Monitoring Report
September 2013

& Reclaiming Redefining Rights

ICPD+20:
Status of Sexual and Reproductive Health and Rights in Middle East and North Africa

by EIPR (Egyptian Initiative for Personal Rights)

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RECLAIMING & REDEFINDING RIGHTS

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Egyptian Initiative for Personal Rights (EIPR) is an independent Egyptian human rights organization that was established in 2002 to promote and defend the personal rights and freedoms of individuals.

EXECUTIVE SUMMARY

The year 2014 was meant to be the year that ended the Program of Action adopted by the Cairo Conference for Population and Development (ICPD) in 1994. The document was a paradigm shift in understanding and framing reproductive health and rights and prioritizing individuals' rights to choose and make decisions with regards to their own bodies. Now that the General Assembly extended the PoA indefinitely, and will review country progress at its 2014 session, it is the right moment to evaluate the extent to which different countries in the region implemented the PoA and how this has changed the realities lived by women and youth regarding their sexual and reproductive health and rights.

In the MENA region, acknowledging reproductive rights in a UN consensus document has greatly contributed in enhancing the countries' policies especially in maternity care, family planning services and HIV/AIDS. Yet, cultural and religious discourses still play a major role in holding back sexual rights especially for young people. Women's autonomy over their bodies is still a highly debated issue because of the deeply embedded patriarchal culture, which is also reflected in an unprecedented increase in the level of sexual violence against women.

Given the diversity of socioeconomic conditions in the MENA region, it is difficult to make categorical statements about the situation of reproductive and sexual health and rights. Yet, in many countries disparities in access to reproductive healthcare persist, where poorer, less educated and rural woman face many barriers to adequate and affordable healthcare services. In most MENA countries, women and young people are excluded from decision-making circles, which is reflected in the gender-insensitive policies adopted by these states.

Adopting a progressive agenda for post-2014 will definitely positively influence women's and young people's lives and make governments more accountable for the health and lives of their citizens. It will also help to integrate women and youth in designing, implementing and monitoring policies that influence their reproductive health and will provide guidance on achieving reproductive justice.

ACRONYMS AND ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ART	Anti-retroviral therapy
ARV	Anti-retroviral drugs
CREDIF	Centre for Studies, Research, Documentation and Information on Women
CEDAW	Convention on Elimination of All Forms of Discrimination Against Woman
CROC/ CRC	International Convention on the Rights of the Child
CRC	Committee on the Rights of the Child
CRR	Center for Reproductive Rights (NGO)
CPR	Contraceptive prevalence rate
CSE	Comprehensive sexuality education
DHS	Demographic and health survey
D&C	Dilatation and curettage
EmOC	Emergency obstetric care
EU	European Union
FGC/M	Female genital cutting or mutilation
FP	Family planning
FSW	Female sex workers
GBV	Gender-based violence
GCC	Gulf Cooperation Council
GGHE	General government health expenditure
GDP	Gross domestic product
GHIS	General health insurance scheme
GDI	Gender Development Index
GII	Gender Inequality Index
GEM	Gender Empowerment Measurement
GTF	Genital tract fistula
HDI	Human Development Index
HIV	Human immunodeficiency virus
HRC	Human Rights Council
HRW	Human Rights Watch (NGO)
HTP	Health Transformation Programme
IARC	International Agency for Research on Cancer
ICCPR	International Covenant on Civil and Political Rights
IDU	Injecting drug users
IEC	Information, education and communication
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference for Population and Development
ICPD PoA	International Conference for Population and Development Program of Action
ICPD+5	ICPD follow up conference for implementation of ICPD recommendations
IHDI	Inequality-adjusted Human Development Index
IUD	Intra-uterine device
KCR	Kuwait Cancer Registry
LGBT	Lesbians, gays, bisexuals, transsexuals
MARP	Most-at-risk populations
MDGs	United Nation's Millennium Development Goals
MENA	Middle East and North Africa
MMM	Maternal mortality and morbidity
MMR	Maternal mortality ratio
MNT	Maternal and neonatal tetanus
MPI	Multidimensional Poverty Index
MSM	Men who have sex with Men
MVA	Manual vacuum aspiration
NCRPE	National Cancer Registry Program in Egypt
NCW	National Council for Women
NGOs	Non-governmental organizations
NHA	National health accounts
NMMSS	National maternal mortality surveillance system
OOP	Out of pocket
OC	Oral contraceptive
OECD	Organization for Economic Cooperation and Development
OPT	Occupied Palestinian territory
PCBS	Palestinian Central Bureau of Statistics
PLWHA	People living with HIV/AIDS
PLHIV	People living with HIV
PNA	Palestinian National Authority
PvtHE	Private health expenditure
PAB	Protection at birth
PAC	Post-abortion care
SBA	Skilled birth attendance
SCAF	Supreme Council of the Armed Forces (Egypt)
STI	Sexually transmitted infection
SRHR	Sexual and reproductive health and rights
TFR	Total fertility rate
THE	Total health expenditure
UHI	Universal health insurance
UN	United Nations
UNDP	United Nations Development Program
UNESCO	United Nations for Education, Scientific and Cultural Education
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNODC	United Nations Office on Drugs and Crime
UN OHCHR	United Nations Office of the High Commissioner for Human Rights
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
VCT	Voluntary counselling and testing
WB	World Bank
WHO	World Health Organization
WID	Women In development
YS	Young people sexuality

CHAPTER 1:

Introduction

INTRODUCTION

Issues of sexual and reproductive health and rights (SRHR) in the Middle East and North Africa remain problematic for several reasons. First, there is a lack of accurate national data concerning these issues either due to the illegality of some practices, such as abortion, or an attendant social stigma, as is the case with sexually transmitted infections and HIV/AIDS. Lack of political will in many of the region's countries further hinders legal, medical and social reform of the SRHR matrix, and hence these rights are violated especially for disadvantaged groups, including younger generations, the less educated and poorer women. Abortion is illegal in most countries of the region, and universal access to a wide range of family planning methods and contraceptives is far from guaranteed. Maternal mortality hits rural, uneducated, non-working women disproportionately; while reproductive cancers are overlooked and never prioritized by health sectors. Lack of rights-based population policies is a common characteristic of the region's countries. Sexual rights, too, are stigmatized and most of the countries tend to engage in denial when it comes to sexually transmitted infections, HIV/AIDS and youth sexual behavior. Countries also use a discourse of cultural relativism to justify the non-provision of comprehensive sexuality education and reproductive and sexual health services to young people.

The Egyptian Initiative for Personal Rights (EIPR), in collaboration with the Asian-Pacific Resource and Research Center for Women (ARROW), produced this desk study as part of a project to conduct evidence-based evaluations of the SRHR situation in different regions of the Global South. Along with other regional studies by other SRHR NGOs, this study aims to assess twenty years of implementation of the International Conference on Population and Development (ICPD) and the progress or lack of progress made on the program of action (PoA), as well as point to the way forward post-2014 across the Global South. It further seeks to protect the gains made on issues of sexuality, reproductive health, reproductive rights and sexual health in the ICPD PoA and push the boundaries for the full realization of sexual and reproductive health and rights for all, taking into account the current context, in the post-ICPD global agenda.

METHODOLOGY

As part of the Global South ICPD+20 monitoring initiative, ARROW brought together partners from the Global South regions of Asia and the Pacific (ARROW), Africa (World YWCA), Central and Eastern Europe (ASTRA), the Middle East and North Africa (EIPR) and Latin America and the Caribbean (LAC)to discuss and plan the design and methodology for the monitoring initiative.

ARROW is a regional women's organization with a history of monitoring ICPD. It completed a monitoring project on ICPD+15 in 2009 and developed a proven list of rights-based SRHR indicators that would assess the progress or lack thereof toward the goals of ICPD. These indicators and the monitoring methodology were introduced to the Global South partners at the planning meeting.

