's lack of physical activity and mobility in public spaces due in part to cultural norms that constrain women's and girls' movement outside the house and de-emphasize the importance of physical education for girls in school.

391 Abassi, Mohamed Mehdi, et al., Gender inequalities in diet quality and their socio-economic patterning in a nutrition transition context in the Middle East and North Africa: a cross-sectional study in Tunisia, Nutrition Journal 18:18, 2019.
392 Ibid.
393 Ibid. p. 10.
394 Ministry of Health, National Health Policy for all Iraqi Citizens 2014-2023, Republic of Iraq, 2016, p. 10.
395 UNICEF, Landscape Analysis of Complementary Feeding in the Middle East and North Africa: Synthesis Report, 2019, p.31.
396 WHO Global Health Observatory.
397 ESCWA, Tracking Food Security in the Arab Region, 2019.
398 Plan International, Equal Measures 2030, Harnessing the Power of Data for Gender Equality, 2019.

Figure 1.17:
Prevalence of Anemia Among Women of Reproductive Age (15-49), %



Source: World Health Organization, Global Health Observatory

BREASTFEEDING AND INFANT AND YOUNG CHILD FEEDING (IYCF) PRACTICES

There is a notable difference between countries in the MENA region regarding adherence to global recommendations for breastfeeding and IYCF. The WHO recommends that breastfeeding be initiated no later than one hour after birth and that babies are exclusively breastfed for their first six months. According to a 2017 regional study that looked at nine countries in the region (Saudi Arabia, Iran, Egypt, Turkey, Kuwait, the United Arab Emirates, Qatar, Lebanon, and Syria) with data from multiple years, the average prevalence for timely breastfeeding initiation was just 34 per cent, with the lowest rate of 11.4 per cent in Saudi Arabia[399] and the highest of 80.6 per cent in Iran.[400] Similarly for exclusive breastfeeding for six months, the rates ranged from 2 per cent in Kuwait to 56 per cent in Iran, with the average being 20.5 per cent.[401] For both key indicators, the region was ranked as 'fair' as per the WHO rating, but remains well below the global average, which is around 40 per cent prevalence for both initiating and exclusive breastfeeding. The main factors identified by the author as having a significant impact on both initiating and exclusive breastfeeding was mode of

399 For more information on attitudes of Saudi mothers towards breastfeeding see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5025930/.
400 Alzaheb, Riyadh A., A Review of the Factors Associated with the Timely Initiation of Breastfeeding and Exclusive Breastfeeding in the Middle East, Sage Publications, 2017, p. 3. For Iran, see CANDS-IR, 2017. For Iran, see CANDS-IR, 2017.
401 Ibid, p. 12.

delivery (deliveries by Caesarean section correlated with reduced prevalence), rooming-in (mothers who roomed-in with their babies had increased prevalence), first-time motherhood (which reduced prevalence), previous breastfeeding history (mothers that had successfully breastfed before had increased prevalence), and national laws around advertisements for breastmilk substitutes, among others.[402] Interestingly, different studies have produced diverging results with regard to maternal education and maternal employment; while both are noted as factors that influence the prevalence initiating and exclusive breastfeeding, it is unclear whether that influence is positive or negative.[403] Additionally, women in the region have a high rate of Caesarean sections, likely above what is medically required, which is considered one of the biggest barriers to both initiating and exclusive breastfeeding.[404] In the region, children from the poorest quintile are 1.6 times more likely to be breastfed at two years of age than children from the wealthiest quintile.[405]

Other regional and national reports also indicate a low prevalence of breastfeeding. In Iraq, the rate of initial breastfeeding within one hour was just under 33 per cent, but exclusive breastfeeding for six months ranged from 14.4 per cent in urban areas and 17.2 per cent in rural areas.[406] Some of the region's lowest rates of breastfeeding can now be found in Syria, where lack of knowledge and skilled support for mothers as a result of the civil conflict has led to rates as low as 3 per cent in the most affected areas.[407] Similarly, in Yemen exclusive breastfeeding for six months is down to 10 to 12 per cent.[408] In the South Darfur region of Sudan, mothers regularly shared the mistaken belief that male infants needed to be fed solid foods starting at three months, as opposed to six months for female infants.[409] And in the UAE, rates of exclusive breastfeeding continue to be under 40 per cent, although campaigns by the national health authorities since 2011 to promote the benefits of breastfeeding have already led to notable improvements throughout the country.[410]

