

REGIONAL ADVOCACY TOOL

Sexual and Reproductive Health and
Rights Advocacy in Egypt, Lebanon,
Morocco, Oman, Syria, Tunisia and
Yemen

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DRAFT for discussion

LIST OF ACRONYMS

AUB	American University of Beirut
CBS	Central Bureau of Statistics
CCCC	Choices and Challenges in Changing Childbirth
CEDAW	Committee on the Elimination of Discrimination against Women
C-Section	Caesarean Section
DAWN	Development Alternatives with Women for a New Era
EIPR	Egyptian Initiative for Personal Rights
EMS	Egyptian Medical Syndicate
ESCWA	Economic and Social Commission for Western Asia
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation/Cutting
FHS	Faculty of Health Sciences
FP	Family Planning
HCP	Haut-Commissariat au Plan
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IRB	Institutional Review Board
LDDF	Ligue Démocratique pour les Droits de la Femme
MAFFEPA	Ministère des Affaires de la Femme, de la Famille, de l'Enfance et des Personnes Agées
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
MoHP	Ministry of Health and Population
MPHP	Ministry of Public Health and Population
MoSA	Ministry of Social Affairs
NBFP	National Board for Family and Population
NCW	National Council for Women
NGOs	Non-Governmental Organizations
PAPFH	Pan Arab Project for Family Health
PC	Population Council
PCEC	Population Council and Egyptian Cabinet

PEEHF	Programme Euromed Egalité Hommes-Femmes
PoA	Program of Action
RH	Reproductive Health
RHWG	Reproductive Health Working Group
SCFA	Syrian Commission of Family Affairs
SEFF	Secretariat of State for the Woman and the Family
SPC	Syrian Planning Commission
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
TECA	Tunisian External Communication Agency
TFR	Total Fertility Rate
UNDP	United Nations Development Programme
UNFPA	The United Nations Population Fund
UNICEF	United Nations Children's Fund
UNS	United Nations Secretariat
WHO/EMRO	World Health Organization, Eastern Mediterranean Regional Office

EXECUTIVE SUMMARY

The International Conference on Population and Development (ICPD) took place in Cairo in 1994 and 20 years on, it is timely to revisit the extent to which its internationally endorsed recommendations were implemented in the Arab countries.

Approach taken to review

This regional review by the Reproductive Health Working Group (RHWG), a regional network now over 25 years old, covers a selected group of Arab countries presenting a spectrum from high income countries such as Oman to low income countries such as Yemen. The range of countries reviewed includes two countries from Al Maghreb (the western sub-region also known as North Africa), namely Morocco and Tunisia; three countries from Al Mashreq (the eastern sub-region) namely Lebanon and Syria, and Egypt (although physically located in North Africa); Oman from the Gulf region, and Yemen from the Least Developed Countries of the region. We chose to focus on countries where we have active RHWG researchers who know the sexual and reproductive health and rights (SRHR) situation in these countries very well. We developed a common framework for the national reports following the guidelines prepared by Development Alternatives with Women for a New Era (DAWN). We then drafted an outline and agreed accordingly on sets of relevant indicators to track. We shared and commented on the national reports among ourselves and submitted these separately to DAWN at the end of July 2013. This report consolidates findings from the national reports and has been reviewed by the national reports' authors as well as other members of the network. Appendix one to the report includes trends for a select number of indicators deemed relevant to this review for the years 1990, 2000 and 2010. Limitations to the approach taken are noted in the report.

Summary of findings

Access to Comprehensive and Integrated Sexual and Reproductive Health (SRH) Services

The review identifies that, in general, there has been significant progress in terms of providing more comprehensive SRH services to women. With a few exceptions such as low-income countries or those with difficult topographies like Yemen and Morocco, SRH services are generally available to many women and are physically accessible. However, barriers exist to access to comprehensive SRH services. High levels of inequities in access to services persist across socio-economic groups and across geographies (with urban areas being much more privileged than rural ones). Many key SRH issues such as infertility and reproductive morbidity remain neglected, at least by the public sector. Moreover, there is poor integration of services and continuity of care (poor post-natal care as a clear illustration of this). Some routine practices particularly related to maternal health are not based on the latest scientific evidence about recommended interventions (such as high and increasing C-section rates documented across most countries under review). The questionable quality of free health services in some contexts, the growing role of the private sector, the lack of integration of services, the proliferation of vertical health programs and fragile health systems (particularly in context of conflict) all pose a risk to the optimum provision of health care services for women in the Arab world. The relative lacks of attention to socio-cultural barriers that limit women's access to available services, as well as the lack of emphasis on eliciting women's perspectives about these services, have both been identified as major gaps both in terms of research and policies and programs.

Specific Sexual and Reproductive Health (SRH) Needs and Rights of Young people

There is strong evidence that the sexual and reproductive health needs of young people in the region are many and yet are not being fully addressed. Young people's SRH needs should be seen in the context of demographic changes characterizing the region, such as a rapidly rising age at marriage, the decline in almost universal marriage and the youth bulge. There has been recent progress both in terms

of generating information on young people (including those who are unmarried) and the development of youth policies, in some cases in a participatory fashion. However, the provision of services to young people has been limited to small-scale efforts, and often only caters to well-off economic groups. Moreover, young people have not been adequately surveyed or involved in the development of services and programs to meet their needs. In many countries, especially where the age at marriage remains low, the special needs of young married women having to undergo an often abrupt transition to marriage during their adolescence are not always considered. While many countries have initiated processes for developing youth policies that include SRH, there remains the need to better link policies and programs across sectors for the benefit of young people.

Sexual and Reproductive Rights

It is difficult to generalize across the review countries about the progress in this area. Outstanding examples of reform of personal status legislation exist, such as the major reform undertaken by Morocco documented in this review. There has also been significant legal reform in a number of countries around marriage (such as age at marriage), divorce and custody, and on conveying citizenship. Egypt has made significant progress on the issue of female genital mutilation/cutting, sparked in large part by the public debate stimulated by the ICPD in 1994. An issue on which there appears to have been little progress, however, is that of abortion that remains a highly sensitive and politicized issue in the region. In addition, the SRHR situation of foreign female domestic workers needs further investigation to offer them more protection than is presently the case.

Conclusions

There are many barriers to implementing the ICPD agenda which lie in the institutional, social and political context of the region. These need much more analysis than has been the case to date. The 20 years since the ICPD have certainly witnessed more willingness of governments in the region to address issues of SRH in terms of policies and programs. Often these governmental initiatives have been jointly led by United Nations bodies, non-governmental organizations (NGOs) and women's organizations at a small-scale, and have then been taken up by governments with international donor support. The ICPD gave prominence and a public platform to the role of NGOs which was very important in countries with authoritarian political systems. Although NGOs which are active on SRH are fairly limited in the region, their particular strength lies in their advocacy for greater attention to these neglected issues and their ability to voice the perspectives of women. NGOs often face particular constraints in the political context of the region. Women's organizations suffer from many of these same problems, but women's movements are further constrained by on-going polarizations along religious, political and other lines. Women's movements and organizations need to be strengthened in general, and particularly concerning their engagement with issues of SRHR. Much of the advocacy efforts of NGOs has been focused on specific issues and is highly dependent on donor funding.

As members of a research network, we also note that there needs to be better engagement in the region between research institutions, civil society organizations and governments.

Our general concern emanating from this review has been that there is a lack of deliberate effort to build the SRHR field as a whole and strengthening the role of institutions within the region whether from a research, advocacy or program perspective. Rather, the last 20 years has seen a fragmentation of the field into specific issues. The focus on the MDGs has been one element of this trend, as have been donor priorities. Work is needed to promote a broader concern and commitment to SRHR as an integral field in the post-2015 plan moving forward.

Finally, we have witnessed first-hand the devastating impact of conflicts in this region on the SRHR situation. This has most severely impacted the SRH needs and rights of populations due to conflict, and yet does not appear to be a central element of displaced response to humanitarian emergencies in

the region. At the same time, the consequences of conflicts have also dominated policy priorities in general and diverted resources, thus affecting all national health systems and their ability to deliver SRHR services to all in diverse ways. This area needs much further research and given that the region has been characterized by periodic and intense conflicts, addressing its effects on SRH should be more central in the region in policies, services and educational programs.

DRAFT for discussion

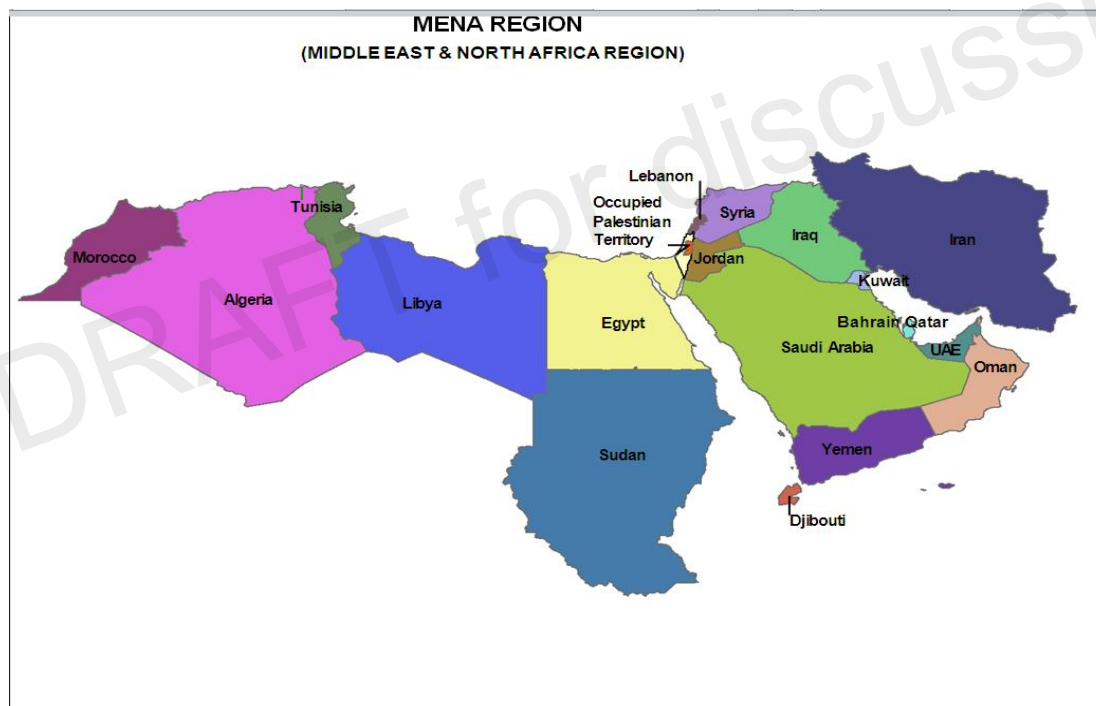
I. INTRODUCTION

This regional review on the Implementation of ICPD @ 20 covers a select group of the Arab countries, presenting a spectrum from high income countries such as Oman to low income countries such as Yemen. The range of countries reviewed includes two countries from Al Maghreb (the western sub-region also known as North Africa) namely Morocco and Tunisia; three countries from Al Mashreq (the eastern sub-region) namely Lebanon, Syria and Egypt (although physically located in North Africa); Oman from the Gulf region, and Yemen from the Least Developed Countries of the region. This review was conducted by the Reproductive Health Working Group (RHWG) in the Arab World and Turkey that is now over twenty five years old.

Background on the region

The Arab region (See figure 1) is one of tremendous demographic, socio-economic and political diversity, despite its common language, the predominance of Islam as the main religion (with significant religious minorities) and similar cultural contexts. It is also a region having some of the poorest and richest countries globally with countries such as Sudan and Yemen on the low-income end of the range and stretching to include countries such as Qatar with the highest per capita income in the world.

Figure 1: Map of Middle East and North Africa Region



Source: MENA REGION (Middle East and North Africa Region) http://www.unicef.org/har07/files/MENA-__15_Nov_2006.pdf

Because of the wide gap in income and their different colonial experiences as well as political trajectories, Arab countries also differ in their provision of social welfare, including health and education, and the extent to which their health systems have been privatized. In countries such as Egypt and Syria and much of North Africa, there has been a long tradition of public social welfare provision, although in all of these countries there is now a burgeoning private sector. In Egypt and Syria, separate fee-paying sections exist in public hospitals and it is also common practice for physicians to work in the public sector in the morning and in the private sector in the afternoon. In the

oil-rich countries of the Gulf, extensive free social welfare is provided for nationals (but not the large foreign work-force) subsidized by oil revenues. In the occupied Palestinian territory, a special case, the Palestinians have gained some autonomy over health policy-making and health services only in the past 20 years, while they have remained heavily reliant on external development aid. Finally Lebanon has one of the most privatized systems of health care in the world, with an estimated 80% of services provided in the private sector.

It thus becomes apparent that any regional review needs to take into consideration the diversity in the socio-economic and political context of different Arab countries. These contexts lead to variability in health systems infrastructure and quality, and the low status of women influencing the achieved legal rights of women and the sexual and reproductive health and rights (SRHR) situation.

In contextualizing the review of progress on SRHR in the Middle East, it is also important to note that the history and political economy of the region has been dominated by the following key issues – The Arab-Israeli conflict; The presence of oil in the countries of the Gulf; The region's geographic position on the crossroads between Asia, Europe and Africa, have all resulted in strong geopolitical interest in it. Moreover, the fact that the oil resource is found in relatively under populated oil-rich countries of the Gulf has created significant demand for labour migration from the other Arab countries rich in human resources but poorer economically. The oil-rich countries of the Gulf have also been sources of foreign aid to these countries, adding to their power in the region.

The protracted and as yet unresolved Arab-Israeli conflict has pervaded the political context of the region particularly in light of high levels of U.S. political and economic aid to Israel. Moreover, it has resulted in considerable amounts of public military expenditure by Arab countries, heavily financed by external aid, sometimes at the expense of providing health and education services. Furthermore, the conflict has severely affected the development of the occupied Palestinian territory, making it economically dependent on Israel, while simultaneously distorting the development of front-line states such as Lebanon and Jordan. Countries that have made peace with Israel have benefitted from significant Western (primarily American) foreign aid.

Moreover, the major political change in the region in recent years has led to a high toll of deaths and injuries, an increasing burden of infectious and chronic diseases, and of psychological illnesses; as well as extreme political instability, conflict and massive refugee flows. We mention the cases of Iraq, Palestine, Sudan and Syria because of the impact of conflict, in addition to the “Arab Spring” countries of Bahrain, Egypt, Libya, Tunis and Yemen.