EIPR took into account these indicators and its own experience of the Middle East and North Africa (MENA)and arrived at the final list of indicators for monitoring ICPD+20. These indicators focus on the issues of women's empowerment, health financing, reproductive health and rights and sexual health and rights. This MENA regional report focuses on Egypt, Kuwait, Palestine, Tunisia, Turkey and Yemen.

The Middle East and North Africa is one of the most complex regions in the world given the diversity of socioeconomic conditions, post-Arab Spring politics and the composition of the population. There is no consensus on the countries comprising MENA region. Most classifications include the Gulf countries (Saudi Arabia, Kuwait, Qatar, Bahrain, Oman, United Arab of Emirates, Yemen and at times Iraq), Egypt and the Levant (Syria, Lebanon, Jordan, Palestine and Israel) and the Maghreb countries (classically Morocco, Tunisia, Algeria and Libya, but sometimes also Mauritania and Western Sahara). Iran and Turkey are at times considered MENA countries and at other times not. The World Bank, for example, considers Djibouti as part of the MENA region. Even within the UN system, different UN entities differ in their classification of the MENA region. While UNICEF includes Iran, Djibouti and Sudan and excludes Mauritania and Western Sahara, OHCHR excludes Iran, Sudan and Djibouti and includes Mauritania and Western Sahara.

Different definitions of what constitutes the MENA region presented an obstacle to data collection for this report. Some references exclude Turkey and/or Iran from the MENA region, while Palestine's non-state status made it difficult to track data on the occupied Palestinian territory. In addition, in many UN reports, MENA is not a recognized, self-contained region, and the relevant countries are distributed between North Africa and West Asia.

Our selection of the focus countries was based on their regional weight, political context and availability of data. Egypt is the most populous country in the region, with a recent popular uprising on 25 January 2011 and an important regional role. Data about Egypt, especially related to SRHR, is abundant. Kuwait was chosen as the Gulf representative. Although it is not as powerful regionally as Saudi Arabia and is not experiencing a revolutionary groundswell as in Bahrain, data on Kuwait is much more plentiful than Saudi Arabia, which is a black hole when it comes to data concerning women's rights or SRHR. Palestine, a Levant country, was chosen to illustrate the influence of a long occupation on women's status and reproductive and sexual rights. Tunisia, a Maghreb country, was the cradle of the Arab Spring. It also represents a peculiar case, as it is one of the few countries in the region with strong guarantees for women's rights. Turkey is a major player in the MENA region; women's status is also advanced, but data is widely available, in contrast to Iran, the other major non-Arab player. The last country chosen was Yemen, which is sometimes classified as a Gulf country; unlike Kuwait, however, Yemen is one of the poorest countries in the region, receiving a constant flow of international aid to support human rights and development, making Yemen an important indicator of SRHR in less developed countries.

This regional monitoring initiative also draws on interviews with nationally based NGOs in the countries under review. The aim of the interviews was to include a voice from the ground and allow activists to comment on the SRHR issues that are their focus.

REPORT STRUCTURE

This report consists of three main sections. The introductory chapter, "Contextualizing Women's Rights and Health Expenditure," describes the political context in the region, the status of feminist movements and each country's position on international obligations, covenants, treaties and consensus documents. It also highlights health expenditure issues and analyzes health policies and budgets in the countries in this study.

The second chapter, "Reproductive Health and Rights," tackles countries' commitments to and progress in achieving global standards in maternal health, abortion, population policies, and contraception and reproductive cancers. The third chapter, "Sexual Health and Rights," covers issues related to young people sexuality in terms of comprehensive sexuality education and access to services; sexually transmitted infections and HIV/AIDS are discussed in this chapter, as are gender-based violence, trafficking and other sexuality issues.

Women's voices, taken from other sources, are presented throughout the report to add a qualitative dimension to the statistical data, followed by a synthesis of the NGO interviews. The report concludes with a set of recommendations for the post-ICPD process.

DATA SOURCES FOR THE INDICATORS

Statistics and disaggregated data were taken from each country's demographic and health survey (DHS) when available, or country specific UN data were used. In addition, research by national or international entities, along with qualitative studies and journal papers were employed for more in-depth insights on topics of reproductive health and sexuality.

Key sources of data include: UN world contraceptive use for different years, UN world abortion policies, the UN Secretary General's database on violence against women, the United Nations Development Program's Human Development Reports, the World Health Organization's National Health Accounts, country demographic and health surveys, the UN General Assembly Special Session on AIDS (UNGASS) Progress Report, government reports for the Convention on the Elimination of All Forms of Discrimination Against Women, NGO shadow reports from the respective countries and scientific papers and journals such as Reproductive Health Matters.

CHAPTER 2:

Contextualizing Women's Rights and Health Expenditure

POLITICAL CONTEXT

The Middle East and North Africa is a diverse region including Arab and non-Arab states (Turkey and Iran). The population is predominantly Muslim, and most countries of the region share similar social and political contexts. However, their developmental challenges vary considerably,[1] with both oil-rich countries in the Gulf as well as low-income and lower middle-income countries. Popular demands for social justice and democracy have been rising in the past few years, and protests have recently swept several MENA countries.

In the past twenty years, the region has experienced various armed conflicts, including the Gulf war (1990–91), the civil war in Yemen (1990–94), the Iraq invasion (2003), the Hamas-Fatah conflict in Palestine (beginning in 2006) and the conflict between Israel and Lebanon (2006). The Palestinian-Israeli conflict, which started early last century, has continued well into the first decade of the 21st century.

Starting in the early 1990s, various countries in the region also experienced waves of terrorist attacks, attributed largely to the rise of religious, mainly Islamic, fundamentalism. In addition, the 2001 attacks in the United States resulted in strategic changes to US foreign policy in the region.

FEMINIST MOVEMENTS IN THE MIDDLE EAST

In the Middle East, the birth of the feminist movement came at a time of conflicting ideologies and identities and debates over modernization and Westernization, authenticity and Islam, and nationalism. Due to the different economic and political contexts in each country, the development of national feminist movements differs greatly, but one can identify general patterns and specific turning points of feminist practice and writing that have influenced feminist movements in the region.

In the late 19th and early 20th centuries, some of the region witnessed a heated debate about "women's liberation."The mainstream history of this period usually glamorizes the role of male reformers while often ignoring the role played by the women's press in addressing the "women's question" in Egypt, Iran and Ottoman Turkey. In the 1920s, various feminist movements were emerging in several countries of the region.

The first wave of feminist writings raised questions of nationalism, followed by a second wave of writings in the 1950s and 1960s that incorporated social sciences disciplines. In the 1970s, many feminists adopted the women in development approach in their writings and criticized modernization theory's promise of trickle-down effects at the core of liberal economic theories.

In the 1980s, feminist writings on the region in Middle Eastern and non-Middle Eastern countries were characterized by a continuous dialogue between local agendas and international trends. A clear example is the debate over female circumcision/FGM that employed the discourses of cultural relativism and human rights.[2]

In the 1990s, the number of NGOs in the region, mainly in Arab states, increased substantially.[3] As a result, the feminist movement began facing what was later labeled the "NGOization" of the movement, defined as "the spread of a different form of structure for women's activism, one which limits the participation of women at the local level to 'their' organization [limiting] the struggle for national causes to 'projects' geared to priorities set by an international discourse without diversity, and fragments the accumulation of forces for social change."

Therefore, many of the issues tackled by feminist-led NGOs were heavily influenced by the donor agenda and not necessarily driven by actual needs of the communities throughout the region.[4]

At the same time, south-to-south dialogues among feminists increased. While at times sharing a similar postcolonial context, most countries of the Global South do share similar sets of economic challenges and social issues. The feminist movement continued striving for a strong and inclusive presence, while contributing to the production of knowledge and advocacy around demands aimed at achieving legal reforms and social change in their communities.