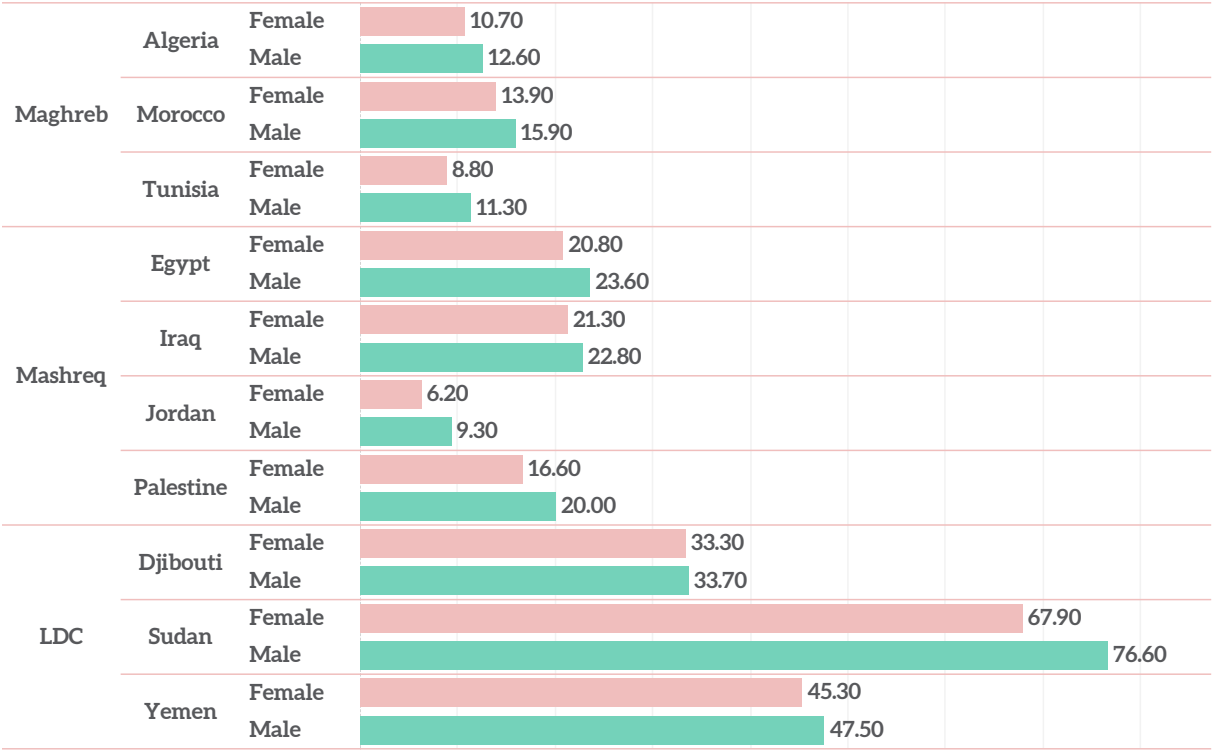
After six months of age, the WHO recommends complementary feeding along with continued breastfeeding until two years of age. A lack of knowledge about what constitutes appropriate complementary feeding, however, often results in poorer nutritional outcomes for women and their children. However, literature indicates that this can be rectified through better education and knowledge; for example, in Iraq, maternal education level is positively correlated to children's increased intake of vitamin A.[411]

402 Ibid., p. 3 and 12-13.
403 Ibid., p. 12.
404 Ibid., p. 13.
405 UNICEF, Breastfeeding: A Mother's Gift, for Every Child, New Year, 2018, p. 3.
406 UNICEF, et al., MNCH-HHS-Iraq (Maternal, Neonatal & Child Health Household Survey-Iraq) 2016 Final Report, Baghdad, 2017, p. 28.
407 OCHA, Humanitarian Needs Overview 2019: Syrian Arab Republic, 2019, p. 75.
408 Republic of Yemen (Ministry of Planning and International Cooperation) and United Nations Children's Fund, Situation Analysis of Children in Yemen, New York, 2014, p.40.
409 UNICEF, Landscape Analysis of Complementary Feeding in the Middle East and North Africa: Synthesis Report, 2019, p.34.
410 Taha, Zainab, Trends of Breastfeeding in the United Arab Emirates (UAE), Arab Journal of Nutrition and Exercise, vol. 2, issue no. 3, 2017, p. 154.
411 UNICEF, et al., MNCH-HHS-Iraq (Maternal, Neonatal & Child Health Household Survey-Iraq) 2016 Final Report, Baghdad, 2017, p. 28.

NUTRITION IN CONFLICT ZONES

Unsurprisingly, in the regions' two countries currently most affected by conflict, Syria and Yemen, women and girls face the direst nutrition needs. In Syria between 2017 and 2018, the prevalence of malnutrition among pregnant and lactating women more than doubled, and substantially more women than men have unmet acute and chronic nutritional needs (3.1 million versus 1.6 million).[412] Furthermore, girls in Yemen often have the least access to food at mealtimes due to cultural norms that determine who within a family eats first, with girl children ranking towards the bottom.[413]