All these experiences have dramatically shaped the SRHR situation in Arab countries in ways that are difficult to capture given the lack of recent data. In this review, we will cover changes in the SRHR situation in select Arab countries from 1990 and until 2009 for which data was available. We will also attempt to analyse the effect of war, conflicts and revolts on the SRHR situation from observations and writings on evolving contexts in societies under conflict and in change. We detail some of these changes below to provide an idea of this evolving context.

Beginning in December 2010, popular uprisings in Tunisia, a country seen by some as a showcase for social development and economic growth, led to the overthrow of Zine El Abidine Ben Ali who had ruled Tunisia since 1987. After nine transitional months, national elections led to the appointment of a temporary President, Dr. Moncef Marzouki, in October 2011.

Popular uprisings followed in Egypt in January 2011, which led President Hosni Mubarak to step down in February 2011 after 30 years in power. The country had two years of continuous political and social changes with Islamists gaining power, led by the elected Mohamed Mursi, member of the Muslim Brotherhood. In June 2013, popular dissatisfaction with his rule led millions of Egyptians onto the streets demanding resignation of the president. The Egyptian military announced the end of Mursi's

rule in support for people's demand. The on-going political instability threatens the country's achievements and increases challenges to achieve its development goals.

In 2011, following popular uprisings in Tunisia and Egypt, Yemen experienced a major popular resistance to the almost four-decade rule of President Ali Abdullah Saleh. After popular protests largely led by young people last more than a year, Yemen witnessed a handover of power to a new President in early 2012. Although the political situation in the country has improved, targeted killing by US drones of Yemeni nationals suspected to be associated with al Qa'eda with casualties among civilians continues to lead to political instability.

Finally, Syria has experienced major political upheaval since the spring of 2011 resulting in major loss of life and a massive flow of refugees to neighbouring countries such as Lebanon and Jordan. While President Assad remains in power, after several decades of rule of Al Ba'ath party, the country is in a state of civil conflict with regional and global dimensions.

Background on Reproductive Health Working Group

The Reproductive Health Working Group (RHWG), which is a network coordinated currently from the Faculty of Health Sciences (FHS) at the American University of Beirut (AUB), is composed of academics and researchers from the Arab World and Turkey, who since 1988 have been undertaking, sharing and disseminating research on reproductive health in the region. Through commitment, flexibility, hard work and successful fund raising, the members of the RHWG have managed to sustain a research network focusing on capacity building for scientific research for over 25 years in the midst of instability and conflict in the region. The multidisciplinary network is composed of women and men from a wide variety of disciplines and specializations such as social scientists, public health specialists, physicians and nurses.¹ The network engages in research for the production, sharing and dissemination of evidence to help improve health conditions and the health systems in the region, focusing on reproductive health. The network also includes younger researchers who are assisted and supported by the more senior members of the network, to join research teams and to carry out research that is relevant and important for the region.

We present our work to each other, beginning sometimes from the proposal writing stage, all the way to the presentation of results. The annual meeting is extremely helpful in providing support as well as exchanging critical comments in a hospitable environment, and has proven to be instrumental in capacity building. We also convene smaller thematic meetings, organize regional exchange between researchers in different countries and run a small grant program for seed research projects. Over time, we have been able to collectively develop more appropriate frameworks for conceptualizing women's health in the region, based on our research and also our lived experiences, and have been developing measures which

¹The RHWG is led by a part-time coordinator, currently Dr. Jocelyn DeJong and is housed at the Faculty of Health Sciences (FHS) at the American University of Beirut (AUB); she is assisted by a program manager, Ms. Noha Gaballah in Egypt and a regional Consultative Committee as follows: Dr. Huda Zurayk also from FHS/AUB, the founder of the network; Dr. Belgin Tekce from Bozagic University in Turkey; Dr. Hyam Bashour formerly of Damascus University but now a board member of the Syrian Commission of Family Affairs; Dr. Rita Giacaman from the Institute of Community and Public Health, Birzeit University; Dr. Atf Gherissi from Tunis-El Manar University, and Dr. Asya AL-Riyami from the Omani Ministry of Health. Health Sciences (FHS) at the American University of Beirut (AUB); she is assisted by a program manager, Ms. Noha Gaballah in Egypt and a regional Consultative Committee as follows: Dr. Huda Zurayk also from FHS/AUB, the founder of the network; Dr. Belgin Tekce from Bozagic University in Turkey; Dr. Hyam Bashour formerly of Damascus University but now a board member of the Syrian Commission of Family Affairs; Dr. Rita Giacaman from the Institute of Community and Public Health, Birzeit University; Dr. Atf Gherissi from Tunis-El Manar University, and Dr. Asya AL-Riyami from the Omani Ministry of Health.

correspond to the new frameworks. The website of the network can be consulted at www.rhwg.org.

Approach to the review

In approaching this regional review in collaboration with DAWN, we chose to focus on countries where we have available Consultative Committee members who know the SRHR situation very well in their countries, particularly as these countries turned out to be well distributed in the region. With the team in place, we met in June 2013 in Beirut, where we had gathered for a RHWG Consultative Committee meeting. We agreed that each member of the team will write a national report on her country and that these reports will be merged to produce the report for DAWN.²

We developed a common framework for the national reports following the guidelines prepared by DAWN. We then drafted an outline and agreed accordingly on sets of relevant indicators to track for the national reports, as delineated in international, regional and national sources for these indicators. July was the month for writing the national reports, while exchange of interesting information continued. We also shared and commented on draft national reports which were submitted to DAWN at the end of July 2013. The final step was to consolidate the national reports into a regional report – this report – soliciting feedback from authors of national reports, as well as other consultative committee members.

There are several limitations in this methodology which should be noted. First, it was not possible within the time-frame agreed upon with DAWN to undertake extensive interviews with stakeholders. Moreover, such interviews would have entailed securing IRB approval at AUB which was also not feasible within the time-frame. Authors did, however, consult with local experts and organizations to obtain the most up-to-date and comprehensive information and documentation available. It became clear, however, that many aspects of relevant policies, programs and services in the region have not been evaluated or documented (even in Arabic), making our task challenging. The chronology of changes in policy or the initiation of programs is for that reason often difficult to establish. Finally, our report addresses the conflict situations described above as far as our knowledge and information allows but it should be noted that most of the data available pre-dates the recent conflicts and may not provide an accurate account of the current situation.

² In the case of two country reports, Yemen and Oman, the reports were not written by nationals or residents in those countries but people knowledgeable about the contexts.

II. SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Evolution of population policies before and after the ICPD

The ICPD brought some positive changes to population policies in the countries under review. For example, Egypt removed a focus on achieving quantitative targets for contraception provision; its population strategy document issued in 1991 specified quantitative demographic targets for 1997, 2002 and 2007 but in subsequent national documents that came out after 1994, no mention of targets is noted (Sayed, 2012).

However, population policies generally continued to stress fertility and express concern over rapid population growth. National population strategies were drafted for Egypt, Yemen and Syria after ICPD. The population issue was seen as one of the most important and challenging issues for Syria's development agenda.

In Yemen, it is to note that even before the ICPD, the national population policy referred to access to family planning (FP) as a right that should not be coerced and that FP should also include the right to treatment of infertility. However, in general, the population policy was narrowly focused on child survival and reducing the population growth rate. After the ICPD, a primarily demographically-driven policy was supplemented with increasing focus on maternal health.

At a larger scale than Yemen, Tunisia had already adopted principles of the ICPD even before the conference. Its population policy and FP program was seen as a model for other countries in the region. In 1959, the authorities launched the debate on the need to improve fertility control, and in 1966, population policy became one of the pillars of Tunisia's first exercise in economic and social planning. This policy to reduce population growth included a number of measures, principally: 1) the legalization of the sale of contraceptives at a token price (1961); 2) the introduction of a national FP program (1966); 3) the legalization of abortion (1965) and the introduction of a post-abortion program in an effort to promote contraceptive use and avoid further abortions (1968); and 4) the establishment of the National Board for Family and Population (1973) (Ghérisi, Zouari, Esseghairi, and Ben Brahim, 2001).

Changes in governmental organizations of Population/Health since ICPD

Following the ICPD, a number of governments made major changes to the ministerial bodies responsible for health and population. In Egypt, for example, a Ministry of Population and Family Planning was created (headed by the former head of the National Population Council) in 1993. After the ICPD, the Ministry of Population and Family Planning was merged with the Ministry of Health to become the Ministry of Health and Population. The overall responsibility for population and family planning programs was transferred to the Ministry of Health and Population (Sayed, 2012). Although this was a positive development, it has been noted that many of the NGOs who took a leading role during preparations for the ICPD, were marginalized after this merger (Landlot, 2007). From 2002 onwards, the National Population Council was chaired by the Ministry of Health and Population but in 2009 the Prime Minister chose the chair, in recognition perhaps of the broad scope of population issues.

In Yemen, the Ministry of Public Health was also changed to the Ministry of Public Health and Population around 2001, and the directorate of Maternal and Child Health in the Ministry was renamed as the Directorate of Reproductive Health. The National Population Council still exists as a separate entity in Yemen.

In Tunisia, several institutional changes deserve to be mentioned for which the 8th Social and Economic National Plan for Development (1992-1996) represented the turning point. In 1992, the Secretariat of State for the Woman and the Family (SEFF) was created to address issues of women

and families and their specific needs. This institution became an autonomous Ministry after 1996 with a strengthened mission related to developing a national policy for women and family promotion and to ensure a multisectoral coordination of related activities. In 2002, the mission of the Ministry was extended to encompass children and then to include the elderly. Its name was changed to the Ministry of Women's Affairs, Family, Children, and Elderly Persons since 2004 (PEEHF, n.d; UN, 2000; TECA, 1994).

In Morocco, after the ICPD, the Mother and Child division within the Ministry of Health was changed to the Division of Reproductive Health. This change strengthened the merging of MCH and FP services. Linkages were established also with the division responsible for HIV/AIDS and sexually transmitted infections (STIs) (UNFPA, n.d.).

In Lebanon, the Ministry of Social Affairs (MoSA) was also established in 1993 with a unit for women's affairs within the department of family affairs that aims to empower women by responding to their needs, developing their capacities and raising their awareness about their rights. In 2011, a reproductive health unit was established within MoSA. In 1996, following Beijing declaration and platform of action, the National Committee for Lebanese Women initiated its activities; the committee is led by the first lady responsible for coordinating women's issues among civil society and public institutions including ministries as well as undertake the CEDAW reporting for Lebanon every 4 years. Additionally, the Ministry of Public Health initiated the reproductive health program that aims to improve access to quality RH services and commodities in the primary health care system particularly in underserved areas.

In Syria, in 2004, a decree was issued to establish the Syrian Commission of Family Affairs (SCFA), a governmental body that strategizes for family affairs with a focus on children, women, youth and the elderly. It works closely with the Syrian General Women's Federation and with NGOs. SCFA is also responsible for following up on implementation of related international conventions ratified by the country (SCFA, 2011).

Description of principal policies and programs to expand SRH services

In the decades since the ICPD, there has been a noted commitment in all the countries concerned to develop policies and expand SRH services, but as noted in the introduction, the starting-points for countries reviewed were very different. There is evidence that since commitments were made to the MDGs, the strongest areas of focus have been those emphasized by the MDGs. This is particularly the case for maternal mortality. Moreover, there has also been a concern that emphasis is being placed on monitoring particular indicators, rather than ensuring the quality of services provided.

Morocco included RH components in its health policy prior to ICPD (UNFPA, n.d.), but RH programs were limited to FP and maternal and child health (MCH). The ICPD program of action (PoA) served as a guide for the Moroccan government to develop strategies and programs on broader population and RH issues. New programs were added to ensure the provision of comprehensive and integrated services, including addressing HIV/AIDS and reproductive morbidity, and the Moroccan Ministry of Health reinforced its FP and maternal and child services at the level of primary care facilities (HCP, 2004). Following the ICPD, the Moroccan government placed RH and gender issues at the core of its programs and, as a result, adopted a decentralized approach to increase the coverage of RH programs. Multi-sectoral regional teams were created to participate in the design and development of these programs which allowed the adaptation of central models to the local context of each region in the country. The national program of FP evolved through the years following the ICPD because of a strong political commitment that reinforced existing programs and aimed to take into consideration the needs of the population (HCP, 2004).

The National Population Commission in Morocco was reactivated in 1996 and it focused on integrating population concerns in strategic planning. The country has made considerable efforts in expanding

service delivery to make modern contraceptives available to low-income women and those living in rural areas (Ayad and Roudi, 2006). In fact, FP services were offered free of charge and high geographical coverage was attained through introducing mobile units, in addition to fixed units, thereby increasing access (HCP, 2004). Contraceptive prevalence increased from 59% in 1997 to 67% in 2011 and this increase was higher in rural areas. Currently 57% of married women in Morocco use a modern contraceptive method with nearly half of these women using contraceptive pills (MoH, 2011).

Like Morocco, Tunisia was a front-runner in the region in terms of its attention to reproductive health before the ICPD. Since the ICPD in 1994, Tunisia promoted and integrated RH as part of its national policy for women's development and emancipation. It included SRH in health policy and strategic plans related to health services and to health education programs. While the range of services has been progressively extended to cover all components of SRH, priority has been given to reducing maternal mortality, empowering young people and developing sexuality education, as well as to expanding screening for breast and cervical cancers, combating gender-based violence and addressing HIV/AIDS (NBFP, 2004).

The Ministry of Health in Syria added sexual and reproductive issues to its mandate soon after the ICPD in 1994. Both the Ministry of Health and women's organizations were the main bodies responsible for implementing the ICPD agenda in the country according to their respective mandates. Safe motherhood with its four pillars, namely providing family planning services, antenatal care to prevent possible complications, clean and safe delivery and postnatal care for the mother and child, and basic obstetric care for high risk pregnancies, were some of the priority approaches of the Syrian Ministry of Health since the 1990s (MoH, n.d.).

In 1994, the Omani government initiated its birth spacing program to limit maternal and neonatal morbidity and mortality associated with high parity. The program was well established in all public health care centres and the private sector was encouraged to participate (MoH, n.d.).

Country and regional socio-demographic and health equity data

Appendix One shows trends in key SRH indicators for 1990, 2000 and 2010. We single out some specific issues here for discussion.

Fertility

Historically, the Arab world shared with Sub-Saharan Africa some of the highest fertility rates globally. However, a demographic transition has progressively occurred in Arab countries and fertility rates have generally fallen, in some countries more than others.