ARAB SPRING

In late 2010 and early 2011, a wave of popular protests and demonstrations, dubbed the Arab Spring, swept many Arab countries. While all these protests shared similar calls for democracy and personal dignity, revolutions across the region demonstrated diverse socioeconomic dynamics unique to each of these countries and their regimes. For example, the Tunisian Revolution started in poorer, rural areas while the Egyptian Revolution was driven by young people in major cities.[5]

In January 2011, Zine El-Abidien Bin Ali stepped down from the presidency of Tunisia after more than twenty years in power (1987–2011). In October 2011, a constituent assembly was elected charged with drafting a new Tunisian constitution.

Inspired by the Tunisian Revolution, protests escalated in Egypt. In February 2011, Hosni Mubarak, who had ruled Egypt for almost thirty years, stepped down. In January 2012, the newly elected Egyptian parliament held its first session.

In Yemen, protests started in January 2011 and lasted for several months, ultimately terminating the presidency of Ali Abdullah El-Saleh. In February 2012, Abd Rabbuh Mansur al-Hadi was elected as the new president of Yemen.

Both in Tunisia and Egypt, women played an important role in bringing about the fall of old regimes. In Yemen as well, women played and continue to play an important role in mobilizing and protesting against the government, demanding social change. However, in the transitional period, women's rights have proven to be far from guaranteed. Women continue to struggle to achieve equal rights and full political participation in new constitutions and parliaments, and women activists point to a backlash against women's rights under recently elected conservative governments. Discrimination and traditional attitudes toward women remain entrenched.

In post-revolutionary Egypt, women protesters have been increasingly targeted for their political participation and subjected to sexual attacks when participating in protests. A recent murder case shows to what extent sexual harassment is a problem in Egypt: in September 2012, a young girl in Assiut, located in Upper Egypt, was sexually harassed by a man who shot her when she reacted to the harassment. In a recent rape case in Tunisia, the victim was allegedly raped by police officers in September 2012, but was subsequently summoned by police herself after being accused of "indecency" by her rapists. This sparked widespread protests and clearly demonstrated the need for thorough legislative and security sector reform in post-revolutionary Tunisia.

In early 2011, Kuwait witnessed a series of protests calling for more rights and freedoms, which started with demonstrations by stateless Bedouins known as bedoun (without nationality) who demanded citizenship and its benefits.[6] Bedoun protesters were followed by wider political protests that resulted in the dissolution of parliament in December 2011. A new parliament was elected in February 2012.

In 2010, the Turkish Constitution was amended to address several issues such as children's rights, freedom of movement and the right to privacy, a move seen as part of Turkey's continuous efforts to join the European Union.[7] In 2011, Palestine was admitted by the United Nations Educational Scientific and Cultural Organization (UNESCO), making it the first UN agency to admit Palestine as a full member. On 29 November 2012, the UN General Assembly voted to approve de facto recognition of Palestine as an independent state, upgrading Palestine's observer status at the UN from entity to non-member state.

Nevertheless, as Palestine is not an official full member of the UN, the Palestinian National Authority (PNA) is not a participating member of any of the treaties discussed in this section.

Women's empowerment and health financing are recognized as two critical factors that can facilitate or hinder the implementation of the Program of Action of the 1994 ICPD. They have an impact on the way women exercise choice, make decisions and execute them, especially with regards to their sexual and reproductive health. In the following section we examine the key indicators pertaining to women's empowerment and health financing in the six countries under review.

SIGNATORIES AND RESERVATIONS: CEDAW, ICCPR, CRC, ICESCR

In order to understand sexual and reproductive rights in the MENA region, it is important to understand the treaties ratified by the various countries that deal, either directly or indirectly, with such rights. These treaties provide significant insight into the steps that MENA countries have (or have not) taken in addressing the sexual and reproductive right issues that arise in the region.

All countries covered in this report have national and international obligations to respect and uphold women's reproductive and sexual rights. They are all therefore expected to respect, protect and fulfill these rights and work actively on advancing and realizing these rights for all women without discrimination. In this regard, some countries have designated government bodies tasked with drafting and executing national

policies and plans on women's rights.

All countries discussed in this report, except the OPT, have ratified on the International Convention on Civil and Political Rights (ICCPR)[8] the International Convention on Economic, Social and Cultural Rights (ICESCR). Ratification of both conventions came in Tunisia in 1969, Egypt in 1982, Yemen in 1987, Kuwait in 1996 and Turkey in 2003. In 1990, Egypt ratified the Convention on the Rights of the Child (CRC). Both Kuwait and Yemen ratified the convention in 1991, while Tunisia ratified it in 1992 and Turkey in 1995. The issue of the compatibility of the conventions and Islamic law (Sharia) was raised by several Muslim states including Egypt and Kuwait. The adoption of children was one of the most controversial issues in the CRC. Tunisia made a declaration on Article 6 of the convention, which addresses a child's right to life, noting that it would not be interpreted to impede a woman's right to an abortion, which is granted by Tunisian law.

Except the OPT, all of the countries examined in this report have ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Yemen ratified the CEDAW in 1984 with a reservation to Article 29.Tunisia, which signed in 1980 and ratified the convention in 1985, lodged reservations to articles deemed non-compliant with the Tunisian Constitution. Specifically, Tunisia noted a reservation to Article 16, which calls for equality between men and women in issues of marriage, stating that the article is not compatible with the Tunisian Personal Status Code on the granting of family names to children and the acquisition of property through inheritance.[9] Among the reservations, Tunisia stated that Article 15, paragraph 4 of the convention, which upholds women's rights of mobility and the right to choose one's residence and domicile, "must not be interpreted in a manner which conflicts with the provisions of the Personal Status Code on this subject."

In 1980, Egypt signed the CEDAW. The compatibility of the convention with Islamic law was at the center of Egypt's reservations. In 1981, Egypt ratified with the reservation, "provided that such compliance does not run counter to the Islamic Sharia."Like Egypt, Kuwait's reservations touched on Sharia and its compatibility with the convention. Upon ratification in 1995, Kuwait expressed its reservation to Article 16, clause F, upholding equality between men and women in respect to the guardianship and custody of children, which Kuwait declared to be in conflict with Islamic law.

Turkey ratified the CEDAW in 1995 with reservations to several articles on the grounds of their non-compliance with the Turkish Civil Code. In 1999, Turkey withdrew its reservation to Article 15 on equality of women before the law and Article 16 on equality between men and women in all matters related to marriage and family. In March 2012, Turkey was the first country to ratify the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence.[10]

Reservations to such critical articles in the CEDAW have limited the scope of protection for women in these countries, and the CEDAW Committee has on occasion called on these member states to consider lifting their reservations, as they are incompatible with the objective of the convention and undermine the general principles and missions of the treaties. While ratification of these treaties is usually viewed as a promising gesture for women's rights, sometimes it is just that—an empty promise. It is easy for countries to neglect their duties under the CEDAW by using the reservations as an escape route whenever they are faced with a dilemma that does not fit neatly with a government's agenda or wishes.