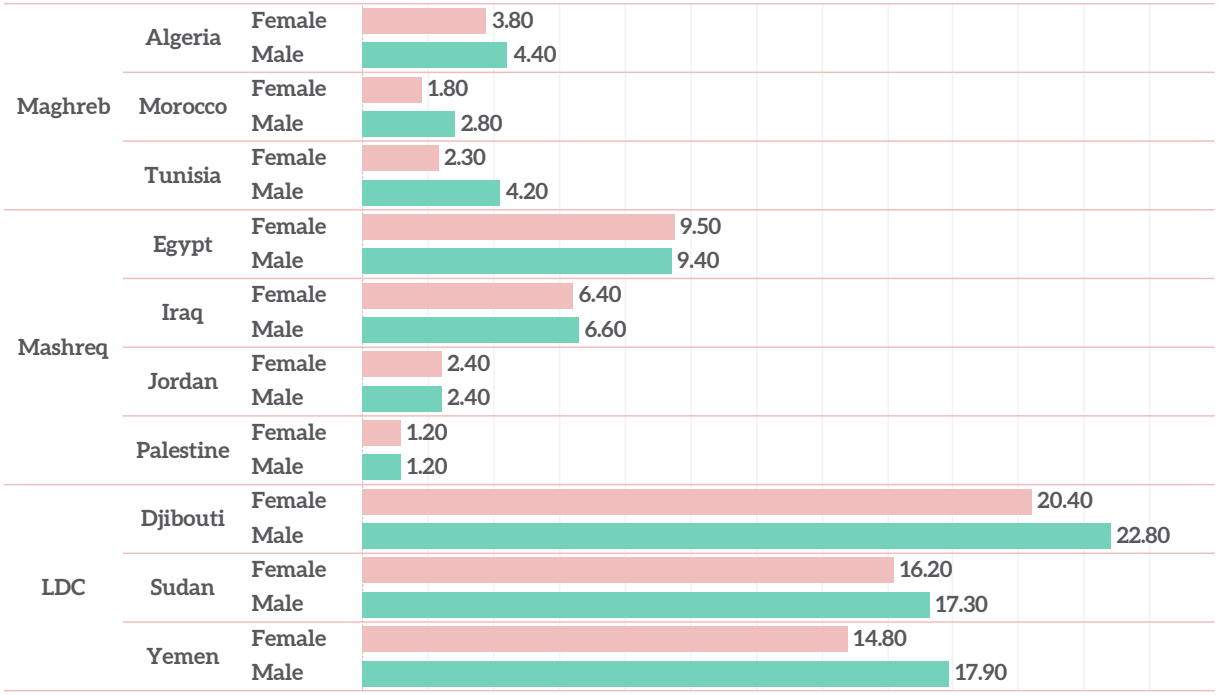
Figure 1.18:
Child Malnutrition Estimates, Height-for-Age <-2 SD (Stunting): % of children under 4



Source: UNICEF Data Warehouse

412 OCHA, Humanitarian Needs Overview 2019: Syrian Arab Republic, 2019, p. 75 and 30.
413 Republic of Yemen (Ministry of Planning and International Cooperation) and United Nations Children's Fund, Situation Analysis of Children in Yemen, New York, 2014, p. 40.

Figure 1.19:
Child Malnutrition Estimates, Weight-for-Height <-2 SD (Wasting): % of children under 4