In Syria, for example, the total fertility rate (TFR) declined from 5.1 live births per woman during 1991-1995 to 3.6 live births per woman more than ten years later in 2004. Still, population size in Syria has increased by over 13 times in the 100 years from 1905 to 2007. Available data indicate that the population growth rate has declined from an average of about 3.3% during the rapid population growth period of 1947 to 1994, to about 2.7% between 1995 and 2000, to 2.45% for the period 2000 to 2005, and to an estimated 2.4% between 2006 and 2007. This population growth rate, according to the 2007 estimate, remains one of the highest not only in the Arab world but globally as well (SCFA, 2008).

Of note, among the countries reviewed, Yemen (the lowest income country) and Oman (the richest) are characterized by very high fertility rates. The TFR was 7.1 in Yemen in 1991 and is currently over 6 (MPHP, 2003). On the other hand, Oman had a TFR of 8 as estimated by the Oman Child Health Survey of 1988-1989, while most recent estimates show a reduction in its TFR to 3.3. As one of the oil-rich countries of the Gulf region, it can be inferred that high fertility in Oman is supported by

subsidized welfare and expansion of health services as is the case of other oil-rich countries of the Gulf. (MoH, n.d.; Fargues, 2005).

In contrast, and partly as a consequence of the high political engagement with population issues, fertility in Morocco has declined considerably between 1980 and 2004, achieving a rapid fertility transition in the country (Ayad and Roudi, 2006; MoH and ORC, 2005). According to the Demographic and Health Surveys, Moroccan women were having 2.5 live births on average in 2003-2004, compared to 5.5 in 1980 (MoH and ORC, 2005; Azelmat, Ayad and Belhachmi, 1989). The change was more significant in rural areas (6.6 live births in 1980 to 3.0 births in 2004). Morocco's TFR has now stabilized at 2.2 live births per woman (Azelmat, Ayad and Belhachmi, 1989).

Lebanon has currently the lowest TFR among Arab countries. Its fertility rate dropped significantly over the past 50 years and reached below replacement level with a current TFR of 1.9. Fertility levels, however, vary by education level of the women and by place of residence.

Although not covered by our national reports, it is worth mentioning that fertility in Iraq, (whose government under President Saddam Hussein took a pro-nationalist policy) remains high, at an estimated 3.5 live births per woman in 2013 down from 6.1 in 1990 (Al Hilfi, Lafta, and Burnham, 2013).

Progress toward the MDGs

The fact that Egypt hosted the 1994 ICPD was a turning point that gave a great deal of attention and debate to issues of women's rights, reproductive health and development in the country. Since then, Egypt has made considerable achievements in certain social and economic indicators, and the recent MDG progress reports suggest that the country is on track to achieve the millennium development goals (UNDP, 2013; UNDP, 2010).

Similar successes were noted in other countries such as Tunisia and Syria (before the conflict). In Syria, the project document of the Millennium Development Goals Report was officially signed, and a provision was made for the project to be implemented with the cooperation of the Government of Syria and UNDP. However, the on-going conflict and disruption of health care and other services throughout the country is likely to completely jeopardize the progress made to date.

There are also significant challenges to achieving the MDGs in Yemen as it has also been disrupted by conflict. Yemen's National RH Strategy for 2011-2015 indicates that it has made significant progress in its reproductive outcomes over the decades since the ICPD. The maternal mortality ratio (MMR) declined in the past 20 years to reach half its value in 2011. There was also a yearly increase of 2% in modern contraceptive use and the total fertility rate fell from 7.7 in the 1990s to 5.2 in 2006 (although there has been an increase in the adolescent birth rate). The Strategy attributes this improvement to a large investment in human resources and in health facilities, and to improvements in the organization of care. However, it concludes that there are persistent problems in reaching MDGs 4 and 5 – namely the lack of skilled attendance at delivery and of emergency obstetric care. The strategy report also highlights problems of a dispersed population in mountainous topography; a lack of midwives operating at the community level; the lack of empowerment of women compounded by poverty and illiteracy and the high cost of transportation. Thus in Yemen, like in other Arab countries, there is political commitment but implementation is weak.

The review team noted that existing assessments of progress tend to focus exclusively on the MDGs, areas where there has been greatest demand for government accountability and action, leaving little room to analyse progress towards comprehensive SRH. This was a constraint to the conduct of this review.

Notable success stories in both MDGs and the ICPD agenda

In the countries reviewed, there have been some successful examples where policy and programs had been galvanized towards specific goals. We cite two as examples.

Reduction of maternal mortality in Egypt

In Egypt, the Ministry of Health (MoH) conducted various national surveys to track trends in the maternal mortality ratio (MMR). Findings indicated that the MMR declined by 52% in less than 10 years from 174 deaths per 100,000 live births in 1992 to 82 deaths per 100,000 live births in 2000 (Campbell, Gipson, Issa, Matta, El Deeb, El Mohandes, Alwen, and Mansour, 2005). According to the National Maternal Mortality Surveillance System, the MMR reached 55 per 100,000 live births in 2008 (UNDP, 2010).

Various factors have contributed to the remarkable decrease of the MMR in Egypt. The 1992 survey revealed that substandard care was responsible for 47% of avoidable factors leading to maternal deaths (Khalil and Roudi-Fahimi, 2004). The findings confirmed the importance of antenatal care services in preventing maternal deaths as 41% of direct and 68% of indirect causes of death could have been detected have prenatal care services been delivered (MoHP, 1998).

The MoH adopted the Safe Motherhood Initiative and deployed efforts to increase the accessibility to care and improve the quality of services (Khalil and Roudi-Fahimi, 2004). In 1996, it integrated maternal and child services in the basic health services offered at all primary health care clinics. With an aim to expand essential obstetric care and improve the management of obstetric and neonatal emergencies, the MoH focused its activities at three levels: the provider level, the health facility level and the community level. National standards for obstetric and neonatal care were developed and professional training was conducted to build the skills of health professionals (Khalil and Roudi-Fahimi, 2004). This included the improvement of Dayas' (traditional birth attendants) skills, the introduction of a revised curriculum for medical and nursing schools, along with in-service training for health care providers working on maternal and child health 2000 (Campbell, Gipson, Issa, Matta, El Deeb, El Mohandes, Alwen, and Mansour, 2005). The MoH also adopted a decentralized approach and established safe motherhood committees in all governorates to coordinate activities. At the facility level, it strengthened health structures to provide obstetric care and primary health care by equipping care centres with drugs and supplies 2000 (Campbell, Gipson, Issa, Matta, El Deeb, El Mohandes, Alwen, and Mansour, 2005). Around 32 maternity homes were opened to allow women living in remote areas to deliver in a health facility (UNDP, 2010).

Integrated policy on improving access and quality of services in Morocco

Until 2011, the Ministry of Health in Morocco addressed various components of reproductive health through separate national programs for family planning, maternal health, HIV/AIDS etc. In 2011, policy makers in the MoH developed a comprehensive RH policy on reproductive health that provided an integrated approach to the existing activities of family planning, HIV/AIDS, maternal health, promotion of youth health, gender-based violence and early detection of reproductive cancers. This approach is based on the following principles: respect of reproductive rights, equity in terms of access to services, resources optimization and continuity of care (MoH, 2011).

Critical Analysis of Available Maternal Health Services

The strong focus on reducing maternal mortality in the region resulted in an emphasis on increasing facility-based delivery. In fact, the shift towards facility-based delivery has been rapid and most women now deliver in hospitals, as opposed to their homes, which was previously the norm. While this has no doubt contributed to a reduction in maternal deaths, concerns have also been raised in the region about the absence of regulation around quality of care, the lack of women's involvement in decision-making around their deliveries and at times, the risk of excessive medical intervention, illustrated best by the rising Caesarean section (C-section) rate in the region. In the latest national DHS data from Egypt, for example, 28% of all births were delivered by C-section (El-Zanaty and Way, 2009; Khawaja, Choueiry, and Jurdi, 2009).

The Choices and Challenges in Changing Childbirth (CCCC) research program is an established regional network linked to the RHWG that has been generating evidence about maternal health and childbirth practices while identifying effective ways to improve the safety of maternity services and women's experience with the received care (www.aub.edu.lb/fhs/cccc). This interdisciplinary network has been active in Lebanon, Syria, Egypt and the occupied Palestinian territory since 2001 and involves professionals from different disciplines such as public health, medicine and the social sciences. The research of this interdisciplinary regional group has provided evidence on the variations in maternal health care in the region and on the discrepancy between routine practices and best practices consistent with current scientific evidence (CCCC, 2005). Specific study teams in the four participating countries of the network have identified problems in the quality of maternal health services and the lack of women's involvement in the decision-making process of care. They have also conducted interventions to promote evidence-based effective care.

In Lebanon which has a very privatized health care system, the birth attendance by skilled personnel increased from 96% in 2000 to 98% in 2004 but was also accompanied by a sharp increase in the c-section rate from 18% in 1997 to 47.3% in 2012 (MoPH, n.d.). A nationally representative hospital C-section rate was identified at nearly 41% based on 2008 births (DeJong, Akik, El Kak, Osman, and El-Jardali, 2006). Various factors have been linked to this increase in c-section rates, foremost being financial motives and the convenience factors for physicians in being able to schedule c-section births. A study conducted by a national private insurance company reports that obstetricians and maternity centres tend to practice non-medically justifiable c-sections because the fees are double those of a vaginal delivery (El Zein, 1999).

In Oman, the c-section rate has also increased from 9.7% in 2000 to 15.7% in 2009. The factors found associated with the increased rate are advanced maternal age, low neonate weight, obesity and previous c-section (Al Busaidi, Al Farsi, Gangul and Gowri, 2012).

In Syria, the c-section rates were rising even before the current political crisis (Bashour, and Abdulsalam, 2005; Khawaja, Kabakian-Khasholian, and Jurdi, 2004) and are higher in private hospitals compared to public hospitals (Abdulsalam, Bashour, Cheikha, Al-Faisal, Gabr, Jorf, et al,

2004). The on-going crisis has further contributed to an increase in c-section rates. Routine statistics from one large maternity teaching hospital in Damascus reports monthly rates that range from 40-60% in 2012-2013 (Personal communication). Women are increasingly asking for c-section deliveries due to the lack of routine access to care because of the security situation and doctors are increasingly recommending c-section deliveries for similar reasons.

Another deficiency in services seen across countries is the weakness in the provision and utilization of postnatal care. In Morocco, for example, few women receive information about the importance of post-natal care at the antenatal clinics or delivery facilities. Despite the improvements in postnatal care that Morocco witnessed in the last years from 7% in 2004 to 22% in 2011, postnatal care utilization remains very low. In Morocco, as elsewhere in the region, calls for the mobilization of health care professionals to sensitize women about the importance of postnatal care and to engage civil society organizations to raise awareness are needed (MoH, 2011).

In Syria, the findings of the Family Health Survey in 2009 similarly showed a major gap in the coverage of postpartum care in the country, with 77.1 % of women reporting that they did not receive postnatal care (CBS and PAPFH, 2010).

Women's perceptions of services

There has been a notable lack of assessment of women's perceptions and experiences of health in the Arab world although some micro-level studies suggest that women are dissatisfied with health services (El-Nemer, Down and small, 2006; Tinsa, 2012). Tunisia is one exception, however, in having conducted national surveys on user satisfaction. For example two national surveys conducted in Tunisia in 2012 among different profiles of users of sexual and reproductive health services, highlight aspects of service provision that are unsatisfactory. These aspects include client-provider interpersonal relations (lack of listening, insufficient answers to questions, dearth of alternatives addressing the concerns of women, absence of a client-empowering approach, lack of respect and of availability), inadequate quality of services and the constellation of services (waiting time, length of consultation), lack of equity (priority given to providers' friends and relatives) and poor continuity in care (re-contact and follow-up mechanisms) (Tinsa, 2012; Ghérissi, 2012).

The CCCC network recently embarked on a quality improvement project funded by the Implementation Research Platform administered by WHO in four countries to address the management of maternal and neonatal near-miss cases (women who almost die in pregnancy or childbirth but who survived or infants who nearly died in delivery) in four public hospitals in Egypt, Lebanon, Palestine and Syria. This involves working with the hospitals to introduce or strengthen their clinical audit process as a means of improving the quality of care. In the context of that study, interviews have also been conducted with health-care providers and women who themselves were near-miss cases or who were mothers of infants who nearly died in delivery to understand their perspectives.

Inequities: Urban-rural differences in access

Lack of equity is a significant challenge in the Arab world. The sizeable disparities between rural and urban areas were noted for all indicators in nearly all countries reviewed and the disparities lie on both the demand and the supply sides. In Syria, for example, MMR was as high as 78.25 per 100,000 live births in the Eastern Raqqa Governorate and as low as 33.08 in Damascus, the capital, according to Central Bureau of Statistics estimates in the year 2008 (SPC, 2010). In Morocco, the MMR declined by 66% between 1992 and 2010 - from 332 deaths per 100,000 live births to 112 per 100,000. The decline was slower in urban settings (from 187 maternal deaths for 100,000 live births to 73) than in rural areas (from 367 maternal deaths for 100 000 live births to 148) (MoH, 2011).

Fertility differentials in Egypt are considerable with a TFR around 3.2 in rural areas compared to 2.7 in urban settings; the highest fertility levels are in Upper Egypt, the most rural district in the country, where the TFR is 3.4 live births per woman (El-Zanaty and Way, 2009).

In Oman the concentration of people in urban areas allows easy access to RH care to more than 90% of women in Oman. Women in rural areas however have to travel longer distances to access care. In urban areas, a health facility is located at a maximum distance of 5 km from a residence for 57% of urban residents, compared to only 27% of those living in rural areas (Hill, Muyeed, and Al-Lawati, 2000; Beyond 2003).

In Yemen (2012), there are significant inequalities in access to skilled attendance at birth by place of residence and income level; 62% of births in urban areas and 26% of births in rural areas are attended by a skilled attendant. Similarly, 74% of births from households in the highest income quintile while only 17% of those in the lowest quintile were reported to have been assisted by a skilled attendant.

Gaps in services: Neglected SRH problems

Infertility

Infertility is a neglected issue in most of the countries reviewed. Services for infertility treatment in the Arab world are mostly available only in the private sector and in the big cities and thus only for couples who can afford treatment. Infertility care is not part of the services of reproductive health divisions in Ministries of Health despite known links between reproductive tract infections and subsequent infertility. Instead, services are provided by burgeoning private clinics using the most up-to-date technologies, and often with poor regulation by governmental bodies (Strum, 2013).