Table 1: Country reservations to the CEDAW

Country	Date ratified	Text of reservation
Egypt	18 Sep 1981	**Article 9** Reservation to the text of article 9, paragraph 2, concerning the granting to women of equal rights with men with respect to the nationality of their children, without prejudice to the acquisition by a child born of a marriage of the nationality of his father. This is in order to prevent a child's acquisition of two nationalities where his parents are of different nationalities, since this may be prejudicial to his future. It is clear that the child's acquisition of his father's nationality is the procedure most suitable for the child and that this does not infringe upon the principle of equality between men and women, since it is customary for a woman to agree, upon marrying an alien, that her children shall be of the father's nationality. **Article 16** Reservation to the text of article 16 concerning the equality of men and women in all matters relating to marriage and family relations during the marriage and upon its dissolution, without prejudice to the Islamic Sharia's provisions whereby women are accorded rights equivalent to those of their spouses so as to ensure a just balance between them. This is out of respect for the sacrosanct nature of the firm religious beliefs which govern marital relations in Egypt and which may not be called in question and in view of the fact that one of the most important bases of these relations is an equivalency of rights and duties so as to ensure complementary which guarantees true equality between the spouses. The provisions of the Sharia lay down that the husband shall pay bridal money to the wife and maintain her fully and shall also make a payment to her upon divorce, whereas the wife retains full rights over her property and is not obliged to spend anything on her keep. The Sharia therefore restricts the wife's rights to divorce by making it contingent on a judge's ruling, whereas no such restriction is laid down in the case of the husband. **Article 29** The Egyptian delegation also maintains the reservation contained in article 29, paragraph 2, concerning the right of a State signatory to the Convention to declare that it does not consider itself bound by paragraph 1 of that article concerning the submission to an arbitral body of any dispute which may arise between States concerning the interpretation or application of the Convention. This is in order to avoid being bound by the system of arbitration in this field. **Reservation made upon ratification** **General reservation on Article 2** The Arab Republic of Egypt is willing to comply with the content of this article, provided that such compliance does not run counter to the Islamic Sharia.
Country	**Date ratified**	**Text of reservation**

Country	Date ratified	Text of reservation
Kuwait	2 Sep 1994	**Article 9, paragraph 2** The Government of Kuwait reserves its right not to implement the provision contained in article 9, paragraph 2, of the Convention, inasmuch as it runs counter to the Kuwaiti Nationality Act, which stipulates that a child's nationality shall be determined by that of his father. **Article 16 (f)** The Government of the State of Kuwait declares that it does not consider itself bound by the provision contained in article 16 (f) inasmuch as it conflicts with the provisions of Sharia, Islam being the official religion of the State. **Article 29** The Government of Kuwait declares that it is not bound by the provision contained in article 29, paragraph 1.
Tunisia	20 Sep 1985	**General declaration** The Tunisian Government declares that it shall not take any organizational or legislative decision in conformity with the requirements of this Convention where such a decision would conflict with the provisions of chapter I of the Tunisian Constitution. **Article 9, paragraph 2** The Tunisian Government expresses its reservation with regard to the provisions in article 9, paragraph 2 of the Convention, which must not conflict with the provisions of chapter VI of the Tunisian Nationality Code. **Article 16, paragraphs (c), (d), (f), (g) and (h)** The Tunisian Government considers itself not bound by article 16, paragraphs (c), (d) and (f) of the Convention and declares that paragraphs (g) and (h) of that article must not conflict with the provisions of the Personal Status Code concerning the granting of family names to children and the acquisition of property through inheritance. **Article 29, paragraph 1** The Tunisian Government declares, in conformity with the requirements of article 29, paragraph 2 of the Convention, that it shall not be bound by the provisions of paragraph 1 of that article which specify that any dispute between two or more States Parties concerning the interpretation or application of the present Convention which is not settled by negotiation shall be referred to the International Court of Justice at the request of any one of those parties. The Tunisian Government considers that such disputes should be submitted for arbitration or consideration by the International Court of Justice only with the consent of all parties to the dispute. **Article 15, paragraph 4** In accordance with the provisions of the Vienna Convention on the Law of Treaties, dated 23 May 1969, the Tunisian Government emphasizes that the requirements of article 15, paragraph 4, of the Convention on the Elimination of All Forms of Discrimination against Women, and particularly that part relating to the right of women to choose their residence and domicile, must not be interpreted in a manner which conflicts with the provisions of the Personal Status Code on this subject, as set forth in chapters 23 and 61 of the Code.

Turkey	20 Dec 1985	**Reservations** Reservations of the Government of the Republic of Turkey with regard to the articles of the Convention dealing with family relations which are not completely compatible with the provisions of the Turkish Civil Code, in particular, article 15, paragraphs 2 and 4, and article 16, paragraphs 1 (c), (d), (f) and (g), as well as with respect to article 29, paragraph 1. In pursuance of article 29, paragraph 2 of the Convention, the Government of the Republic of Turkey declares that it does not consider itself bound by paragraph 1 of this article. **Declaration** "Article 9, paragraph 1 of the Convention is not in conflict with the provisions of article 5, paragraph 1, and article 15 and 17 of the Turkish Law on Nationality, relating to the acquisition of citizenship, since the intent of those provisions regulating acquisition of citizenship through marriage is to prevent statelessness." **20 September 1999** On 20 September 1999, the Government of Turkey notified the Secretary-General of a partial withdrawal as follows: "[...] the Government of the Republic of Turkey has decided to withdraw its reservations made upon [accession to] the Convention on the Elimination of All Forms of Discrimination Against Women with regard to article 15, paragraphs 2 and 4, and article 16, paragraphs 1 (c), (d), (f) and (g). [...] the reservation and declaration made upon [accession] by the Government of Turkey with respect to article 29, paragraph 1, and article 9, paragraph 1 of the Convention, respectively, continue to apply."
Yemen	30 May 1984	The Government of the People's Democratic Republic of Yemen declares that it does not consider itself bound by article 29, paragraph 1, of the said Convention, relating to the settlement of disputes which may arise concerning the application or interpretation of the Convention.

NATIONAL INSTRUMENTS

All countries examined in this report have national mechanisms aimed at achieving gender equality. All countries,[11] except the OPT, report to the CEDAW Committee.

In 1990, the General Directorate of the Status and Problems of Women was established in Turkey.[12]

In Tunisia, the State Secretariat for Women and Family was founded in 1992, becoming the Ministry of Women, Family and Children's Affairs in 2002.[13] In 1990, the Center for Studies, Research, Documentation and Information on Women (CREDIF) was established. CREDIF, under the supervision of the Ministry of Women, is a governmental research organization aimed at gender mainstreaming.[14]

In Yemen, the Women's National Committee was established in 1996, followed by the Supreme Council for Women's Affairs in 2000, when the Women's National Committee became the technical committee of the Supreme Council. Directors of women's departments in other ministries and governmental institutions are members of the Women's National Committee in Yemen.[15]

The National Council for Women (NCW) was established in Egypt in 2000. The NCW manages various projects aimed at social, political and economic empowerment of women in Egypt.[16]

In 2002, the Kuwaiti Council of Ministers issued a resolution approving, in principle, the establishment ofthe Women's Affairs Committee. The committee's charter and bylaws were issued in 2003.[17]

In the OPT, the Ministry of Women's Affairs was established in 2003 under the PNA. Although the PNA does not report to the CEDAW and is therefore not legally bound by its articles, the ministry reported that the PNA ratified the convention in 2009. In 2000, Security Resolution 1325 was issued addressing women's rights in respect to peace and security under armed conflicts. According to the United Nations Development Fund for Women (UNIFEM), UN Resolution 1325 played a major role in making CEDAW relevant to territories under conflict, such as the OPT. [18]

Gender Empowerment and Inequality Measures
In 1995, the Human Development Report (HDR) introduced two gender-related measures: the Gender Development Index (GDI) and the Gender Empowerment Measure (GEM). The GDI "measures achievement in the same basic capabilities as the HDI does, but takes note of inequality in achievement between women and men," while the GEM is "a measure of agency [evaluating] progress in advancing women's standing in political and economic forums." [19]

While measurements such as the HDI, GDI, and GEM provide useful insights on the status of human development and gender equality, there are several problematic issues with the structure of the indices, data collection and the presentation and interpretation of results. A study conducted by the Institute of Development Studies at the University of Sussex to discuss the shortcomings of UNDP gender-related indices shows how the "choice of indicators, data collection methodologies and statistical analysis techniques can produce not only different kinds of data, but also different results. By choosing what and how to measure, the policymaker, advocate, researcher or practitioner can present the story he or she wants to tell." [20]

Hence, the biases and limitations inherent in these indices should be taken into consideration. The GDI, for example, focuses on gross domestic product (GDP), thus favoring economic development over social development. Similarly, the focus of the GEM on the number of women in a country's parliament fails to provide data on the actual involvement of these women in decision-making processes.