Source: UNICEF Data Warehouse

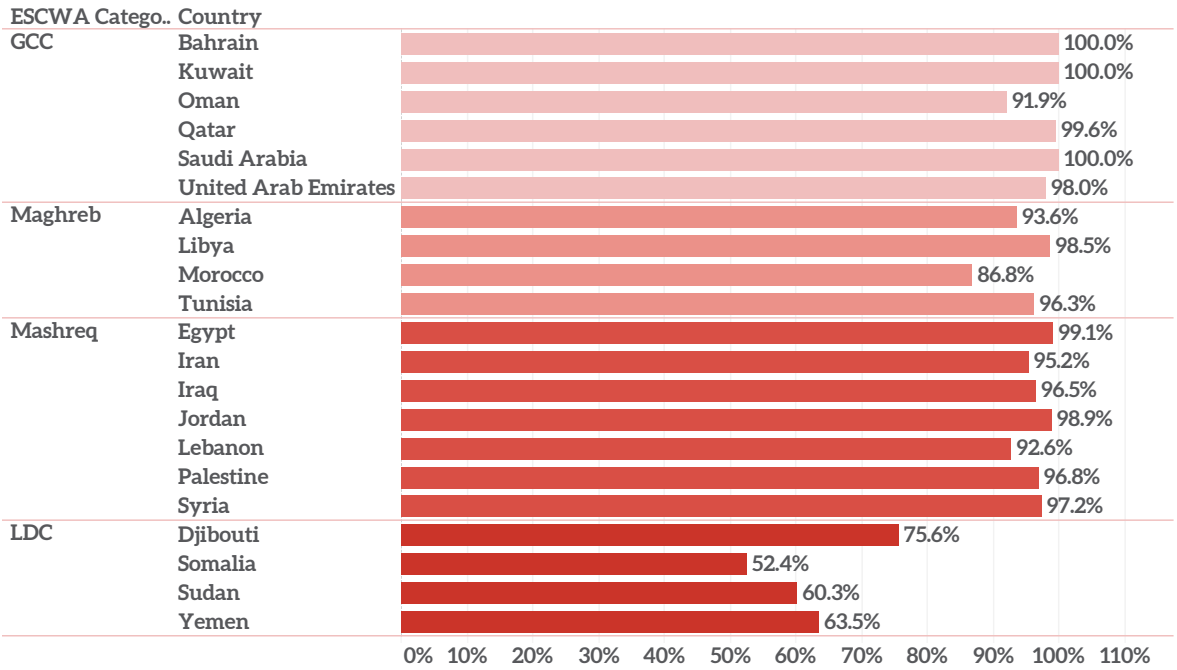
WATER, SANITATION AND HYGIENE

Overview

WASH is one thematic area where there is a great deal of disparity between the region's wealthier and poorer countries, as well disparities within countries themselves. For example, GCC countries report very high percentages of people with both safely managed and basic drinking water services (see Figure1.20, below). Comparatively, the LDCs have much lower rates of access to basic drinking water services. For women and girls, WASH challenges often revolve around issues related to access.

Figure 1.20:
Drinking Water

This figure shows the percentage of the population who have access to at least basic drinking water services



Source: WHO/UNICEF Joint Monitoring Program (JMP)

Households: Globally, women in poor households are less likely to have access to clean, safe places for menstrual health management (MHM) or other sanitation facilities that provide appropriate security and hygiene standards to maintain women's unique needs related to privacy and dignity. Furthermore, a lack of access to WASH services at schools for women and girls may lead to their missing school or dropping out altogether (discussed further below). The same holds true in the MENA and Arab States region even though, as a region, it scores slightly higher than the global average for gender equity within progress towards SDG 6 (water and sanitation for all).[414] These access issues are exacerbated in very impoverished and/or conflict-affected countries in the region, such as Yemen and Libya, and more generally there are gaps in access to services between rural and urban communities. Further, because suitable drinking water sources are also frequently missing at a family's home site, cultural norms throughout the region that designate women and girls as responsible for their household's water collection can involve long walks that expose them to protection and security risks. This risk is particularly heightened for refugees and internally displaced persons (IDPs) who lack access in their residential settings.[415]

Health Care Facilities: WASH in these settings is an additional challenge to the health and welfare of populations. Data from the WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene in 2019 indicates that WASH services in health care facilities are substandard in every global region. Worldwide, the WHO estimates that 896 million people use health care facilities with no water service and 1.5 billion use facilities with no sanitation service.[416] Moreover, the WHO highlights a comprehensive lack of usable data on the MENA region – no MENA countries had usable data to contribute to this 2019 report, suggesting that they do not systematically track the availability or quality of WASH services to WHO standards.[417] The lack of WASH in health facilities has a particular impact on women and girls, for example in Yemen disrupted WASH and sanitation infrastructure affects women's adequate access to reproductive health services.[418]

Education facilities: Lack of proper WASH services, rights and practices have multiple implications for girls and women's education, protection and socio-economic development. Ensuring that girls have access to safe and clean water, appropriate, private and safe toilets, soap and proper materials such as sanitary pads for taking care of their menstruation is crucial for their dignity, empowerment and ability to take part in society, education and work at equal footing to boys and men. Inadequate toilets and access to water in schools is one driver leading to girl drop out.

Climate Change: The MENA region is the most water scarce region in the world, including 15 of the most water-scarce countries worldwide.[419] The past year have seen an increased extreme heat and drought, making some regions unliveable and agricultural lands arid.[420] Climate change, recurrent droughts and scarceness of natural resources combined with recent years conflicts and humanitarian crisis is putting extreme pressure on water and sanitation service provision impacting the most vulnerable populations, especially women and girls. For example, water scarcity can amplify domestic work burden on women and girls at both household and community level. Moreover, employment in agriculture sector accounts for one third of total female employment in Arab world compared to 18 per cent of total male employment and is mainly through informal work sectors. As such, water scarcity jeopardizes women and adolescent girls income opportunity, amplifying economic vulnerability while also risking food insecurity.

414 Plan International, Equal Measures 2030, Harnessing the Power of Data for Gender Equality, 2019.
415 United Nations, Women, Water Security, and Peacebuilding in the Arab Region, Policy Brief, 2018.
416 WHO and the UNICEF, WASH in health care facilities: Global Baseline Report 2019, WHO and UNICEF, Geneva, 2019.
417 World Health Organization and the United Nations Children's Fund, WASH in health care facilities: Global Baseline Report 2019, WHO and UNICEF, Geneva, 2019.
418 OCHA, Humanitarian Needs Overview, Yemen 2021.
419 World Bank, 'Climate change in MENA : challenges and opportunities for the world's most water stressed region : Climate change in MENA : challenges and opportunities for the world's most water stressed region', 2018.
420 Ibid.