Data is lacking on infertility in the region given that population-based surveys do not address the topic. Regional and country estimates of primary infertility indicate prevalence of 2.6% among child-bearing women in 2010 in the North Africa/Middle East region. Reports on Morocco and Yemen indicate slightly higher prevalence (3%) (Mascarenhas, Flaxman, Boerma, Vanderpoel, and Stevens, 2012).

Cultural and religious obstacles to certain forms of infertility treatment are found in all countries. For example, third party donation is banned in all countries of the Arab region (although has recently been allowed in Iran). Among Shi'ites living in Lebanon, using culturally accepted practices such as temporary marriage has been one way of allowing surrogate donations (Inhorn, 2004). Few countries in the region have developed health policies concerning infertility and the use of assisted reproductive technologies; this is an area that is often left to regulation by religious bodies and leaders (Inhorn and Tremayne, 2012).

Reproductive Morbidity

Reproductive morbidity – both gynaecological and obstetric – has been neglected in the region despite its importance for women's wellbeing and its considerable impact on their lives, in a context where many of these conditions are highly stigmatized. Pioneering research based on micro-level population-based studies in the region has provided some evidence on the prevalence of these morbidities. Most notably, the Giza study in the early 1990s by colleagues from the Reproductive Health Working Group inspired a series of other similar studies (Khattab, Younis, and Zurayk, 1999). This study was one of the first to demonstrate that women bear a heavy burden of reproductive morbidity but often do not bring them to the attention of health services. Among the countries reviewed, only Oman has conducted a national study on the prevalence of reproductive morbidity. That study found that 4% of women surveyed had a sexually transmitted infection (STI) (with younger women twice more likely than older women to have a STI), 25% had a reproductive tract infection (RTI), 10% suffered from genital prolapse and 11% had urinary tract infections (UTI) (Mabry, Al-Riyami, Morsi, 2007).

Yemen is an example of a country with high maternal mortality but where morbidity has been relatively neglected, despite the emphasis of the MDGs on maternal mortality reduction. Reproductive morbidity falls in the grey area between the Reproductive Health Department, the Population Sector of the Health Ministry and the National AIDS Program. Given Yemen's high MMR, one would expect high levels of reproductive morbidity. National population-based surveys have included questions for self-reporting of symptoms of reproductive ill-health. Although not a valid indicator of prevalence without clinical confirmation (Sadana, 2000), these indicators provide some evidence of the level of suffering perceived by women. The Family Health Survey of 2003 found that 22% of ever-married women of reproductive age and 10% of those aged 15–19 reported symptoms of genital prolapse and more than half of those reporting prolapse have been affected by it for five years or more. Overall 14% of urban and 16% of rural ever-married women reported symptoms of vaginal discharge indicative of a RTI. In the same survey, women also reported major barriers to their utilization of services for these conditions, including cost and perceptions of poor quality of care. Of note is that many of these studies have not been well-disseminated.

The above studies have focused on gynecological morbidity; but there have also been relatively few studies on obstetric morbidity in the region. An exception is a study mentioned above on maternal near-miss cases currently underway in Egypt, Lebanon, the occupied Palestinian territories and Syria. Out of a total of 9,063 deliveries of live births were reported through the data collection period in the four settings, a total of 77 cases of severe maternal morbidities (71 maternal near miss and 6 maternal deaths) were noted (personal communication).

Of concern is the lack of attention throughout the region to STIs among women, including HIV. Indeed, as is shown in the appendix table, few countries have incidence or prevalence data on HIV in women or data on testing for ARVs. A recently UNAID report on women and HIV is a useful advocacy tool but it provides little new data on the incidence of HIV among women in the region, and on testing and treatment for women (UNAIDS). Epidemiological studies from the region suggest that the biggest risk factor for acquiring HIV among women is marital sexual intercourse. More data and research is warranted in this area.

Ageing and Menopause

Menopause is another neglected issue that was not referred to in the RH strategy documents in most of the countries reviewed. The term used socially for menopause in Arabic is 'age of despair' reflecting the value placed on women's reproductive roles. Although not significantly researched, there are many social and cultural barriers for post-menopausal women to seek RH services.

Population ageing is now recognized as a critical public health issue in the Arab world and there has been particular concern about the situation of older women, given their longer life expectancy. Although social norms have historically strongly favoured care and respect for the elderly, these norms are breaking down with urbanization, the breakdown of extended families and migration. It is interesting to note that in both Morocco and Tunisia, ministries dealing with women have been renamed to include a focus on the elderly population. However, to date, there has been little focus on the SRH needs of older women with the exception of some research on menopause. There has also been little focus on adopting a life-cycle approach to women's health and interactions with the health care system are not used as opportunities to address a range of women's health needs.

Socio-cultural barriers to accessing SRH services

There are also socio-cultural barriers to access that policymakers need to address if health services are to be more widely utilized by women. For example, in some contexts women clearly prefer, for cultural reasons, to see female providers, yet this is not possible. In many cases, it is difficult for women to seek healthcare without a male guardian or male permission. Finally, women face economic barriers

to pay for key services. The particular barriers faced by non-married women (whether young or older) also need attention, particularly given demographic changes in the region where marriage is no longer as universally practiced and the cohort of never-married women. There has been little discussion or research on how health services are meeting the diversity of their health needs. Indeed these socio-cultural barriers in the region have been under-researched and insufficiently addressed by the public health system despite their obvious importance.

Resources and SRH in Health System Contexts

It was not possible for this report to track expenditures on SRH and related services and activities by governments and international donors for all review countries. A recent initiative of the global consortium, Countdown for Maternal, New-born and Reproductive Health has tracked donor expenditure for certain countries earmarked for SRH, but not all review countries were included in that exercise. Moreover, governments in the region do not make available publically their budgetary allocations to SRH. It is therefore difficult to push for more accountability in this area without more transparent information being available.

We note that historically several countries in the region were heavily dependent on foreign aid for the provision of contraceptives. This was the case in Egypt, although the population program has been severely reduced in the context of a shift in the type and level of aid provided by the United States government to Egypt. In Morocco, the government has made a deliberate effort to increasingly rely on its own resources for population and RH and by 2003, the Moroccan government was no longer dependent on donors to purchase contraceptives.

It is clear from the national reports, on which this regional report is based, that SRH implementation has been clearly affected by wider constraints in the health system and low salaries and weak distribution of health care providers. But even in middle-income countries, the budget for SRH is not always secure. Moreover, a number of studies in the region have shown that out of pocket expenditures by households on health-care in general, including maternal and RH services, is very high.

Yemen is perhaps the best example of a country where SRH implementation has been highly constrained by a weak health system. The Ministry of Public Health and Population has made many efforts to improve RH services. However, RH services are undermined by the same problems affecting the health system as a whole, including the shortage and uneven allocation of human and financial resources and poor managerial skills (Goy et al, 1998). The physical accessibility or geographical coverage of health services is very limited, and health facilities are lacking in terms of personnel, supplies, medications, blood bank and laboratory services. The 2011 State of Midwifery report cites a density of 3366 people per nurse and 2517 people per doctor, while the Countdown Accountability Report 2013 for Yemen shows a per capita health expenditure of \$104 in Yemen in 2007, and overseas development assistance for maternal and neonatal health per live birth of \$18 in the same year.

It is important to note that the conflict the region has experienced has also skewed health-care expenditure as well as the organization of the health sector. Lebanon is the best example in this regard, having suffered from 15 years of civil war, the 2006 war with Israel and on-going internal conflicts. One of the consequences of these wars is the proliferation of the private sector at the expense of the public sector (Aamar, 2009). The licensing records of the Ministry of Public Health reveal an oversupply of hospital beds with 193 licensed private hospitals and 30 public hospitals. Additionally, the oversupply of physicians from different specialties and different medical schools making the setting of clinical protocols and guidelines challenging (WHO/EMRO, n.d.). According to the National Health Account Survey 2005, governmental hospitals consume 1% of health expenditures while private hospitals consume 37 % (Jurdi, and Khawaja, 2004; Ammar, Wakim and Hajj, 2007).

Conclusion: some observations on available services

Significant progress has been made in the countries under review in terms of providing more comprehensive SRH services to women. With a few exceptions in low-income countries or those with difficult topographies such as Yemen, Morocco and Sudan, SRH services are generally available and are physically accessible to women. However, many key SRH issues remain neglected at least by the public sector. Problems in the lack of integration of services and in continuity of care (with the example of poor postnatal care a clear illustration) continue to persist. Inequalities in access to services based on geographical location (urban vs. rural) and income/wealth need to be addressed to improve equity. Overall, the sub-standard quality of free health services, the dominance of the private sector, the lack of integration of services, the proliferation of vertical health programs and fragile health systems (particularly in context of conflict) all pose a risk to the optimum provision of health care services for women in the Arab world. Moreover, there is evidence of non-medically justifiable practices such as very high C-section.

The ICPD gave prominence and a public platform to the role of NGOs, which was very important in countries with authoritarian political systems. Although NGOs active on SRH are fairly limited in the region, their particular strength lies in their ability to advocate for greater attention to these neglected issues and also voice the perspectives of women. NGOs often face particular constraints in the political context of the region. Moreover, there is some evidence that the role of NGOs has been marginalized after the ICPD (as was illustrated in Egypt). Women's organizations suffer from many of these same problems, but the women's movement is further constrained by on-going polarizations between secular and religiously-based organizations – differences which are often highly politicized. More discussion on this topic will follow in the section on rights.

III. THE SPECIFIC SRH NEEDS OF YOUNG PEOPLE

The Socio-Demographic Context of Young People in the Region

Arab society is largely a youthful one. While the percentage of youth is decreasing globally, this is not the trend in the Arab world: around 60% of Arabs are below the age of 25. All countries under review have a young population and many, owing to the rapid decline in fertility as well as the continued population momentum, are experiencing a youth bulge. In Egypt, the most populous country in the region, youth aged 18-29 represent a quarter of Egyptian population and the youth bulge that started in 1995 is expected to continue till 2045 (UNDP, 2010). Youth also represent the largest demographic group in Morocco; youth below 25 years of age represent almost half of the population (46%) and those aged 10-24 years represent one-third of the population (MoH, 2012).

Our definition of youth in this report is flexible. Formally, youth includes the group aged 15-24, but there is some overlap with the adolescent (ages 11-19 according to the WHO) age group or even the young adult population from ages 25 to the early 30s. Thus, in this report, we consider “youth” as a transition from childhood to adulthood.

Arab countries have mostly succeeded in increasing enrolment in schools and more recently have made significant progress in narrowing the gender gap. Even at the university level, girls often outnumber boys. Yet, the issue of youth unemployment is a serious one and a key issue raised by young people. According to the International Labour Organization (ILO), the Middle East and North Africa region has among the highest rates of youth unemployment in the world.

During the ICPD, governments pledged to improve the SRH of young people by providing integrated health services, including contraception for sexually active adolescents, and comprehensive sexuality education. Additionally, the right of individuals to access SRH services and information, to use services with privacy and confidentiality and to be treated with dignity and respect was explicitly recognized in the program of action of the ICPD (UNFPA, 1995). A successful approach requires enabling youth to make choices and take the lead in encouraging others to do the same (Bruce and Bongaarts, 2009). Yet, research from the Middle East and North Africa reveals that little is known about the SRH concerns and needs of young people and recommends closing this knowledge gap (Shepard and DeJong, 2005; Oraby, 2013).

National Youth Policies in the Region

According to a review by the United Nations Economic and Social Commission for Western Asia (ESCWA) a number of countries in the region have developed youth policies and strategies relatively recently (UN, 2011). Others are attempting to address youth issues within sectoral and national development plans. However, the ESCWA report concludes that these efforts have been weakened by social, economic and institutional challenges, the absence of regulatory mechanisms and the lack of follow-up. Conflicts in the region, both recent and longstanding, are also weakening efforts to address youth issues.

The Egyptian National Council for Youth (NCY) is the governmental body responsible for youth issues in the country (Tohamy Abdelhay, 2005). A national policy for youth in Egypt was launched in 2009, covering twelve areas related to youth, including health and awareness activities on population issues. The policy document stresses the importance of an integrated approach to youth development (UNDP, 2010).

The Tunisian government has given special attention to adolescents and youth in all its development policies since the 1990s, considering the changing sexual behaviour norms among young people and the increasing percentage of young people in the total population. It committed in several programs to develop a culture of rational and responsible sexuality, based on needs awareness in relation to RH.

Sexual and reproductive health for adolescents and young people was included on the agenda of the Councils of Ministers chaired by the Head of State and recommendations focused on: 1) strengthening the SRH programme for young people; 2) supporting actions among youth in formal and informal areas; 3) launching health services adequate for young people through implementing pilot services within the national board for family and population, schools and university medical centres; and, 4) creating a national committee to identify and analyse issues related to young people and to find adequate solutions.

In the 1990s, Morocco did not have a specific health policy for youth and adolescents. However, population and FP programs included components dedicated for youth. The national population policy claimed that FP services were available to all including youth, but these services did not address the needs of young people. Similarly, youth were not targeted in the country's National AIDS programs until 2000 (Beamish and Tazi Abderrazik, 2003). Nevertheless, political will to improve youth health was high. In 2003, the Ministry of Health in collaboration with the Ministries of Education and Youth and Sports, and international organizations developed a national project dedicated for youth. This project incorporated active participation of youth in the design and implementation. The new constitutional changes in Morocco stipulated the creation of a council for youth and associated actions and this council was charged with identifying key issues related to young, and making proposals to the government based on their social and economic needs (Yaakoubd, 2012).

Research on Young People in the Region

Most countries across the region have begun to conduct youth surveys, obtaining data on the needs of young people, including of those unmarried. The Arab League has sponsored youth surveys in its member countries, although these are not always comparable because each country's government determines which questions will be included in the survey. Moreover questions on sexual and reproductive health are very limited as such content is deemed sensitive. The focus of these surveys is on knowledge and attitudes rather than behaviours. Consequently, most lack information about sexual behaviours of young people, although small-scale studies are beginning to research this topic.

Egypt was one of the first countries to conduct a major national survey on young people in the 1990s and a revised and expanded survey in 2010. Although developed under the auspices of the Population Council, the questions in the survey related to SRH were limited due to the need for government approval of the research tool (Barsoum, n.d Yaakoubd, 2012). According to the findings of the Survey of Young People in Egypt (PC, 2010.), youth in Egypt have limited information about RH. Around 67% of the girls who participated in the survey were shocked when they had menarche and only 3% of youth could identify all modes of HIV transmission (Barsoum, n.d.). The survey confirmed findings by other organizations that access to information about RH remains very limited among young people in Egypt (EIPR, 2009).