Interpretation of the data presented in these indices is another critical issue. Academics, policymakers and activists have been warned against interpreting the GDI as a measure of inequality [21] for neither the GDI nor the GEM were structured to "measure gender (in) equality as such." [22] While the GEM includes measurements of relative empowerment and absolute levels of income, the GDI is a human development measurement modified for gender inequality. In addition, GEM has been criticized for including indicators that are more relevant in developed countries than in developing countries and that express an urban bias. [23]

In an attempt to avoid the key drawbacks of the GEM and GDI, the 2010 HDR introduced the Gender Inequality Index (GII), which is a "measure that captures the loss in achievements due to gender disparities in the dimensions of reproductive health, empowerment and labour force participation [and the] values range from 0 (perfect equality) to 1 (total inequality)." [24]

MEASUREMENTS OF WOMEN'S EMPOWERMENT

Gender Related Measurements in the MENA region
The Multidimensional Poverty Index (MPI) was introduced in the 2010 HDR. The MPI attempts to measure the complexity of poverty by examining three dimensions: 1) health, 2) education and 3) living standards. For measuring health, MPI uses the indicators of child mortality and nutrition, while education is measured using the child enrollment rate and the years of schooling. The living standard dimension is measured by six indicators; assets, floor, electricity, water, toilet and cooking fuel.

Table 2: Comparison of HDI values and ranks, IHDI values, MPI values and GII values and ranks

Country	HDI value and rank (2012)	Inequality-adjusted HDI (2012)	MPI	GII value and rank (2012)
Egypt	0.662 112	0.503	0.024 (2008)	0.590
Kuwait	0.790 54	N/A	N/A	0.274
Palestine	0.676 110	N/A	0.005 (2007)	N/A
Tunisia	0.712 94	N/A	0.010 (2003)	0.261
Turkey	0.722 90	0.560	0.028 (2003)	0.366
Yemen	0.458 160	0.310	0.283 (2006)	0.747

Source: HDR 2013

The most recent HDR of 2013, The Rise of the South: Human Progress in a Diverse World, shows the status of MENA countries in comparison to the rest of the world. The report examines the HDI and the Inequality-adjusted Human Development Index (IHDI). By considering inequalities, IHDI provides the actual level of human development while HDI provides the level of potential human development. [25]

Yemen, one of the poorest countries in the region, had an HDI of 0.458, ranking 160 of 186 countries. On the IHDI, Yemen dropped to 0.310. Among the countries examined in this report, Kuwait had the highest HDI of 0.790, ranking 54 in the world, which means that it ranks high in terms of life expectancy, education and GDP. While there is not a big gap between the most recent HDI values in Tunisia (0.712) and Turkey (0.722), the difference between each country's GII is significant. Tunisia has a GII value of 0.261, while Turkey has a value of 0.366 (the lower the value, the less gender inequality). Kuwait is achieving both high HDI value and relatively low GII value. Yemen has a very high GII value of 0.747, one of the highest in the world.

GENDER INEQUALITY INDEX

The GII measures three dimensions: reproductive health (indicators are maternal mortality and adolescent fertility), empowerment (indicators are parliamentary representation and educational attainment) and labor market (indicator is labor force participation).

Table 3: Gender Inequality Index

Country	1995	2000	2005	2008	2012
Egypt	0.669	0.650	0.599	0.578	0.590
Kuwait	0.593	0.436	0.359	0.297	0.274
Palestine	---	---	---	---	---
Tunisia	0.424	---	0.335	0.326	0.261
Turkey	0.591	---	0.515	0.443	0.366
Yemen	0.879	0.823	0.791	0.773	0.747

Source: HDR 2013

Table 3 shows a general improvement in GII values in countries examined in the reports, although data on the OPT is unfortunately limited. In this section, we will discuss data on the indicators included in the GII, focusing only on two dimensions of GII—labor force and participation—since the third dimension, reproductive health, will be discussed in detail in the next chapter.

a. Seats in Parliament Held by Women

Despite the different political contexts of countries reviewed in this report, all share a low level of political participation among women. Recent political changes in the region highlighted the issues around women's political participation. Table 4 shows the percentage of seats won by women in recent parliaments. It is worth noting that in 2005 Kuwaiti women gained the right to vote and run for office.[26]

Table 4: Seats in parliament held by women (% of total)

Country	1997	2003	2011
Egypt	2.0	2.7	12.7
Kuwait	0.0	0.0	7.7
Palestine	5.6 (2000)	12.8 (2006)	
Tunisia	6.7	11.6	27.6
Turkey	2.4	4.4	9.1
Yemen	0.7	0.7	0.3

Source: United Nations Statistics Division 2011, UNDP-POGAR 2008 for the OPT

b. Educational Attainment

The education of women and girls is considered a measurement of empowerment, as education is believed to be an important factor in increasing women's autonomy and ability to make decisions on their own and for their own benefit. In the six countries examined, Yemeni women have the lowest share of formal education with 44% of primary enrollment, 37% of secondary enrollment and 44% of post secondary enrollment.

Table 5: Girls' share of primary, secondary and tertiary enrollment

Country	Girls' share of primary enrollment (%)	Girls' share of secondary enrollment (%)	Girls' share of tertiary enrollment (%)
Egypt	48	47	43
Kuwait	49	49	64
Palestine	48	51	56
Tunisia	48	50	60
Turkey	49	47	44
Yemen	44	37	29

Source: UNESCO Institute for Statistics 2010.

NATIONAL DOMESTIC VIOLENCE LEGISLATION

a. Domestic Violence

Domestic violence against women, defined as violence perpetrated by intimate partners and other family members, is a serious human rights issue and a public health concern. Domestic violence manifests through sexual violence, physical violence, psychological abuse and/or economic violence.[27] ICPD called for governments and non-governmental organizations to address the issue of domestic violence with innovative ideas.[28] In its general recommendations in 1992, the CEDAW Committee stressed the importance of combating gender-based violence within the family structure.[29]

Although female members of a household, in particular wives, face different forms of domestic violence, many countries in the MENA region do not have effective anti-domestic violence laws. For instance, Turkish Law 4320 allows women subjected to domestic violence to seek remedy, but the law refers to the perpetrator as the spouse. As a result, a woman may face difficulties filing charges if she is not married to the perpetrator of violence.[30] In Palestine and Yemen, there are no specific laws addressing domestic violence. In Egypt, the law criminalizing intimidation or the threat of force against a wife, offspring or progenitor fails to address the various physical, psychological and sexual aspects of domestic violence.