Conflict Settings: Access to water and sanitation are human rights that all children should enjoy, but essential services become targets during conflict and then the critical infrastructure required for children's access is disabled or destroyed. [421] As such, in conflict settings, inadequate WASH infrastructure poses major health risks for women and children. In fragile and conflict-affected areas, schools and hospitals have greater difficulties to function when access to safe water is compromised by damaged infrastructure; children fall ill, disease and malnutrition spread, and children miss out on their education. [422] This is particularly relevant in the water-scarce countries of the MENA region. A 2020 review of WASH interventions being delivered to women and children in conflict settings in low-income and middle-income countries revealed gaps in the current evidence on WASH intervention delivery in conflict settings, suggesting that the WASH needs of women and children have not or are not being sufficiently considered in the humanitarian response in many conflict settings. Little information is available on the delivery of water treatment or environmental hygiene interventions, or about the sites and personnel used to deliver WASH interventions.[423] Of the limited data available, a study of conflict-related cholera outbreaks in Yemen noted that organizational responses were more focused on case management than on outbreak prevention via appropriate and effective WASH investment.[424] In humanitarian settings such as refugee camps, poor lighting, non-gender sensitive WASH facilities as well as unfriendly designs can increase the risk of sexual harassment and abuse. Repeated cycles of infrastructure destruction mean that the livelihoods and security of generations of citizens suffer, hindering the rebuilding of state institutions that are necessary for peacebuilding. This may affect generation of children living with broken public institutions and inadequate provision of health, education and other critical services; making children and communities more vulnerable to disease, disaster, hunger and malnutrition.[425]

COVID-19 and WASH: The interlinkages between the pandemic, gender and WASH is one of the aspects highlighting COVID-19's disproportionate effect on women and girls.[426] Due to gendered household roles, women and girls, as both care-providers and water-bearers of the community, carry the burden of assuring household water needs.[427] As the pandemic has exacerbated the need for adequate sanitation and water distribution, women and girls responsibility has been further stressed. Moreover, for women and girls in the region living in humanitarian settings, such as conflict, refugee camps or IDPs, where access to safe water is already limited, the crisis has caused limitation to access to safe menstrual hygiene management due to disruptions in supply-chain and stigma.[428] Lack of adequate sanitation causes both physical and mental stress and has a negative effect on the well-being for women and girls as well as their mobility. [429]

421 UNICEF, Water Under Fire, VOLUME 3, Attacks on water and sanitation services in armed conflict and the impacts on children, United Nations Children's Fund, 2021.
422 Ibid.
423 Als D, Meteke et al., Delivering water, sanitation and hygiene interventions to women and children in conflict settings: a systematic review, BMJ Global Health, 2020.
424 Federspiel, F., Ali, M. The cholera outbreak in Yemen: lessons learned and way forward. BMC Public Health 18, 1338, 2018.
425 UNICEF, Water Under Fire, VOLUME 3, Attacks on water and sanitation services in armed conflict and the impacts on children, United Nations Children's Fund, 2021.
426 United Nations University, WOMEN, WASH & COVID-19: THE 'BURDENS OF' AND 'OPPORTUNITIES FOR' THE VULNERABLE, 2020.
427 Ibid.
428 Ibid.
429 Ibid.

Laws and Policies

The Arab Charter of Human Rights refers to the right to water and sanitation services under articles 38 and 39 (see text box).

The charter came into force in 2008 after ratification by the seventh member of the League of Arab States. Currently it is ratified by 13 States (Algeria, Bahrain, Jordan, Kuwait, Lebanon, Libya, the State of Palestine, Qatar, Saudi Arabia, Sudan, Syria, UAE and Yemen).[430]

At national level, several States have recognized the right to water in their constitutions, such as:

- **Egypt** (2014), article 79: *'Each citizen has the right to healthy, sufficient amounts of food and clean water'*.

- **Morocco** (2011), article 31: *'The State, the public establishments and the territorial collectives work for the mobilization of all the means available to facilitate the equal access of the citizens to conditions that permit their enjoyment of the right: to the access to water and to a healthy environment'*.

- **Tunisia** (2014), article 44: *'The right to water shall be guaranteed. The conservation and rational use of water is a duty of the state and of society'*.

As reported in the Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) report in 2019, only one country in the region, Iran, has formally approved WASH policies related to drinking water, sanitation, and hygiene in both rural and urban areas of the country. Lebanon and Morocco are close behind but missing a national policy on hygiene.

Box 1.2: Arab Charter of Human Rights

Article 38: 'Every person has the right to an adequate standard of living for himself and his family, which ensures their well-being and a decent life, including food, clothing, housing, services and the right to a healthy environment. The State Parties shall take the necessary measures commensurate with their resources to guarantee these rights';

Article 39, parts 2e and 2f: '… the measures taken by States shall include the following, 'Provision of basic nutrition and safe drinking water for all' and 'Combating environmental pollution and providing proper sanitation systems''.