The Syrian Commission for Family Affairs (SCFA) commissioned five studies on youth in preparation for the National Strategy of Youth and health behaviour was included as an important component of those studies (SCFA, 2007). It included issues such as nutrition, smoking, drug use and RH. The survey findings revealed that young people's sources of knowledge on health came mainly from the media and pointed that reproductive health and rights should be an important part of any strategy. The survey also identified the need to set the ground for integrated adolescent friendly health services with better participation of adolescents.

Although focus on youth in Syria has been prioritized with a lot of activities at the country level by governmental, grass roots organizations (namely the Syrian Youth Association) and NGOs, it is fair to say that even before the current crisis, health aspects and specifically SRH were very limited in all activities and initiatives and that the beneficiaries were usually the well-off. The SCFA study highlighted the great challenges facing youth in terms of the high school drop-out rates (32%) and the

lack of clear vision for their future. A 2003 MoH study was the first in the country to collect data on the RH of adolescents (MoH, 2003). The study was carried out with secondary school students in three governorates and showed that 13% of the students had not seen a diagram of the reproductive system at school (8% among males and 16.5% among females). Only 5% of the students reported that RH concepts are not taught in the curriculum. Amongst respondents, while 29% of girls and 17.3% of boys expressed a feeling of shyness when concepts of RH are taught in the school. However, 65.7% of all students felt that their knowledge about the reproductive system and puberty is not enough. The MoH study showed that there is lack of knowledge on SRH among Syrian adolescents but also highlighted the sensitivity of the subject as science books that showed the anatomy of the reproductive systems were omitted from class teaching.

In Morocco, a national study conducted among youth in 2006-2007 was a stimulus to develop relevant youth policy (detailed below). One of the first challenges identified was the lack of knowledge about sexual and reproductive changes that occur during adolescence. For example, 52% of young girls in Morocco reported they were shocked when they reached menarche. The study also indicated a lack of knowledge of contraceptive methods as 15% of youth surveyed were unable to name a contraceptive method. A recent study by the MoH showed that youth may be at increased risk for STIs, including HIV, as nearly 40% of young males had their first sexual experience with a sex worker, and only one in four had used a condom (MoH, 2007).

Access to Youth-Friendly Services

In recent years, largely funded by external support, there have been a number of initiatives led by UNFPA and others to initiate youth-friendly services in some Arab countries. However, these services are generally small in scale, not well-advertised and are not national in scope. Moreover, there are barriers to access even where services exist. For example, a study conducted on youth friendly clinics in Egypt revealed that they are under-utilized by youth because of the low visibility of clinics, and also because of parents' restrictions and fear of social stigma as unmarried young people are not supposed to seek information on FP and RH (Oraby, 2013).

In Morocco, FP services provided by the MoH target mainly married women. Morocco is a conservative country and it is inconceivable to have services for unmarried women, who are sexual activity. However, a KAP study conducted by the MoH in 2007 among young people revealed that 12% of unmarried girls aged 15-24 have already had an unintended pregnancy (MoH, 2007).

In Egypt, the priority SRH issues facing young people are early marriage and childbearing, female genital mutilation, and lack of access to RH information and services for unmarried youth (Khalil, Boog and Salem, 2003). There is some evidence from Egypt that the rising housing costs and the costs of getting married, along with other factors such as increasing educational enrolment, are contributing to a rising age at marriage.

The adolescent health program established in the late nineties at the Syrian Ministry of Health is a vertical health program with focus on adolescents aged 10 to 19 years. The program started with introducing pilot youth centres in localities where RH knowledge was being introduced to adolescents among other services. Other services included counselling, computer literacy, and library facilities. Furthermore, the premarital examination was introduced in 2001 and was expanded in coordination with the Syrian Medical Association beginning in 2008 (www.moh.gov.sy). The examination which include testing for infectious and genetic diseases as well as genetic counselling is obligatory for couples about to be married and is an opportunity to provide counselling if needed. Counselling services are also provided by NGOs functioning at the country level such as the Syrian Family Planning Association.

Lebanon has a compulsory pre-marital testing program for some genetic diseases as well as HIV. Since 2000, there has been joint effort between the Lebanese government, civil society and the United

Nations to produce national youth policies and promote the role of youth in society. Some of the key achievements include the establishment of a youth forum for youth policies whose recommendations of which were approved by the government in April 2012. Lebanon has also with UNFPA support, initiated youth-friendly services that include SRH services at a limited number of service delivery points. An interactive website for young people on SRH has also been developed.

Interventions for young people in Tunisia have been supported by a preventive and integrated multi-dimensional plan aiming at: 1) facilitating access to information about SRH with the aim of translating knowledge into responsible health behaviour; 2) providing an adequate environment to initiate and expand a dialogue among youth about risky behaviours; 3) facilitating access to RH services for youth, and integrating these services provided by all health centres, including those located in school and universities; 4) training service providers in effective communication, education and provision of medical services in youth centres; 5) reinforcing cooperation and partnership with all the sectors and organizations working on youth; and, 6) extending the activities to reach other counselling units in the youth centres. Counselling and psychological care have been integrated as major components in the wide range of services provided by the centres of the National Board for Family and Population which established "youth friendly centres" in 22 out of 24 governorates (Ben Romdhane, 2012; MoH, 2004). The services in these centres are fast and free of charge, ensure privacy and are accessible for young girls and boys without distinction of gender.

In Yemen, despite the fact that early marriage is very common, SRH of young married women is under-emphasized and under-researched. Although there have been some youth surveys and strategies for addressing young people's needs, these issues are not addressed in the National RH Strategy for 2011-2015.

School-based SRH education

As a general trend, school-based comprehensive sexuality education programs are lacking in the region although other initiatives are beginning to be implemented. To date, most efforts have been on an extra-curricular basis and there has been strong resistance to integrating comprehensive sexuality education within school curricula. Lebanon has recently made progress in this area with efforts to scale up nationally a sexuality education curriculum led by UNFPA, and in collaboration with the Ministry of Education and Higher Education and the Educational Centre for Research and Development (UNFPA, n.d.)

Morocco and Tunisia are exceptional amongst countries under review for having had SRH education for youth as a central part of their health policy for a long time.

In Morocco in the early 1980s, there was no notion of sexuality education but rather the concept of population was introduced as a multidisciplinary field and in relation to economic, social, cultural and religious issues important within Moroccan society. It took about 10 years (from 1981 till 1990) to have the concept of population introduced into the formal curriculum and to have educational staff trained to deliver the content. The concept was integrated into various study subjects, including Arabic, history, Islamic education, natural sciences and family education; the point was not to overload students with more subjects but rather to integrate the notion of population into various subjects. Family education was taught to girls in preparatory school until 1996 and the textbook addressed human reproduction, STIs, pregnancy, FP, childbirth, infant feeding, physical and mental development of children, childhood diseases, immunization, prevention and first aid. In 1996, it was decided that both boys and girls should take this curriculum as it addresses issues of benefit to both sexes, however, this curriculum was not mandatory and not generalized to all schools in Morocco. In the last year of high school, students learn about human reproduction in Biology class. Topics include the anatomy of the reproductive system in men and women, fertilization, fetal development, contraceptive techniques and the prevention of STIs; this curriculum only addresses the biological aspects of reproduction

(Dialmy, 2010; Kadiri, Moussaid, Tirraf, and Jadid, 2004; Selmaoui, Agorram, Khzami, Abboudi and Berger, 2010).

In addition to formal education, several ministerial agreements were signed between the Moroccan government and UNFPA to promote the concept of education on population through the establishment of an information, education, communication unit within the Ministry of Health and the publication of a newsletter since 1994 called “Attarbiya Assukania” (“Education on Population”) (Dialmy, 2010). However, sexuality education remains a taboo. Religious scholars consider sexuality education and condom promotion for unmarried youth as a transgression of Islam (Beamish and TaziAbderrazik, 2003). Despite advances since the ICPD in sexuality education, Morocco still faces considerable challenges. There is a need to initiate a national debate about sexuality education and its importance to youth. The conservatism of the Moroccan society applies also to teachers whose beliefs deeply influence their way of conveying information (Selmaoui, Agorram, Khzami, Abboudi and Berger, 2010).

Conclusion

There is strong evidence from the countries under review that the SRH needs of young people in the region are many and are not yet being fully addressed. There has been recent progress in generating information and policy development, but the provision of services has been limited to the micro-level and often caters to higher income groups. Moreover, young people have not always been adequately surveyed or involved in the development of services and programs to meet their needs.

IV. SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Reforms to personal status legislation in the Arab region

Tunisia was at the forefront of reform in personal status legislation well before the ICPD. The most noteworthy of these reforms was the Personal Status Code - which abolished polygamy and repudiation (husband's exclusive privilege to end his marriage whenever he desires and without having to refer to the court (Linant de Bellefonds, 1962) , set the legal age of marriage at 15 for girls and at 18 for boys (raised to 17 and 20 respectively in 1964) – and the introduction, in 1958, of free education for all children (girls and boys) that became compulsory to the age of 15 in 1991.

Morocco provides a model of more recent legal reform benefitting women. In 2001, the king of Morocco announced the creation of a royal commission to reform the family code known as “Mudawana.” Members included of the Supreme Court justice, religious scholars, political representatives and intellectuals from a number of different backgrounds, including representatives from women's organizations (Harrak, 2009). The main changes that were brought by the new family code included the change in the legal age of marriage for women from 15 to 18 (same age as men), placing the responsibility of family with under both spouses, and removing the phrase “obedience to husbands” from the list of wives’ duties. The new code also waived the requirement of a marital tutor for women, allowed divorce by mutual consent and made polygamy conditional to the approval of the first spouse (HCP, 2004). Children custody was reformed also to reinforce gender equality; previously boys were allowed to choose their guardian at the age of 12, this age was elevated to 15 to be similar to that of girls. The new Mudawana legally recognized children born to unmarried mothers, who are now able to register their kids in the civil registry and widened legal options to enforce fathers’ recognition of these children (HCP, 2004).

In Syria, the Syrian Commission for Family Affairs (SCFA) has been heavily engaged with religious leaders, parliamentarians, judicial cadres and many NGOs to promote women's rights including reproductive rights (SCFA, 2011). Furthermore, the SCFA undertook a complete review of legislations and laws related to women’s rights and is still working to make changes and amendments to some articles especially the provision related to guardianship (increased in 2003 to 13 years for boys and 15 years for girls), custodianship, inheritance, citizenship and age of marriage (currently the minimum legal age for marriage is 17 for girls).

In Egypt, the government has made considerable steps to reduce gender gaps and improve the situation of women in the society through institutional amendments and legislative changes (UNDP, 2010). In 2000, the Egyptian parliament passed a law that aimed at facilitating litigation process in family disputes. In addition, this law granted the women the right to divorce (Khulaa) provided that they give up their dowry (Al Sharmani, 2007). A family insurance fund was established and family courts became effective in 2004 (NCW, 2009). In the same year, Egypt issued a reformed law which gave Egyptian mothers the right to convey nationality to their children born to foreign fathers (Baitelmal, 2012). Despite these changes, more advocacy work should be conducted to achieve gender equality. The Egyptian personal status law includes gaps such as allowing the husband to discipline his wife and limiting rights of women in ‘Urfi (unofficial) marriages (NCW, 2009).

Lebanon is a particular case because of the sectarian nature of the political system, and the fact that matters of personal status legislation are left to the diverse religious courts. Lebanon agreed and signed the CEDAW convention but kept reservations made on nationality, the Civil Status Law, and on arbitration. The penal legislations are gender-based with a clear distinction between men and women with respect to adultery, rape and so-called “honour crime”. A man is not punished for adultery, while if a woman has an extramarital relationship, she will be penalized by 3 months to 2 years of prison. A man has the right for intercourse even by force with no risk for prosecution. As for honour crimes, in 1999 the law was amended to require a lesser penalty.

Marriage/Divorce/Custody

In 2006, the Basic Law of Oman was promulgated in the Sultanate, prohibiting discrimination on the basis of gender; however continue to face legal discrimination under the Personal Status Law of Oman of the Sharia in all matters of marriage, divorce, inheritance child custody and other matters. The personal status law of Oman is very vague about polygamy; it only specifies that a man should treat all his wives equally which is what is stipulated in the Qur'an. Omani customs still favour practices such as polygamy, women's guardian for marriage who can decide for her such as her father and dowry, all of which negatively impact women's rights (UN, 2011)). Men still decide to whom women should be married and what is to be offered in the marriage context. The head of a family is male and has the full and sole right to decide about marriage, divorce and place of residence. Previously, women were not allowed to obtain a government housing loan or possess government land unless they were widowed, divorced or in charge of their families, but this right was recently granted to women in Oman through the royal decree No 125/ 2008 (UN, 2010).

Although Yemen ratified the CEDAW convention in 1984, there have been few recent legal reforms to improve the legal status of women in Yemen. Polygamy remains legal and women do not have the right to convey citizenship to their offspring if their husband is not Yemeni. Yemen has one of the highest rates of polygamy in the Arab world and approximately 6% of women report that their husband has another wife; this estimated has remained relatively stable over time. Consanguinity (historically a widespread cultural norm in Arab countries) is also persistently high, with the latest figures from the Yemen Family Health Survey in 2003 reporting that nearly half of all marriages are consanguineous.

Legal minimum age at marriage

Age at marriage for women in the region has generally risen over the past several decades, but pockets of early marriage remain. The table below provides details on the legal minimum age at marriage for select countries in the region.

Early marriage is prevalent in Egypt, particularly in rural areas. The legal age of marriage was raised from 16 to 18 (NCW, 2009), however, available data suggests that many girls are married before reaching the legal age. A survey published by the National Council for Women in 2012 showed that 22% of girls were married before the age of 18 (El Masry, 2012). Despite the law amendments, some legislative gaps are being exploited to allow early marriage. While the law requires an official birth certificate to prove the bride's and groom's ages, it is stated that age can be proven using other official document that has the date of birth; the other documents are easily falsifiable and are being used to circumvent the law in Egypt (NCW, 2009). Anecdotal evidence also suggests that 'urfi' (unofficial) and so-called summer marriages are increasing, especially among young Egyptian girls for financial motives (Cattane, 2011; DeJong, Jawad, Mortagy and Shepard, 2005).

Yemen has the lowest average age at first marriage in the region. The latest population-based data for 2003 indicates that 56% of ever-married women aged 20 to 49 married before the age of 18. Advocacy efforts to increase age of marriage for girls have been resisted and as of 2013, there is no minimum age at marriage for girls in Yemen. Yemen's National RH Strategy 2011-2015 states that a Safe Motherhood Law was drafted and presented to parliament for approval included clauses on FGM and early marriage.