Table 6: Anti-domestic violence laws in six countries in the MENA region

Country	Anti-domestic violence law
Egypt	Law 6/1998 criminalizing intimidation or the threat of force against a wife, offspring or progenitor
Kuwait	There are no laws that explicitly address domestic violence
Palestine	There are no laws that explicitly address domestic violence
Tunisia	Act 93-72 of 12 July 1993 amending certain articles of the Penal Code
Turkey	Family Protection Law 4320 entered into force in January 1998. The scope of the law was widened on 26 April 2007, entering into force on 1 March 2008
Yemen	There are no laws that explicitly address domestic violence. [31]

Source: The UN Secretary-General's database on violence against women and Social Institutions and Gender Index (SIGI) 2012

In 2005, the Egypt Demographic and Health Survey presented shocking numbers on the prevalence of domestic violence in the country. The DHS found that approximately 47.4% of ever-married women aged 15-49 had experienced domestic violence in various forms, such as being hit, slapped or kicked.[32] The report showed that while both urban and rural women were equally likely to be subjected to domestic violence, rural women were more likely to report such incidents. Interestingly, the report noted that many of the Egyptian women interviewed in the study believed that wife beating was justifiable. The following are a few of the justifications for domestic violence given by interviewed women: the women's refusal to have sex with her husband, going out without her husband's permission, burning the food while cooking, neglecting the children, or arguing with the husband.

While Egypt does not have a specific domestic violence law, Egyptian law criminalizes intimidation or the threat of force against a wife, offspring or progenitor. In the early months of 2012, the Nadim Center for the Management and Rehabilitation of Victims of Violence, an Egyptian NGO, drafted a law for the protection of victims of domestic violence in coordination with other feminist and women's organizations in the country. [33]

Due to the social stigma associated with domestic violence, women rarely report such incidents in Yemen. In addition, women's fear of retaliation from the perpetrator of the violence hinders a woman's willingness to report domestic abuse .[34] In 2009, the National Women's Committee proposed amending the laws addressing issues of violence against women.

In 2008, the National Research on Domestic Violence against Women in Turkey conducted a study on domestic violence

that explored the prevalence of violence by husbands and male relatives against women. The study showed that 42% of married Turkish women had experienced either sexual or physical violence.[35] In this study, interviewed women listed various possible reasons for violence, including problems within the husbands' family, financial problems and a husband's jealousy. More than 90% of women who experienced violence did not seek help from any official or non-governmental organizations such as the police, clinics or women's NGOs. In March 2012, Human Rights Watch reported that a new law for the protection of the family and prevention of violence against women was drafted, intended to overcome the problems of the existing law, which provides protection against domestic violence only for married women. The proposed law aims to protect all women, including married and unmarried women, while also expanding the protection against domestic violence tochildren and other family members.[36]

In Kuwait, incidents of domestic violence are rarely reported. In its comments on the report provided by the Kuwaiti government in 2011, the CEDAW Committee raised the issue of domestic violence in Kuwait. Using data from the Kuwaiti Interior Ministry, the committee found that more than one-third of Kuwaiti women suffer from domestic violence. [37] The rights of domestic workers, mostly migrant women workers, are some of the most important issues in relation to domestic violence, for in addition to the denial of essential labor rights; domestic workers in Kuwait face physical violence and sexual abuse.[38]

Data on domestic violence in Tunisia is limited. The Tunisian law against domestic violence provides protection against violence by spouses and other family members.[39] With assistance from the UNFPA, the Tunisian government reportedly proposed a plan to combat many forms of gender-based violence, including domestic violence.

In Palestine, the Jordanian law in force in the West Bank lacks specific articles on domestic violence (like the Egyptian law that is applied in Gaza). Human Rights Watch has reported the utilization of relevant provision of the criminal law by judges to try crimes of domestic and sexual violence.[40] According to the Palestinian Central Bureau of Statistics (PCBS), in 2005, more than 20% of married women reported that they had been victims of domestic violence. After the second intifada in 2001, Palestinian women's organizations noted an increase in the level of violence against women.

Women's Voices from Palestine

On the magnitude of the problem in Gaza, a research consultant says, "Violence against women in Gaza basically means domestic violence," adding, " Women are beaten by their husbands, beaten by their fathers, and even beaten by their brothers."The consultant stated, "Women accept violence from the husbands but they [can't] handle violence from their mother-in-law."[41]

Below is a personal story narrated by a victim of gender-based violence:
Mariam Isma`il (pseudonym), 35, told Human Rights Watch that, after enduring years of physical and sexual abuse, she was forced to take desperate measures:
"He used to beat me everywhere. I never went to the hospital, and I didn't even tell my parents. I was just thankful to be alive. But the violence became more and more physical and sexual. He brought other people to have sex with me and to abuse me. He held me while other people abused me... If I thought that I had even a 1 percent chance of changing the situation any other way, I would never have done it.
"The police asked me why I didn't just go to my family, but I said that my family would probably try to kill me because I had slept with others. Until now, my family doesn't believe me. The police showed my family the police report that documented how I was forced to have sex with other men. Even the police said that they didn't blame me for killing him after that. My family was surprised by the report and didn't believe it."

Source: A Question of Security: Violence against Palestinian Women and Girls, 2006

b. Labor Force Participation

Table 7 describes the female to male ratio of labor force participation in 2012. Kuwait has the highest female labor force participation rate among the six countries (43.4) while Palestine has the lowest (15.1). Typically, rates of higher labor force participation indicate that a country is more advanced in regards to women's rights than countries with lower rates—women who work are often better situated in the financial and political arenas. However, high labor force participation is not dispositive of the advancement of women's rights in the MENA region, but is simply a factor used to better understand the lives of women and girls in this region.

Table 7: Male and female labor force participation rate

Country	Labor force participation rate- female	Labor force participation rate- male
Egypt	23.7	74.3
Kuwait	43.4	82.3
Palestine	15.1	66.3
Tunisia	25.5	70
Turkey	28.1	71.4
Yemen	25.2	72

Source: HDR2013

SUMMARY

Countries across the MENA region differ in their socioeconomic contexts, but they share similar cultural backgrounds. In the past twenty years, the MENA region has witnessed various political changes that influenced the status of sexual and reproductive health and rights for all populations and for women in particular. The recent Arab Spring has significantly impacted the lives of those in the MENA region in ways yet to be seen; in particular, its effect on the status of women is continuously changing and still indefinable.

Starting from the late 19th century, the feminist movement in the MENA region has developed into a social and political movement calling for better conditions for women. However, until recently, sexuality and reproductive issues were rarely addressed.

Except the OPT, countries examined in this report have ratified the ICCPR, ICESCR and CEDAW. All countries examined in this report have national mechanisms aimed at achievement gender equality.

Countries examined in the report show general improvement in measurements such as the HDI, the IHDI and the MPI. However, Yemen still falls behind in human development and inequality-adjusted development. In addition, data from the OPT is still limited.

HEALTH FINANCING

The provision of a comprehensive sexual and reproductive health program requires a functioning health system and the effective delivery of an integrated package of services as outlined in the ICPD PoA. Because this package involves a wide variety of services for a broad range of people in society and includes services that some regard as sensitive, sexual and reproductive healthcare requires special consideration in policy formulation, especially as it relates to health financing.[42]

The situation in many countries in the MENA region regarding domestic funding for healthcare is not encouraging. Governments raise funds for healthcare through a combination of direct or indirect taxes, health insurance premiums and fees charged for services provided by the public health system. Because of the severe constraints on government revenues in low-income countries, little improvement in the amount of funds from these sources for sexual and reproductive health programs can be anticipated.

Health financing, among other factors affecting the health system, reflects the priorities of governments and makes them responsible and accountable for the resources they have allocated within the health sector. Health financing for SRHR supports women in realizing their rights and affects their ability to access services.

In this section we review health expenditure, the share of government and private sector expenditure and the share of out-of-pocket expenditure on health with the aim of establishing financing trends in the region and their impact on sexual and reproductive health.