Country	Existence of National WASH Policies				
	Drinking Water		Sanitation		Hygiene
	Urban	Rural	Urban	Rural	National
Iran	●	●	●	●	●
Jordan	◕	◕	●	◕	●
Lebanon	●	●	●	●	○
Morocco	●	●	●	●	○
Oman	●	●	◕	◕	◗
Palestine	●	●	●	●	●
Sudan	◗	◗	◗	◗	◗
Syria	◗	◗	●	●	●
Tunisia	●	●	●	◗	●

Source: GLAAS 2018/2019 Country Survey

● Formally approved ◕ Undergoing revision
◗ Under development ○ None

430 ESCWA, Moving towards Water Security in the Arab Region, 2019.

While Iran has formally approved plans, Morocco and Oman lead the region in the existence of approved and executed WASH implementation plans. Further, Morocco and Oman have also already completed costing estimations and human resource assessments related to their drinking water and sanitation policies. GLAAS findings from 2018/2019 country surveys revealed that Morocco is the only country that has sufficient financial and human resources to implement all WASH-related plans.[431]

Socio-cultural Norms and Practices

The current situation is due to pre-existing vulnerabilities of water services throughout the region. These pre-existing issues are complex, but centre around the fact that the region is one of the most water scarce regions in the world. This is deepened by unsustainable management practices and political, infrastructural and governance challenges.[432] Socio-cultural norms and practices further compound these vulnerabilities as additional pressures on national systems are experienced with the influx of refugee and IDP populations, or water conflicts, for example the inability of Palestinians to access their water resources.

During crisis situations, gender-based water insecurity is amplified, especially for refugee or internally displaced women and girls who face major barriers in access to basic services that are essential to their and their families' health and well-being. In addition to accessing basic services, women-headed households experience financial burdens that further limit their abilities to purchase water. In some countries water rights are tied to land rights which in certain instances restrict women's access to these rights (discussed under Food Security above).[433]

In some situations within the region, women's and girls' health and personal hygiene is compromised due to the potential exposure to sexual violence or threats when accessing WASH facilities outside the home.[434] Further, women living in informal settlements and other vulnerable settings in the region are at risk of being exposed to unsafe conditions while when collecting water and washing in communal water spaces, which may be contaminated by untreated sewage or chemicals.[435] Conflict and continued unrest in Iraq, Somalia, Sudan, Syria and Yemen has led to the severe contamination of water sources, depletion of the government's financial and human resources, and has resulted in the spread of water-related diseases.[436]

Socio-cultural traditions within the region have, in most cases, excluded women from meaningfully participating in water-related management – both in private and public spaces and especially in rural areas.[437] In recent years, there has been an increasing amount of support for initiatives that focus on water-related training and education for women and girls. As an example, the Water Wise Women programme in Jordan trains women as plumbers and also increases their awareness of water issues through education including water conservation and technical skills. The project has been successful in knocking down barriers and discrimination due to traditional gender roles and has increased women's voices in decision-making. Understanding and overcoming stigmas to women's participation in water diplomacy is critically important.[438] Co-operation within communities regarding shared

431 UN-Water Global Analysis and Assessment of Sanitation and Drinking-water (GLAAS), 2018/2019 Country Survey, 2019.
432 Diep, Loan, et al., Water, Crises and Conflict in MENA: How Can Water Service Providers Improve Their Resilience? Working Paper, International Institute for Environment and Development, 2017.
433 United Nations, Women, Water Security, and Peacebuilding in the Arab Region, Policy Brief, 2018.
434 United Nations, Women, Water Security, and Peacebuilding in the Arab Region, Policy Brief, 2018.
435 Ibid.
436 Ibid.
437 United Nations, Women, Water Security, and Peacebuilding in the Arab Region, Policy Brief, 2018.
438 United Nations, Women, Water Security, and Peacebuilding in the Arab Region, Policy Brief, 2018.

water resources is essential for efficient and peaceful water management, especially in times of conflict or crisis. The inclusion of women into water management processes strengthens a community's capacity to respond to and mitigate challenges. For example, in Yemen, with support from the FAO, women worked to resolve a 15-year-old water-related dispute between two villages. By establishing a water users association and continued dialogue, the villages ultimately agreed to share the well-water resources which was able to serve 7,000 people.[439]

Services, Programming and Information

Ensuring access to water and sanitation infrastructure requires adequate funding and effective financial management, as well as proper governance and management tools. Several countries reported an increase in prioritization and financial allocations for WASH in recent years, however, countries in the region also reported that national funding continues to not meet programmatic needs and, as such, remains a major obstacle to progress.[440]

In countries most affected by conflict within the region, WASH needs for women and girls primarily relate to access to products and services. Throughout the region, but particularly in conflict-affected countries and LDCs, the burden of collecting water for household use is often a gendered task assigned to women and girls. As represented in the graph below, Somalia and Yemen have the greatest gender imbalance with regard to water collection.