In Oman, the legal age for marriage for both men and women is 18; if either the male or the female is below 18 years of age, they cannot register the marriage officially. However, marrying girls below 18 is still socially accepted and widely practiced in Oman, despite the royal decree No 55/2010 that aims to support women's freedom of choice for her marriage and protection from her guardians. According to census data from 2003, 3.7% of girls and 0.2% of boys between the ages of 15-19 were married. (Beyond 2003)

In Syria, there has been considerable advocacy on the issue of early marriage. The legal minimum age at marriage is 18 years for males and 17 for females and it is 13 for females and 15 for males with judicial discretion; the judge may withhold permission for marriage if court finds incompatibility in age between betrothed parties. There have been reports in the media that early marriage is on the rise in the context of the current crisis and the massive flows of refugees to neighbouring countries (www.nesasy.org).

Table 2: Legal minimum age of marriage females in Arab countries¹ (This table has been updated as of February 2009)

Puberty	Age 9	Age 15	Age 16	Age 17	Age 18	Age 20	Unlegislated
Sudan	Gaza	Kuwait West Bank Yemen	Egypt	Syria ² Tunisia	Algeria Djibouti ³ Iraq ⁴ Jordan ⁵ Lebanon ⁶ Morocco	Libya	Bahrain Oman Qatar Saudi Arabia UAE

Notes:

1. All data, unless otherwise noted, has been retrieved from the Women's Learning Partnership for Rights, Development, and Peace (WLP). http://www.learningpartnership.org/legislat/family_law.phtml with information compiled from the Emory Islamic Family Law Project, <http://www.law.emory.edu/ifl/index2.html> (accessed 3 March 2009).
2. In Syria women can be married at 13 with the permission of a judge.
3. UNFPA report on Djibouti acknowledges that the latest Djibouti Family Code legislates the female age of marriage at 18. <http://www.un.org.dj/UNFPA/CP%202003-2007%20DJIBOUTI.pdf> (accessed 18 January 2009).
4. Women can get married in Iraq at 15 with parental consent.
5. A temporary law in Jordan raised the age of marriage for both girls and boys to 18; this remains a temporary law until it is passed and endorsed by parliament.
6. Lebanon allows marriage at younger ages based on religious affiliation or sect. As described on the Emory Islamic Family Law project, "age of capacity is 18 years for males and 17 for females; scope for judicial discretion on basis of physical maturity and wali's permission from 17 years for males and 9 for females; real puberty or 15/9 with judicial permission for Shi'a; 18/17 or 16/15 with judicial permission for Druze". <http://www.law.emory.edu/IFL/legal/lebanon.htm> (accessed 18 January 2009).

Source: Afifi, R., DeJong, J., Bose, K., Benkirane, M., Salem, T. and Awad, A. (2012). *Adolescent and Youth Health: Challenges and opportunities in Jabbour, S., Giacaman, R., Khawaja, M. and Nuwayhid, I. (Eds). Public Health in the Arab World. Cambridge University Press.*

Maternity leave

Maternity leave is one of the issues of utmost importance to working mothers. Women's participation in the labour force in the Arab world is one of the lowest in the world (Seif El Dawla, 1999). There has, however, been good advocacy on this issue in many of the reviewed countries and in some cases, progress has been achieved since the ICPD in some cases.

In Syria, in 2002, the law for maternity leave was amended to increase paid maternity leave to 120 days for first-time mothers, 90 days for second-time mothers, and 75 days for third-time mothers, with hours for breast feeding for one year after this period.

In Oman, employment laws have been amended to grant women 50 days that can be taken in the pre-and/ or post-natal period. A special leave without pay of up to one year can be granted to women who request it to care for their child in the first year of life. By law, no employer can dismiss a woman because of her pregnancy or delivery (UN, 2010).

In Morocco, changes that encouraged greater participation of women in political activities were accompanied by a decree to prolong the duration of maternity leave for women. Additionally, various

reforms were introduced to the code of work including the sanction of sexual harassment at the workplace (HCP, 2004).

In Tunisia, regulation related to pregnancy and childbirth was strengthened in 2000 by extending the duration of maternity leave, and by requiring employers to give a prenatal leave if requested by the employee. Women who are employed have a right breastfeeding leave (2 half-hour sessions per day during working hours) for a period of one year starting from the day of birth. In workplaces that employ at least 50 women, a special room has to be reserved for women to breastfeed their babies (PEEHF, n.d.; UN, 2000; TECA, 1994).

Table 3: Maternity leave policies in Arab countries

Country	Public / Private sector	Duration of maternity leave	Report Year
Algeria	Public and private sectors	3 months, full pay	2010
Bahrain	N/S	60 days, pay N/S	2010
Djibouti	N/S	14 weeks, full/partial pay	2005
Egypt	N/S	90 days full pay	2010
Iraq	Public sector Private sector	6 months 72 days	2010
Jordan	Public sector Private sector	90 days 70 days	2010
Kuwait	Public and private sectors	40 days, full pay; additional 4 months, no pay (conditional)	2010
Lebanon	Public sector Private sector	60 days, full pay 7 weeks, full pay	2010
Libya	Public and private sectors	3 months, full pay	2010
Morocco	Public and private sectors	12 weeks, full pay	2010
OPT	Public sector and private sectors	10 weeks, full/partial pay	2010
Qatar	Public and private sectors	50 days, full pay; additional 60 days, no pay (conditional)	2010
Saudi Arabia	N/S	10 weeks, full/partial pay	2010
Syria	Public and private sectors	120 days for 1st child 90 days for 2nd child 75 days for 3rd child (pay N/S)	2010
Tunisia	Public sector Private sector	2 months, full pay 30 days+15 days conditional	2010
Yemen	Public and private sectors	60 days, full pay	2010

N/S: Not Specified

Sources:

The Freedom House Report. Women's Rights in the Middle East and North Africa 2010.
<http://freedomhouse.org/template.cfm?page=384&key=270&parent=23&report=86>

Conveying citizenship

One critical issue taken up by the women's movement throughout the Arab region has been the inability of women to convey citizenship to their offspring; if their spouse is a non-national, the children can only be the citizens of the father's country. This often deprives them of social and economic rights including access to public education.

Of the countries reviewed in this report, overall progress has been made on this issue in Egypt (in 2004), Morocco (since 2007), Tunisia, and also in Algeria. The issue has not been addressed and therefore no progress has been made in both Oman and Yemen. In Lebanon, despite active civil society advocacy, this issue it has become mired in wider political problems concerned with the sectarian balance of the country's population. Women conveying citizenship to their offspring has also been a subject of considerable advocacy in Syria before the current conflict but as yet no progress has been made (www.scfa.gov.sy).

Female Genital Mutilation/Cutting

Female genital mutilation/cutting (FGM/C) is only practiced in four countries in the Middle East and North Africa region – Egypt, Oman, Sudan and Yemen. However, cases have been reported in other countries and there has been some anecdotal evidence of a resurgence of recommendations for the practice in Tunisia. In countries where it is practiced, it is sometimes misunderstood as being recommended by Islam, although in Egypt it is practiced among both Muslims and Copts. Female genital mutilation/cutting is not practiced in Saudi Arabia.

Following the ICPD, FGM/C became a highly politicized issue in Egypt. During the conference week, CNN aired a film showing a circumcision that was performed concomitantly; this movie shocked the world and embarrassed the Egyptian delegation that was claiming that the practice was fading in the country. A taskforce of civil society organizations and individuals was created in 1994 to end the practice in Egypt. After the ICPD, FGM/C became a women's rights issue and efforts were made to understand the social constructs of FGM in order to initiate social debates and induce a change in attitudes and behaviours related to it. The fight against FGM became a symbol for women's struggle to accomplish their rights and achieve gender equality (www.who.int). The Ministry of Social Affairs eventually took up the issue and began training and awareness programs at a national level. This is an example of how civil society organizations galvanized attention to an issue that was subsequently taken up by the public sector. The fight to end FGM met strong resistance as, for some in Egypt, the perpetuation of FGM/C was a means to resist western cultural invasion. The advocacy work conducted under the umbrella of the FGM taskforce resulted in a decree issued by the Minister of health to ban the practice. The decree banning FGM was challenged in court by religious spokespersons but the case was lost in the lowest court and the Minister of health won the appeal. FGM/C has been a banned practice in 1997 (www.who.int). Prior to this decree, the practice of FGM/C was allowed by physicians and led to the deaths of several young girls in hospitals because of hazards associated with the practice, even in medical settings.

The 1995 Demographic and Health Survey in Egypt found the practice to be virtually universal among women of reproductive age. According to the latest national Demographic and Health Survey in 2008 (El-Zanaty and Way, 2009), 91% of all women aged between 15 and 49 years have been circumcised. Nevertheless, trends suggest that this practice may be on the decline; in the age group below 25, as the circumcision rate is around 80% compared to 94-96% in the 25-49 age group. Attitudes towards

FGM/C also seem to be changing, as indicated by a reduction in the percentage of women who believe that this practice should continue from 82% in 1995 to 63% in 2008.

In Oman, laws prohibit the practice of FGM/C, yet it is still accepted and practiced. There are no data about the prevalence and extent of FGM/C practice in Oman. The National Health Survey conducted in 2000 showed that FGM/C is accepted by 85% of women and 53% have undergone this procedure (UN, 2010). In various cultures FGM/C is believed to purify the girl, help prevent illicit sexual activities and be an act of modesty (UNICEF, 2012). Yet, perception about necessity of FGM/C was found among 80% of respondent which affirms its original cultural roots (UN, 2010). Recently there have been discussions between the Mufti of Oman and the Ministry of Health around Fatwas against FGM/C to abolish the practice (Hessini, 2007).

In Yemen, although the Ministry of Public Health and Population passed a decree prohibiting FGM/C, the procedure is still practiced.

Abortion

In the countries under review, there has been some advocacy on the issue of safe abortion; however, there have been minimal revisions to abortion related legislation. Tunisia remains the only Arab country to have legalized abortion on demand but since its popular uprising there has been heated debate on whether the progressive laws should be amended. The legalization of abortion in Tunisia dates back to the Bourguiba period; in 1965, abortion was legalized from the 5th child and in 1973, abortion became legal irrespective of the number of children.

Table 4: Legal Grounds for Abortion in Arab Countries

Risk to women's life	Risk to physical health	Risk to physical and mental health	Fetal impairment	Rape or Incest	All grounds in first trimester
All countries except South Sudan		Algeria	Sudan	Sudan	Tunisia
		Morocco	Oman		Bahrain
		Jordan	Jordan		
		Kuwait	Kuwait		
		Qatar	Qatar		
		Saudi Arabia			
		UAE			

Sources:

http://www.un.org/en/development/desa/population/publications/pdf/policy/WorldAbortionPolicies2013/WorldAbortionPolicies2013_WallChart.pdf

Abortion remains illegal in Morocco, however anecdotal data suggests that about 600 abortions are conducted every day in the country, out of which 200 are conducted with no medical assistance (Aufait, 2012). An NGO was created in 2008 to advocate for safe abortions and legalization of abortion in Morocco and in 2010, it hosted the first conference on unwanted pregnancies in Morocco. The national RH strategy elaborated by the MoH mentioned the illegal nature of abortion without suggesting

measures to change it or listing statistics to evaluate its magnitude (MoH, 2011). Conservative political parties, currently in power, show resistance to the idea of having a law to legalize abortion. The Minister of Social Development, Women, Family and Solidarity suggested holding a referendum to gauge the views of Moroccan society on the issue (Chraïbi, 2010).

In Syria, a study on unmet needs noted that 3.9% of women reported having had at least one induced abortion in their reproductive lifetime (UN, 2005). This study identified that 92% of induced abortions were carried out by qualified doctors in safe circumstances, although abortion is illegal in Syria. In accordance with the Syrian law contraceptive methods as well as abortion are prohibited and are both subject to penalty. Extensive efforts by general women's union and other women's NGOs to change the law have been met with no success so far (UNS, n.d.).

Abortion is illegal in Egypt according to the Egyptian Penal Code of 1937 but can be allowed in exceptional circumstances in order to preserve the life of the woman (EIPR, 2009). Both pregnant women and healthcare professionals involved in the abortion procedure are subject to imprisonment (www.ems.org.eg; EIPR, 2009). The code of ethics of the medical profession stipulates that doctors are allowed to perform abortion for medical reasons threatening a woman's life, provided that they receive a written approval from two other specialist physicians (Lane, Jok, and El-Mouelhy, 1998.). Despite these restrictions, clandestine abortions are reportedly frequent in Egypt but there are no official estimates of the incidence of abortion in Egypt (Huntington, Nawar, Hassan, Youssef and Abdel-Tawab, 1998). A hospital-based study conducted in 1998 revealed that one in five obstetric cases were associated with post-abortion treatment and this drained important resources for emergency medical treatment of other obstetric conditions (Huntington, Hassan, Atallah, Toubia, Naguib and Nawar, 1995). Since the ICPD, no changes have occurred at the legislative level regarding abortion in Egypt. However, the MoH has invested in improving the quality of post-abortion care in collaboration with international organizations. An operations research study was conducted in 1995 to improve post abortion medical care, through training of health providers on the use of manual vacuum aspiration (MVA), and counselling of post-abortion patients. Using pre- and post-interventions surveys, the study showed the improvement of providers' and women's knowledge about post-abortion complications (UN, 2011).

Clandestine abortion is still practiced in Oman which increases the risk of maternal complications. By law, abortion is permitted on strict medical grounds to save the life of the mother or in the case of severe congenital fetal abnormalities. Moreover, the abortion should be performed before the seventeenth week of pregnancy, and the state covers all health care expenses for such abortions (UN, 2010; UN, 2011).

With regards to abortion in Lebanon, statistics are poor and virtually non-existent. Abortion is religiously unacceptable and illegal. The Lebanese law affirms that abortion should only be performed to save the mothers' lives. Unless unconscious, the woman should consent for the abortion and two physicians confirm that the intervention is life-saving. In Lebanon, clandestine abortion is still performed which increases the risk of mortality. Moreover, access to safe abortion is highly inequitable in that those who have the ability to pay are able to access high-quality abortion care but that is not true for most women (Inhorn and Tremayne, 2012).

Reproductive rights of foreign domestic workers

One major issue that needs further research and policy attention in the Arab region is the reproductive rights of foreign workers (largely from Asia and Africa) who work as migrant workers mainly at a domestic level in the region. While there has been some progress on social and economic rights of these workers, as detailed below, their reproductive rights and broader access to health care has been minimally addressed. Instances of violence against migrant women and women's trafficking have been

reported by the media (Boy and Kulczycki, 2008) but by and large have not been researched because of political and legal restrictions which make it difficult to obtain any information on the issue.