Table 8: Trends in healthcare financing (2000, 2005, 2010)

Country	Total health expenditure as % of GDP			General government expenditure on health as % of total expenditure			Social security expenditure on health as % of general government health expenditure			Private expenditure on health as % of total health expenditure			Out of pocket expenditure as % of private health expenditure		
	2000	2005	2010	2000	2005	2010	2000	2005	2010	2000	2005	2010	2000	2005	2010
Egypt	5.4	5.2	4.7	40.5	40.6	37.4	24.3	23.3	22.4	59.5	59.4	62.6	97.4	98.4	97.7
Kuwait	2.5	2.4	2.6	76.0	79.8	80.4	0.0	0.0	0.0	24.0	20.0	19.6	93.2	90.6	90.6
Palestine	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tunisia	6.0	6.2	6.2	54.9	51.5	54.3	28.9	42.3	48.4	45.1	48.5	45.7	80.3	84.3	87.0
Turkey	4.5	5.4	6.7	62.9	67.8	75.2	55.5	56.1	60.1	37.1	32.2	24.8	74.6	70.8	64.4
Yemen	4.5	4.9	5.2	53.8	33.9	24.2	0.0	0.0	0.0	46.2	66.1	75.8	94.5	98.0	98.6

Source: National expenditure on health, global health expenditure database, WHO 2012

Total Health Expenditure

According to the WHO 2010 national health accounts, with the exception of Palestine, the countries surveyed spent an average of 5% of GDP on total health expenditure, with Yemen (5.2%), Egypt (4.7%) and Kuwait (2.6%) spending the least and Tunisia (6.2%) and Turkey (6.7%) spending relatively more.

Public health expenditure in Palestine represented 13% of GDP in 2004, up from 7% in 2003 and 8.6% in 1995. [43] In reality, the general situation during and immediately after the first intifada (1987–1993) and second intifada (2000–2005) did not allow positive changes toward the extension of coverage or improvement of the quality of health services apart from emergency services. However, the PCBS recently published the primary findings of the national health accounts for 2009 and 2010, showing that the proportion of total health expenditure to GDP in the OPT declined from 15.6% in 2008 to 15% in 2009 and 13.7% in 2010.[44]

Kuwait and Tunisia, with slight fluctuations from year to year, maintained a stable rate of total expenditure on health as a percentage of GDP over the past decade. The ratio has risen slightly in Yemen, while Turkey reported the highest increase (1.3% of GDP from 2005 to 2010). Only Egypt showed a decrease in expenditure on health as a percentage of GDP.

While this measure gives us some indication of health spending trends, it is important to further understand the nature of total health expenditure within each country, as this includes both public and private spending.

Government Expenditure on Health

General government expenditure percentages are used to examine a government's commitment to providing healthcare to their citizens. This percentage shows how much each government is spending on health as a percentage of their total expenditure. In 2010, Yemen (4.3%), Egypt (5.7%) and Kuwait (6.9%) were spending the least, while Tunisia (10.7%) and Turkey (12.8%) allocated more of their total government budget for expenditure on health.

In any country, total health expenditure (THE) comprises both general government health expenditure (GGHE) and private health expenditure (PvtHE). GGHE as a percentage of THE reflects the priority of health for each government.

General government expenditure on health as a percentage of total expenditure on health accounted for 80.4% in Kuwait, 75.2% in Turkey, 54.3% in Tunisia, 37.4% in Egypt, and only 24.2% in Yemen in 2010. According to the WHO global health expenditure database, GGHE as a percentage of THE has remained almost the same in Tunisia since 2000. While it has decreased in Egypt and Yemen, Kuwait and Turkey reported a substantial increase in their GGHE as a percentage of THE during the same period.

External resources for health as a percentage of total expenditure on health were 0.6% in Egypt, 0.3% in Tunisia, and 4.3% in Yemen. External funding to Egypt decreased by almost half in Egypt and about one-third in Yemen from 2005 to 2010. Turkey and Kuwait do not rely on external resources to finance health services. [45]

However, the Ministry of Health in Turkey has enjoyed, since the 1960s, the benefits of external assistance for its family planning program, especially from the US Agency for International Development (USAID). In 2001, the ministry dispensed about 70% of all intra-uterine devices (IUDs) and about 30% of all oral contraceptives and condoms in the country. The ministry's family planning service provision has traditionally been based on free and universal access. The only exception has been that some facilities in recent years have started to collect donations from better-off IUD clients as a result of spontaneous trend. [46]

In Palestine, external sources still have the upper share (48%) in supporting the health sector. External funds are distributed among the UNRWA (10%), NGOs (14%) and the Ministry of Health (22%) due to the need of services outside the public sector, mainly primary care offered by UNRWA to refugees. External funding is also used to support non-governmental institutions in order to alleviate the burden on the public sector. There has been no change in the pattern of external donations in supporting the health sector in Palestine since 1994.

Out-of-Pocket Expenditure as a Percentage of Private Sector Expenditure on Health

With exception of Turkey and Kuwait, private expenditure on health as a percentage of total health expenditure has increased in the countries under review where reliable data was available. Only Turkey has reported a decrease (-12.3%) in PvtHE as a percentage of THE. Whereas in Yemen it increased by almost two-thirds from 2000 (46.2% of THE) to 2010 (75.8% of THE), PvtHE has seen less significant change since 2000 in Kuwait (+4.4% of THE) and Egypt (+3%) and remained virtually unchanged in Tunisia (+0.6%).

Change in PvtHE has been correlated to a commensurate change in out-of-pocket expenditure (OOP), decreasing in Turkey and Kuwait and increasing in Egypt. In Tunisia, however, OOP increases since 2000 are probably due to an equivalent decrease in private insurance during the same period. Interestingly, data on both OOP and private insurance from Yemen do not explain how the increase in PvtHE over the past ten years is being met.

In all six countries under review, almost all or most private expenditure on health is out-of-pocket expenditure by households. OOP expenditure as a percentage of PvtHE is high in all countries. Private health insurance and aid from non-profit institutions cover the remaining costs of private expenditure on health.

Yemenis and Egyptians bear the burden of out-of-pocket spending more than in any other MENA country. In Egypt and Yemen, nearly 98% of PvtHE is OOP. PvtHE is steadily increasing in both countries, reaching 62.6% and 75.8% in Egypt and Yemen respectively.

Out-of-pocket expenditure as a percentage of PvtHE is still high in both Kuwait (90.6%) and Tunisia (87%), but in Kuwait PvtHE is less than 20% of THE, so OOP does not represent

huge problem for the population. Turkish households pay the lowest OOP at nearly two-thirds (64.4%) of PvtHE. In 2003, 12% of OOP expenditure in Turkey was for preventive care such as family planning and prenatal and postnatal care. Preliminary data from Egypt in 2002 indicates that households pay around 45% of reproductive health services while the public sector finances 50% of reproductive health expenditures.[48]

Data from Yemen and Tunisia indicate a gradual increase in the percentage of OOP, while Egypt showed a relatively fixed OOP expenditure since 2000. Turkey made a breakthrough in decreasing OOP expenditure in the same period of time. In 2010, Turkish households paid 10% less than they did ten years earlier. Kuwait also reported improvement in this regard, but with only 2.6% decrease.