In Yemen, access to drinking water is a primary concern. A situational analysis from 2014 revealed that nearly 30 per cent of households face a minimum 30-minute walk to collect water.[441] This equates to at least one million Yemeni women and girls facing this task daily, which can expose them to protection violations and other dangerous situations that result in girls being kept home from school.[442]

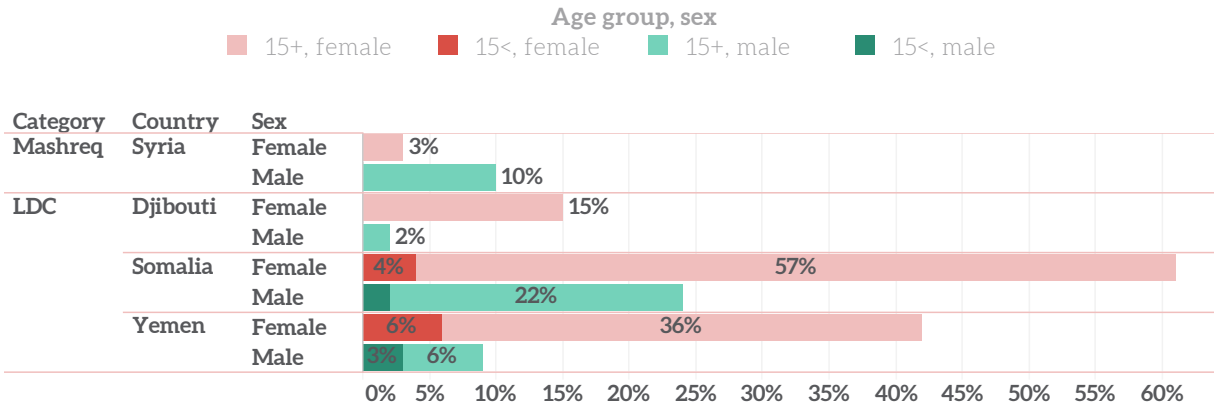
The countries with high rates of women and girls as primary water collectors are also among those most affected by insufficient WASH resources in schools, which can be a key factor in girls' school attendance. Few schools in Somalia, Sudan and Yemen have clean water or safe sanitation spaces, which makes attendance particularly difficult for adolescent girls when trying to manage their menstrual hygiene.[443]

In protracted humanitarian crises, like in Sudan, an increase in WASH necessities is often exacerbated by deteriorating economies, conflict, civil unrest, natural disasters, large refugee and IDP populations, food insecurity, and disease outbreaks. As of 2019, only 23 per cent of the population in Sudan had access to basic hygiene services, 74 per cent had access to basic drinking water services, and 39 per cent had access to limited sanitation services. Nearly 50 per cent of schools did not have improved sanitation facilities nor did they have access to clean water. This lack of services is further compounded by the lack of gender-segregated sanitation facilities and accessibility of existing facilities among children with physical disabilities.[444] Open defecation is also

439 Ibid.
440 UN-Water and WHO, Investing in Water and Sanitation: Increasing Access, Reducing Inequalities, GLAAS 2014 findings – Highlights for the Eastern Mediterranean Region, 2015.
441 Republic of Yemen (Ministry of Planning and International Cooperation) and United Nations Children's Fund, Situation Analysis of Children in Yemen, New York, 2014, p. 46.
442 OCHA, Humanitarian Needs Overview 2019: Yemen, 2019, p. 24.
443 Republic of Yemen (Ministry of Planning and International Cooperation) and United Nations Children's Fund, Situation Analysis of Children in Yemen, New York, 2014, p. 47.
444 WASH Cluster, WASH Sector Sudan Annual Report 2019, 2019.