A law to defend the rights of domestic workers was issued in Syria in 2010 and this law secures their rights to health and RH services (<http://www.dw.de/foreign-domestic-workers-suffer-abuse-in-mideast/a-16423615>).

Gender-based violence

Research that attempts to measure the level of violence against women in the Arab region is relatively recent and comparisons across surveys are made difficult by the different definitions used (Boy and Kulczycki, 2008) ; nevertheless this is a topic that is increasingly being focused on by researchers, advocates and policy-makers. In the 1990s, DHS surveys, in some countries began to introduce a module on women, including questions on domestic violence against women. In addition, some governmental surveys have also included questions on this topic, although most studies performed in the region on violence against women have been on defined populations (such as refugees), have been at a small-scale, and have focused on violence against ever-married women. A recent study also explored violence against never-married women in the occupied Palestinian territories using data collected by the Palestinian Central Bureau of Statistics (Assaf and Chaban, 2013).

In general, North African countries have been ahead of those in the Mashreq and Gulf regions in measuring, reporting on, advocacy and taking action on violence against women. In virtually all settings, NGOs and women's organizations in particular have taken the lead in advocating for further attention to this issue.

In what follows we briefly summarize the situation in each of the countries under review:

In Egypt, available data on gender-based violence suggests that it is quite widespread. The DHS of 2005 found that 36% of women have experienced some form of marital violence and 24% had experienced violence in the year preceding the survey (El-Zantary and Way, 2006). Moreover, in recent years, Egypt has witnessed a growing phenomenon of sexual harassment in public spaces; women are trapped in closed circles and molested (EIPR, 2009). There is legislation in Egypt that criminalizes violence against women, however, efforts are needed to explicitly criminalize marital violence, which seems to be high and mostly underreported (NCW, 2009).

Gender based Violence in Morocco

Morocco remains a patriarchal society (Beamish and TaziAbderrazik, 2003), where women and girls are under males' guardianship from birth until death (LDDE, 2000). Despite the political engagement and the legal advances to promote gender equity and fight against gender based violence (see below), the social perceptions of gender roles and Moroccan traditions remain a barrier to achieve this goal.

Violence against women is widespread and culturally acceptable in Morocco. According to a study conducted in 2009 by the Haut Commissariat au Plan (HCP), 63% of women aged 18 to 64 in Morocco were subjected to violence. This was the first study addressing violence against women in the country. It revealed that in more than half of the cases, women were subject to violence by their husbands and only 3% of women reported it (HCP, 2009). Another report released in 2011 about human rights violations in Morocco reported that husbands are responsible for 8 out of 10 violence cases towards women (www.state.gov/documents/organization/160470.pdf). Moreover, there is a general acceptance of marital violence and a mistrust of the judicial system.

Violence against women in Morocco relates also to their personal freedom. According to the 2009 study, 68% of women need to permission family member to go out to a public space (HCP, 2009).

13% of women surveyed stated that they are not free to wear whatever they want; husbands are the ones to decide what women should wear, followed by fathers, mothers and brothers.

Another challenge in addressing violence is the absence of a law that prohibits domestic violence. However, with the changes in the family code, physical abuse could be a legal justification for divorce. The problem is that authorities are reluctant to implement the law on husbands who are violent against their wives and it is rare for police to intervene to address domestic problems. NGOs report that courts rarely prosecute husbands due to societal concerns and conservative aspect of Moroccan families (www.state.gov/documents/organization/160470.pdf).

There are no statistics on child abuse in Morocco, but anecdotal data suggest that abuse of female domestic workers is still an issue (www.state.gov/documents/organization/160470.pdf). The media, NGOs and the UNICEF in Morocco publically condemn violence cases against young domestic workers, which they claim to be widespread (UNICEF, 2014).

Actions taken by Moroccan government since 1994 to fight again gender based violence could be categorized into three levels:

At the institutional level

In 1996, the State Secretariat for social protection, family and children was created to address gender related matters. The creation of this body was a frank expression of the government's commitment to gender. Through this body, funds were allocated to support civil society activities such as the establishment of listening and counselling centres that provide psychological and legal support to women victims of violence. Fifty-eight NGOs benefited from this fund in 2003 and 175 in 2004.

In 2002, a national strategy was established to address violence against women, using a participatory approach that involved civil society and governmental organizations (HCP, 2004). The strategy highlighted priority issues in terms of gender-based violence including the need for legislative reforms, care and follow-up of women victims of violence, the creation of structures, education, awareness and social communication, research and a multisectorial approach, capacity building of human resources and development of a general policy against violence (SEFF, 2005). In 2004, an operational manual was developed to describe the implementation steps of the strategy.

Consideration of gender as a cross-cutting issue within various governmental bodies. This was corroborated for instance by the creation of a committee within the Ministry of Justice to address gender-based violence. It aimed at observing and analysing judicial issues related to violence against women and children (HCP, 2004).

In 2006, a consortium of NGOs created a national Observatory to track different types of violence against women to reinforce data generation, documentation and synergize the collaborative efforts of civil society organizations to better advocate against gender based violence.

Establishment of a governmental hotline dedicated for women victims of violence.

At the legislative level

Morocco removed the reservations it had on the CEDAW and ratified it and published it in its official bulletin in 2001 which was another expression of the country commitment to gender equity. The judicial reforms of the penal code in 2003, work code in 2004 and family in 2004 supported the governmental efforts towards promoting gender equity and ending gender-based violence. A law project was adopted by the council of the government in 2013; this law specifies work conditions for domestic workers. The project aims to define the relationship between employers and employees and to guarantee the protection of the social and economic rights of domestic workers. The law was suggested mainly to protect young girls working as "servants" from various forms of violence. The law criminalizes the labor of girls below 15 years of age (Yabiladi, 2013).

At the advocacy level

- Launch of the first governmental campaign about violence against women in 1998, in collaboration with civil society actors.
- Launch of hotlines for victims of violence.
- Revision of school curricula in order to improve the perceptions of women's rights (HCP, 2004).

In Lebanon, the Women's Affairs department created under the Ministry of Social Affairs (MoSA) in 1993 is charged with the formulation and institution of programs that aim to empower women. Among the projects conducted is "Families without Violence: a Safe and Sound Society" that aims to fight domestic violence against women, children and older adults. The department also works on modification of laws and regulations like its participation in the draft law on protection of women against domestic violence in 2010 (UNFPA, 2010). It has also collaborated with civil society institutions, in the training of social workers and counsellors to provide support to victims of violence. NGOs in Lebanon have been the most active on the issue, such as the NGO KAFA ('enough'), having established hot-lines and run national campaigns on the issue.

Tunisia is one of the countries of the region that has been the most active on the issue of violence against women. Figures on gender-based violence, which have been more recently and newly estimated, highlight that more than a third of women experience violence. A national survey was conducted in 2009 to evaluate how women victims of violence are received and cared for in health centres. It identified a number of important gaps such as: 1) Inadequate screening and identification of such women; 2) Unsatisfactory and diverse information systems; 3) Non-operational referral system to other health services in the absence of a clear task distribution; 4) the large number of consultations which overloads service providers and affects quality of care. (For example, the survey estimated the number of women victims of violence at 300 per day in the emergency services of the Grand Tunis which covers 4 governorates close to the capital); 5) the absence of information, education and communication (IEC) strategies in primary health centres. Recommendations included legal and social support as a necessary element of care in the health sector and improved efforts to involve other stakeholders. The lack of social support including accommodation and employment was highlighted as a weak aspect of the strategy.

Tunisia developed a National Strategy for prevention of violent behavior within the family and the society: Gender-based Violence throughout life cycle in Tunisia (MAFFEPA, 2009). The added value of the strategy is the harmonization of interventions of the partners of the Ministère des Affaires de la Femme, de la Famille, de l'Enfance et des Personnes Agées (MAFFEPA) against gender-based violence through better targeting of activities. This is expected to improve the Woman's Personal Status Code which represents one of the major objectives of the independent Tunisia and that has been promulgated in 1956. Within this strategy, the MAFFEPA, the Tunisian Association of Democratic Women and the National Board for Family and Population set diverse field interventions that include listening units, a hotline, screening and orientation in the existing RH services as well as several surveys that explore the victims' profile, the types of violence and their determinants. The findings regularly inform decision-makers and program managers who use them to sensitize public opinion through media activities and to tailor other interventions.

In Oman, there is no law with regards to domestic violence, but the Ministry of Social Affairs conducts individual investigation of cases and provides shelter to women victims of violence. However in the absence of an efficient mechanism for reporting of incidents/perpetrators, cases are under reported, hence deficiency in related documentation (UN, 2010).

In Syria, a population-based study carried out by the Syrian Commission for Family Affairs (SCFA) in 2011 found that nearly one half of the sampled women had been subjected to violence (SCFA, 2011). Amongst all women surveyed, 22% had experienced domestic violence. Symbolic violence at

work or in the community such as bullying and other manifestations accounted for 52% of all gender-based violence in Syria while emotional abuse accounted for 26% and physical violence accounted for 18% followed by sexual violence which accounted for 4%. Approximately half of the survey participants pointed out that they cannot leave their home without being accompanied by a family member while four out of ten women were prohibited from working outside home. The initiative of the SCFA to have a national observatory of domestic violence was a step forward. Syria still lacks shelters for battered women. An NGO known as Sisters of the Good Shepherd run one shelter with good services, however, its capacity is limited (UNS, n.d.). Human rights were introduced into higher education teaching by a ministerial policy (Bashour, 2010). More importantly, a recent change in law (2009) concerning honour killings has increased the penalty for perpetrators, but women activists in the country continue to push for further amendments (<http://sana.sy/ara/2/2009/07/02/pr-233705.htm>).

In its 2007 report on Yemen, the CEDAW committee remarked on the absence of a systematic approach to collecting data on violence against women in Yemen and that both violence against women and marital rape are accommodated within the Personal Status Act and that there is no separate legislation on domestic violence. Article 232 of the Penal Code stipulates that a husband who kills his wife on suspicion of adultery should not be charged with murder. In 2001, Oxfam initiated a network of NGO and governmental organizations to work on the issue of gender based violence, and in 2004 hosted the first seminar on the topic in Yemen. Population-based data does exist on violence against women although the figures may be subject to under-reporting. In the 2003 Yemen Family Health Survey, 5% of women reported they were beaten mainly by the husband (56%) compared to the father, brother or other members of the family (not mentioned whether male or female). Family disputes were cited as the most common reason. Due to social norms and customs, an abused woman is expected to take her complaint to a male relative rather than the authority to intercede on her behalf or provide a sanctuary if required. Half of the victims complained to a relative while 5% notified the police (although there is no mention of any action taken), while 33% kept silent. Of those who reported abuse, 83% mentioned they did not receive any medical care. Some telephone hotlines were set and operated in Sana'a and Aden but with moderate success and a small shelter exists for battered women in Aden.

Conclusion

It is difficult to generalize across the study countries about the progress in this area. Outstanding examples of reform of personal status legislation exist, such as the major reform undertaken by Morocco documented here. There has also been some significant legal reform in a number of countries around marriage (such as legal age at marriage), divorce and custody and on conveying citizenship in some but not all countries. Egypt has made significant progress on the issue of female genital mutilation/cutting, sparked in large part by the public debate stimulated by the ICPD in 1994. One issue on which there has been little progress, however, is abortion which remains a highly sensitive and politicized issue in the region. In addition, the SRHR situation of foreign female domestic workers working in the region needs much further investigation to offer them more protection than is presently the case.

V. CONCLUSIONS

There are many barriers to implementing the ICPD agenda which lie in the institutional, social and political context of the region. These need much more analysis than has been the case to date. The 20 years since the ICPD have certainly seen governments in the region much more willing to address issues of SRH in terms of policies and programs. Often these governmental initiatives have been led by NGOs and women's organizations at a small-scale, and then have been taken up by governments with international donor support. The ICPD gave prominence and a public platform to the role of NGOs which was very important in countries with authoritarian political systems. Although NGOs which are active on SRH are fairly limited in the region, their particular strength is their advocacy role in demanding greater attention to these neglected issues and their ability to voice the perspectives of women. NGOs often face particular constraints in the political context of the region. Moreover, there is some evidence that NGOs were often marginalized after the ICPD (as was illustrated in Egypt). Women's organizations suffer from many of these same problems, but women's movements are further constrained by on-going polarizations along religious, political and other lines. Women's movements and organizations need to be strengthened in general particularly concerning their engagement with issues of SRHR. Much of the advocacy efforts of NGOs has been focused on specific issues and is highly dependent on donor funding.

As members of a research network, we also note that there needs to be better engagement in the region between research institutions, civil society organizations and governments.

Our general concern emanating from this review has been that there is a lack of deliberate effort to build up the SRHR field as a whole and strengthening the role of institutions within the region whether from a research, advocacy or program perspective. Rather, the last 20 years has seen a fragmentation of the field into specific issues. The focus on the MDGs has been one element of this trend, as have been donor priorities. Work is needed to promote a broader concern and commitment to SRHR as an integral field in the post-2015 plan forward.

Finally, we have witnessed first-hand the devastating impact of conflicts in this region on the SRHR situation. This has severely impacted the SRHR of displaced populations resulting from conflict, and yet does not appear to be a central element of the response to humanitarian emergencies in the region. But the consequences of conflicts have also dominated policy priorities in general and diverted resources, thus affecting all national health systems and their ability to deliver SRHR services to all in diverse ways. This area needs much further research and given that the region has been characterized by periodic and intense conflicts, addressing its effects on SRH should be more central in the region in policies, services and educational programs.