Figure 1.21:
Water Collection Responsibility

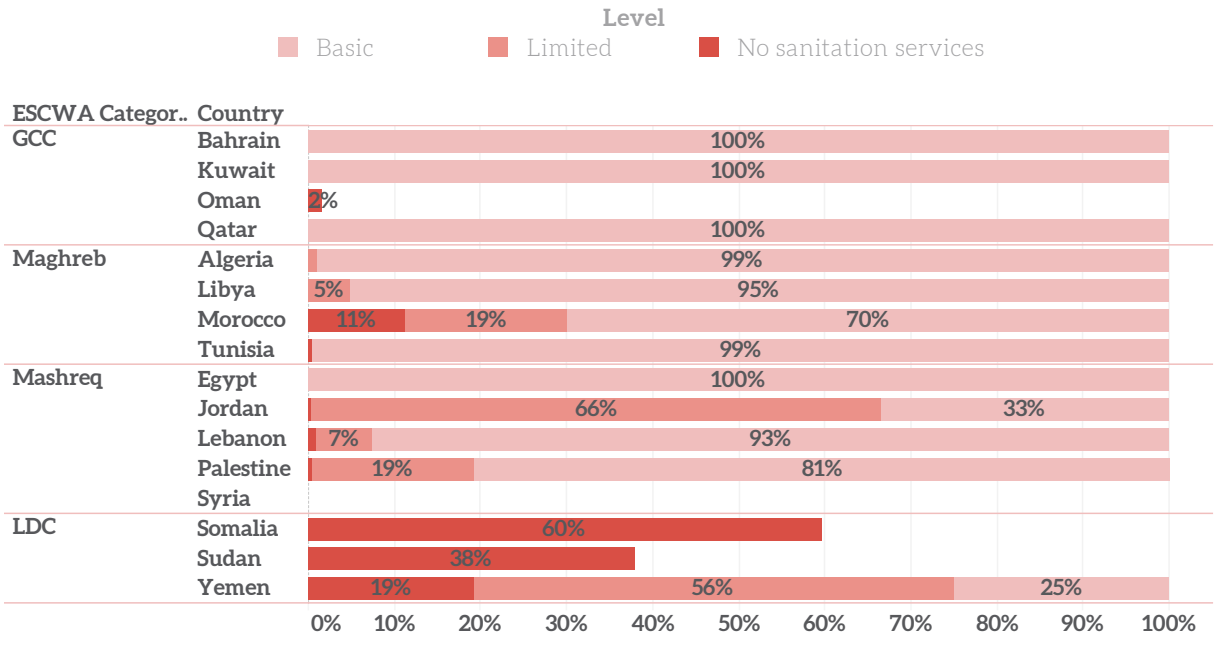
This figure reflects the % of the population where water collection is primarily the specified actor.



Source: WHO, Safely Managed Drinking Water- thematic report on drinking water, Geneva, Switzerland, 2017.

Figure 1.22:
Sanitation Services in Schools

The figure shows the proportion of schools in each country that have basic, limited, or no sanitation services.



Source: WHO/UNICEF JOint Monitoring Program (2018)

a major concern in Sudan with many related health andenvironmentalconcerns.[445]

In Libya, almost 40 per cent of people in need of WASH humanitarian assistance are women and girls. While this proportion may not seem initially alarming, after considering that over half of the people in Libya who require assistance are refugees who are overwhelming male, the actual number of Libyan women who require WASH assistance becomes substantially more than the number of Libyan men.[446] The few female refugees in Libya have even less options for accessing appropriate WASH facilities, and government initiatives to invest in infrastructure related to WASH that would reduce women's domestic work remains 'barely tangible'.[447],[448]

In Syria, WASH and protection issues are often interlinked, as women and girls often have issues accessing WASH services due to safety concerns. Female-headed households within internally displaced and returnee populations face the most difficulty in both accessing and affording hygiene and sanitation products.[449] Furthermore, as a result of the ongoing humanitarian crisis which has caused several national systems to be overstretched, Syrian refugees are among the most deprived when it comes to accessing and using improved drinking water and sanitation facilities.[450]

Iraq's government has focused on infrastructure investments to reduce women's water collection burden and taken steps to be more inclusive of women in water management and decision-making activities at the national level.[451] In Morocco, the government has expanded the drinking water network, from individual connections to collective water points) to the benefit of more than 33,000, primarily rural, women.[452] Lastly, the Jordanian Ministry of Health developed a hygiene lecture programme in 2017 that specifically targets pubescent girls in order to encourage awareness and share important hygiene information.[453]

445 UNICEF, Water, sanitation & hygiene, ensuring that all Sudanese children have access to clean water and basic sanitation, n.d. Accessed at: https://www.unicef.org/sudan/water-sanitation-hygiene.
446 OCHA, Humanitarian Needs Overview 2019: Libya, 2019, p. 23.
447 Ibid. 57.
448 Comprehensive National Review of the Progress Made Towards the Implementation of the Beijing Declaration and Platform for Action +25, Libya National Report, 2019, p. 27.
449 OCHA, Humanitarian Needs Overview 2019: Syrian Arab Republic, 2019, p. 83.
450 UNICEF, Progress for Children with Equity in the Middle East and North Africa, 2017.
451 Alwash, Thikra Mohammed Jabir, et al., National Review of the Implementation of Beijing +25 Declaration and Platform for Action, Republic of Iraq, 2019, page 21 and 55.
452 Ministry of Family, Solidarity, Equality, and Social Development, National review of the implementation of the Beijing Declaration and Platform for Action, after 25 years, Kingdom of Morocco, 2019, p. 30.
453 The Jordanian National Commission for Women, Comprehensive National Review of the Progress in the Implementation of the Beijing Declaration and Platform for Action 25 Years On, The Hashemite Kingdom of Jordan, 2019, p. 36.