RECOMMENDATIONS

- 1) Sexual and Reproductive Health services in the region continue to show good improvement and there have been some successful areas. However, services are challenged by lack of integration and inequity in access as well as questionable quality. We thus urgently call for integrated SRH services in the countries of the region making sure that access to those services is not distinguished between socio-economic levels, urban or rural residence or between different age groups. It is of utmost importance to improve the quality of services.
- 2) Our analysis showed that most of the work in the region is driven by the international agenda and funding. It is of utmost importance to hold governments and their partners accountable and to make sure that all services are based on appropriate and contextual needs assessments that includes the views of key stakeholders. Research and action into neglected areas such as infertility and maternal morbidities need to be addressed.
- 3) Youth constitutes a large segment of population in our region and though many countries started to introduce some components of adolescent health, it was noted that those services are patchy and not fully integrated in the health system. Defining priorities for specific policy areas and actions for engaging youth in shaping their SRH is needed. All stakeholders need to tackle the challenges and dilemmas of introducing SRH services for young people.
- 4) Policies and projects on Sexual and Reproductive Rights were introduced in some countries in the region. Pioneer examples and some successes were noted from the region. However, it is of utmost importance to work to assure those rights in a more comprehensive manner. All efforts by all stakeholders are needed to ensure the following:
 - a) Prevention of early marriage of girls through projects and programmes that takes into consideration the circumstances and needs of girls themselves, their parents and communities including men.
 - b) Prevention of harmful practices such as FGM. All efforts need to be taken in countries where such practices are implemented
 - c) Abortion has been stigmatized in the region for cultural and religious reasons and needs to be handled with special care making use of integrated services. Legislative reform is needed.
 - d) As the number of migrant workers is high in the region, it is very important to advocate for the SRH rights of those migrant workers. Special policies need to be considered.
 - e) There is a need to develop comprehensive sexuality education as an integral part of school curricula.
 - f) There is a need to develop a comprehensive strategy to prevent Gender based violence in the region.

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DRAFT for discussion

APPENDIX

Country		Egypt			Lebanon			Morocco			Oman			Syria			Tunisia			Yemen		
Year		1990	2000	2010	1990	2000	2010	1990	2000	2010	1990	2000	2010	1990	2000	2010	1990	2000	2010	1990	2000	2010
Health Indicator																						
% births attended by skills personnel		37	61	79		98 ¹ (2004)	-	31 ¹ (1987-1991)	63 ² (1998-2002)	73.6 ⁴	-	-	95.4 ¹ (1993)	89.7 ³ (2001)	96 ¹ (2009)	76 ² (1994)	90 ³ (2006)	95 ¹ (2006)	83 ^{of} births at home; 12% in health facilities and 16% attended by medical personnel (1991, ref 1)	22 ⁵ (1997)	35.7 ⁵ (2006)	
Antenatal care	At least one visit	39	503	74	87 ² (1995)	96 ² (2002)	-	24 ¹	37 ² (1998-2002)	44.4	57.6 ²	64.9 ²		51 ¹ (1993)	70.9 ³ (2001)	96 ¹ (2009)	71 ² (1994)	91.9 ⁴ (2002)	96 ¹ (2006)	34 ⁵ (1997)		47 ⁵ (2006)
	≥ 4 visits	28	37	66	-	-	-	8 ¹	31 ² (1998-2002)	55.3	-	96.4 ⁴		n/a	58.3 ⁴ (2001)	Papfam 3 average no of ac visits is 5.3 with overall coverage of 87.7	13 ² (1994)	71.4 ⁴ (2002)	64.2 ⁵ (2006)	11 ⁵ (1997)	11 ¹⁰ (1999)	14 ⁵ (2003)
Postnatal care (≥ one visit during the 2 months after delivery) %		-	58 (2005)	30		50 ¹ (2004)		n/a	6.6 ²	22 ⁴	-	1.3 ²	1 ²	n/a	22.9 ³ (2001)	27.2 ² (2009)	14 ² (1994)	48.9 ⁴ (2002)	59.3 ³ (2006)	6 ¹		13.8
	Overall	47	56	60	61 ²	58 ¹ (2004)	53.7 ³ (2009)	36 ⁷ (1987)	58 ² (1997)	67.4 ⁴ (2011)	28 ³	32 ⁴	24.4 ⁴	40 ^{1,5} (1993)	46.6 ⁵ (2001)	58.3 ^{1,5} (2006)	60 ² (1994)	62.6 ⁴	60 ³¹ (2006)	21 ⁵ (1997)		27.7 ⁵ (2006)

Contraceptive prevalence rate (%)					(1996)												(2002)					
	Traditional contraception	2	2	3	-	66 ¹ (2004)	8.9 ³ (2009)	7 ⁷	6 ² (1997)	10.6 ⁴ (2011)	7 ⁵	-	9.1 ⁴	14.2 ⁵ (1993)	11.5 ⁵ (2001)	15.7 ⁵ (2006)	9.8 ² (1994)	9.6 ⁴ (2002)	-			
	Modern contraception	45	54	58	37 ² (1996)	34 ¹ (2004)	44.8 ³ (2009)	29 ⁷	52 ⁷ (1997)	56.7 ⁴ (2011)	21 ⁴	24.6 ⁶	15.3 ⁴	25.7 ⁵ (1993)	35.1 ⁵ (2001)	42.6 ⁵ (2006)	49 ² (1994)	53 ⁴ (2002)	52 ³¹ (2006)	7 ¹ (1991)	13.4 ³ (2003)	19.6 ⁴ (2006)
Abortion rate (%)								n/a	n/a	n/a	20.8 ²	11.9 ²	10.8 ⁴	n/a	n/a	n/a	-	-	15 ²² (2011)			
Adolescent birth rate (per 1,000 women 15 to 19 years) (‰)		59	55	43				23.2 ⁶	28.5 ⁶	18 ⁵ (2005)	-	-	14 ⁸	61 ¹ (1993)	75 ¹ (2004)	1	-	-	6 ³	66 ⁵ (1994))	102 ²	80 ⁵ (2005)
Percentage of births that are to teenagers (%)																				14 ¹)of women aged 15 – 19 percentage who are mothers or currently pregnant	9.4 ³ (2003)	8.5 ⁴ (2006)
Adolescent delivery rate (%)					26 ² (1995)	18 ² (2001)	-				-	-	14 ⁸	n/a	n/a	11.6 of 15-19 married women in papfam 3	16 ¹⁵ (1988)	3.2 ⁹ (1996)	1.5 ¹⁰ (2006)			
C section rate (population-based) (%)		7	10	28	-	23 ¹ (2004)	-	2 ¹	5.4 ⁴	16 ⁴		9.7 ²	16.4 ⁷	The cesarean section rate was 12.7 in governmental hospitals,	14.8 ⁶ (2000)	n/a	9.9 ² (1994)	18.5 ⁴	21 ¹⁴ (2006)	11.2 ¹ (1991-2)	6.3 ² (1997)	1

													and 22.9% in private hospitals In 2000									
HIV prevalence among women (15-24 years)		0.1	0.1	0.1	-	-	0.1				18 ²	17 ²	8 ⁷	n/a	n/a	n/a	n/a	-	< 0.1 ⁶ (2009)	n/a	n/a	n/a
Incidence of HIV among women (number of cases)					-	-	-				59 ⁷	105 ⁷	55 ⁷	n/a	n/a	90 ⁷ (1987- June 2010)	n/a	16 ⁵	25 ⁵	n/a	n/a	n/a
Anemia among women in reproductive age (%)			28	39	-	16 ¹⁴ (2003)	-		5.8 ²		-	30 ⁶	-	-	40.6 ⁸ (1997)	-	-	34.9 ⁷	-	n/a	n/a	n/a
Anemia among pregnant women (hb < 110g/l) (%)					-	20 ¹⁵ (1998)	32 ¹⁵ (2005)				27.9 ²	42.7 ⁶	27.9 ⁷	-	40.6 ⁸ (1997)	39.3 ⁹ (2009)	-	32.3 ⁷	-			
Smoking among women (daily) (%)			0.7	0.3	-	16.5 ¹ (2004)	27.6 ¹⁸ (2008)	9.1-14.9 ⁹	0.6 ¹⁰	3.1 ⁸ (2009)	1.5 ¹²	-	1.3 ¹³	-	-	8 ² (2009)	-	-	6.6 ⁸	n/a		12.8 ³ (2002)
First and second most common cancers among women(%)	First				-	Breast ¹ 37 (2004)	Breast ⁴ 38.9 (2007)		Breast ⁴ (2004) 47.3/ 100 000 women	Breast ⁴ (1993- 1997)	-	-	-	Breast ¹⁰ 30.6 (2002- 2007)	-	-	Breast ²¹ 27.5 (2008)	Breast ¹⁷ 26 (2008)		Uteri ne ⁶ (2003)		
	Second				-	Uterus ¹² (2004)	Lips, Oral Cavity, Pharynx (13.3) ⁴		Cervix ⁴ (2004) 13.5/ 100 000 women	Cervical ⁴ (1993- 1997)	-	-	-	Leukae-mia ¹⁰ 6.9 (2002- 2007)	-	-	-	Cervix ¹⁷ 6 (2008)		Breast ⁶ (2003)		
Social and demographic indicators																						

Population size		55,768,000	63,305,000	77,840,000	2.703 ⁵	3235 ⁵	4341 ⁵	24,167,000 ¹¹	28,466,000 ¹¹	31,894,000 ¹¹	1810 ¹⁴	2193 ¹⁴	2803 ¹⁴	11.531782 ¹¹	18.352953 ¹¹	23.531195 ¹¹ (2009)	8.215 ¹		10.5471 ¹¹	11,948 ⁵		24,053 ⁵
Proportion of youth (%)																	20 ¹	27.9 ³⁹	19 ¹			
Population growth rate (%)		1.7	2.11	2.3	3.2 ²	1.7 ⁶ (1996)	1.8 ⁷	2.2 ¹² (1980-1990)	1.7 ¹² (1990-2000)	1.1 ¹² (2000-2010)	3.6 ¹¹		2.7 ¹¹	3.3 ¹¹ (1947-1994)	2.7 ¹¹ (1995-2000)	2.5 ¹¹ (2006-2007)	1.1 ¹ (1990-1995)	1.10 ²⁰ (2003)	1.3 ¹¹	4.7 ⁵		3.1 ⁵
Life Expectancy at birth	Male							63 ¹⁹	67 ¹⁹	73.9 ¹⁴ (2009-2010)							68 ¹	-	72 ¹			
	Female							66 ¹⁹	71 ¹⁹	75.6 ¹⁴							72 ¹	-	76 ¹			
Total Fertility Rate (%)		4.4 (1988)	3.5	3.0 (2008)	3.1 ²	1.9 ¹	1.9 ⁷	5.5 (1982)	3.3 (1994)	2.2	8 ¹⁰	4.8 ⁶	3.3 ⁷	5.1 ¹¹ (1991-1995)	3.58 ¹¹ (2004)	2.9 ¹	3.6 ¹	2.0 ¹⁹	2.0 ³	8.7 ⁵ (1990)	7.7 ¹ (1991)	5.2 ⁵
Maternal mortality Ratio (per 100000 live births)		174 (1992)	84 (2005)	55 (2008)		86.3 ¹	23 ¹⁷ (2009)	332 ¹ (1987-1991)	227 ² (1994-2003)	112 ³	-	16.1 ¹⁵	26.4 ⁹	107 ⁵ (1993)	58 ⁵ (2004)	52 ¹² (2009)	130 ¹	84 ¹	56 ¹	610 ⁵	380 (YFHS 2003)	200 ⁵ (2005)
Neonatal death rates (1 – 28 days) ‰		20	13	8	-	11.7 ¹	12 ⁸ (2010)	35 ¹⁷ births	27 ¹⁷ births	19 ¹⁶ births (2011)	-	-	5 (infochild)	18 ¹	12 ¹	9 ¹	24 ¹	15 ¹	10 ¹	37 ¹ (1991)	41 [?]	37 (2006)
Gender-based violence (%)						33 ¹²				62.8	-	-	-	n/a	n/a	22 ¹³ (2011)	-	-	32.9 ²² (2011)			

Average age at first marriage	For girls	19.2	19.5	20.6	-	32.8 ¹	-	18.8 ₁	21.4 ²	26.3 ⁴	20.7 _{15, 16}	23.3 ¹⁵	26.8 ⁴	-	25.6 ³ (2001)	25.3 ² (2009)	26.6 ₁₀ (1994)	29.2 ₁₀ (2001)	-	16 ¹ (women 15 – 49, 1991)		17.2 ³ (median, age group 20 – 49, 2003)
	For boys				-	28.8 ¹	-				24.7 _{15, 16}	26.2 ¹⁵	29.1 ⁴	-	29.4 ³ (2001)	29.1 ² 2009	30.3 ₁₀ (1994)	32.9 ₁₀ (2001)	-			
Legal age at marriage for women	Without parental consent	16	18	18	-	-	17 ² (2011)	--	15 ¹⁸	18 ¹³ (2004)	-	-	-	17	17	17 ¹⁴	-	-	18 ¹	None	None	None
	With parental consent				-	-	9 ² (2011)				-	-	-	15	15	15	-	-	< 18 ¹	None	None	None
% of women over 15 who are illiterate		43.6	59.4 (2005)	63.5	11.8 ⁹ (1995)		13.7 ⁷				29.4 ₁₆		17 ⁴	-	26 ¹ (2002)	23 ¹	42.3 ₃₉ (1994)	39 ⁴⁰	28.5 ¹⁶ (2007)	89.2 ¹ (15 – 49)		67.1 ³ (women over 10, 2003)
Socioeconomic indicators																						
Human development index		0.502	0.593	0.661	-	0.714 ¹ ₀ (2005)	0.745 ¹⁰ (2012)				-	-	0.728 ₁₇	0.557 ¹⁵	0.596 ¹⁵	0.648 ¹⁵ (2012)	0.656 ¹²	0.695 ¹²	0.753 ¹²	0.286	0.376	0.575 ⁷ , 140 out of 182 countries HDI 0.458 ⁸ , 160 out of 182 countries (2006)

Poverty (% of populatio n living with less than \$1 per day)		24.2	16.7	21.6		8 ¹³ (2005)					-	-	-	7.9 ⁵ (1996- 1997)	1.8 ⁵ (2004)	0.3 ⁵ (2006- 2007)	5.9 ¹⁸	2.5 ¹⁸	1 ¹ (2005)		12.9 ⁸ (2000)	17.5 ⁸ (2010)
																						46.6 ⁷ (under \$2/day, (2005)
Urbaniza tion as % of populatio n					83 ¹⁶	86 ¹⁶	87 ¹⁶	48.2 ²¹	55.3 ²¹	61. 6 ²¹	66 ¹¹	-	73. 6 ⁴	-	51.9 ¹⁵	56.5 ¹⁵ (2012)	58 ¹	63.4 ²⁰ (2002)	66 ¹¹			
% of women over 15 in the labor- force		28	21	25.3	18	21	25 ¹⁶				7 ¹⁶	17. 14 ¹⁹	28. 3 ¹⁸	-	-	13.1 ¹⁵ (2011)	20.9 ²¹ (1989)	25.1 ²⁰ (1999)	27.3 ²⁰ (2007)		18 ⁸ (2000)	20 ⁸ (2010)

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