Health Insurance

While Egypt spends 21.6% of the GGHE to cover the social security expenditure, Tunisia and Turkey cover almost half of their social security expenditure on health from governmental resources (49.4% and 60.1% respectively). General government expenditure does not contribute to social security expenditure in either Kuwait or Yemen. [49]

In countries where the facilities available to the insured population are inadequate, those who can afford it prefer to pay out-of-pocket or buy private health insurance to gain access to better services. Over the long term, this phenomenon may endanger the whole system. In Tunisia, for instance, many private sector employees who are covered by a social health insurance scheme, which gives them only the right to be treated in public facilities, voluntarily take outprivate insurance to be able to use private providers.[50]

Some countries, such as Kuwait and Tunisia, have a rapidly expanding private health insurance sector, and more countries seem to be following this trend.[51] However, a few places involved in conflict situations, in particular Iraq and Palestine, are unable to do this. Given the political instability in the region, reforming health financing is not currently a principal concern for many of these countries.[52]

A study in 2008 analyzed the redistributive effects of current healthcare financing schemes in the OPT, using data from the first Palestinian Household Health Expenditure Survey conducted in 2004. Significantly, it reveals that the government health insurance scheme has a progressive distribution effect for over half of the population, while the regressive impact of out-of-pocket payments is most pronounced among the worst-off classes of the population. Recommendations sought to improve the performance of the government insurance scheme to enhance its capacity in limiting inequalities in healthcare financing in Palestine.[53]

Health Financing and Its Impact on Sexual and Reproductive Health

Box 1: Health Financing in Egypt

Social health insurance schemes normally provide health insurance coverage only to contributing members. However, in the context of universal coverage, a social health insurance scheme pays for the healthcare of all, regardless of ability to pay the set premium; the government makes a contribution to the scheme on behalf of those who are unable to pay.[54]

The government of Egypt has declared health a national priority and is currently considering policies to reform healthcare financing. After embarking on economic liberalization during the 1990s, Egypt has received considerable amounts of foreign aid and assistance to restructure its healthcare system, notably fromthe World Bank, USAID and the European Commission. [55]

A review of post-ICPD implementation in six developing countries, including Egypt, found that sources and levels of overall health sector financing were a major concern. Improving reproductive health is a major preoccupation of the Egyptian pilot program insofar as basic packages of reproductive health and other services are provided in family health units, with referrals for obstetric complications to nearby hospitals.[56] Funding through the Family Health Fund is provided through government tax revenues, contributions for social health insurance (for those who pay into Egypt's Health Insurance Organization), a fee to join the roster of a family practice and co-payments for services obtained.

Many financing systems in middle-income countries are fraught with duplication and inefficiencies. Fragmentation of health systems often precludes consistent policy focus and incentives for efficiency on both risk pooling and purchasing grounds. In Egypt, there are many organizations pooling resources and allocating health spending. The list of actors includes social health insurance organizations, central and local governments, health authorities, the military and security agencies and commercial insurers. For example, there are 29 public agencies in Egypt managing health financing with service provisions linked to specific schemes.[57]

A study in 2004 concluded that the Egyptian government would need to raise public health expenditure substantially to finance care at an adequate level. The study recommended expanding and refining the present tax-based financing scheme, rather than switching to an insurance-based scheme, which seems to be the technically superior strategy. Other measures to improve the coordination of financing, such as the creation of a single fund-holding agency, are needed, as well as tighter regulation of private providers and the pharmaceutical market.[58]

Box 2: Health Reform in Turkey

In 2001, Turkey initiated a series of reforms to align its healthcare system with the health regulations of the European Union and the OECD countries. As a result, the Health Transformation Program (HTP) was launched in 2003 and the Universal Health Insurance (UHI) system or General Health Insurance Scheme (GHIS) was implemented in October 2008. GHIS provides health services under one scheme instead of the five different public schemes that existed previously. Providing financial protection is one of the main goals of the Turkish healthcare reform.

To better align itself with more progressive healthcare systems and to alleviate the burdens associated with unstable health financing from various donors, the Turkish health system has undergone a transformation over the past few years. This process was dominated by the reforms attempted before 2003 and the HTP initiated in 2003. The program was introduced with the following objectives: administrative and financial restructuring of the Ministry of Health; coverage of all citizens by universal health insurance; gathering the health institutions under one umbrella; providing hospitals with an autonomous structure administratively and financially; introduction of family medicine implementation; prioritizing mother and child healthcare; generalizing preventative medicine; promoting the private sector to make investments in the

field of health; devolution of authority to lower administrative levels in all public institutions; eliminating the lack of health personnel in the areas which have priority in development; and implementation of electronic transformations in the field of health.

Estimates from the Household Budget Survey of 2006 suggest that financial burdens of medical expenses are lower after the HTP. This may indicate that the health system reforms were successful in providing financial protection against high health expenses.[59] Official figures estimate that 94.2% of the population was covered by public health insurance in 2008, compared with 99.8% in 2007.

The implications of this data isthat although Turkey spends a considerable amount of its economic wealth on health services, there is room for improvement in the utilization of these resources for better health outcomes. Therefore, efficient use and sustainability of health expenditures are of vital importance. In order to examine the efficiency of the reforms in the health sector and the sustainability of health expenditures, detailed analysis on each reform component must be conducted. [60]

SUMMARY

National health accounts (NHA) is a widely accepted policy tool that allows countries to clearly visualize national expenditures on healthcare as it provides evidence to monitor trends in health spending for all sectors.

Recently the WHO has adapted the widely used NHA to the reproductive health context. The development of an NHA-RH subaccount will offer detailed health accounts in middle- and low-income countries on reproductive healthcare focusing on specific categories of spending that contribute to reproductive health, including antenatal care, childbirth and family planning.

It also provides a comprehensive approach that can be adapted to the country-specific setting while maintaining international comparability.

NHA has revealed new profiles of health spending in the MENA region. The private delivery sector consumes the largest share of health expenditures in MENA countries. Health funds were found to originate primarily fromprivate sources (61% of total health spending), and in particular from households, which represent the single largest source of national expenditures (51% of THE). This raises concerns about equity and the fairness of letting households carry such a substantial burden of financing their health systems. [61]

Approximately 56% of health spending in the MENA region occurs via external financing. The significant involvement of outside funders raises the need to clearly define their roles so that bureaucratic procedures are minimized and efficiency in transferring health funds to providers is maximized.

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CHAPTER 3:

Reproductive Health and Rights

Chapter three focuses on reproductive health issues in the MENA region, such as maternity care, abortion, fertility and family planning and reproductive cancers. Each section in this chapter attempts to explore and analyze the various aspects of each issue to better understand the struggles women in this region face in obtaining reproductive health services.
A thorough examination of the topics in this chapter will help identify both problems and solutions to some widespread, serious health risks facing women in the six countries discussed in this report. Moreover, this section examines how much progress countries have made in achieving their international obligations in reproductive health issues, ICPD goals and the UN MDGs. Disparities between countries and within one country will be scrutinized, in addition to the determinants of reproductive health services.

I- MATERNITY CARE

Maternity care receives a significant amount of attention in the international arena. Unfortunately, much of that attention is focused on the shortcomings of maternity healthcare providers in various regions. The MENA region, too, is no stranger to criticism aimed at governmental maternity care plans (or lack thereof).

Comprehensive maternity care should include high quality antenatal care that screens mothers for malnutrition, anemia, sexually transmitted infections (STIs) and other diseases, and educates women about high-risk symptoms. Skilled birth attendance at delivery is also a key component of antenatal care, while the provision of emergency obstetric care is pivotal as it can save women in the event of eclampsia, postpartum hemorrhage and other high-risk conditions.[1]

Paragraph 8.17 of the ICPD addresses issues of prenatal care. It calls on governments to provide needed maternal care and counselling with a focus on high-risk pregnancies and to provide proper delivery assistance and neonatal care, including the provision of micronutrient supplementation and tetanus toxoid.[2]

The ICPD PoA set a target of 60% of primary healthcare units providing essential obstetric services by 2015 while eliminating avoidable maternal mortalities. ICPD+5 called for skilled attendants at 60% of deliveries in countries where maternal mortality is high and 90% globally by 2015.

While the ICPD addressed reproductive and sexual health as a set of interrelated issues, the maternal mortality ratio (MMR) was singled out in the MDGs. The fifth MDG is improving maternal health, with two targets: MDG5.A, to reduce the MMR by three-quarters and MDG5.B, to achieve universal access to reproductive health. Adopting a results-based approach, governments tackled maternal mortality and morbidity merely as development issues instead of health and human rights issues. As a result, attention has largely been focused on reducing MMR while neglecting other aspects of maternal health, such as maternal morbidity and improving pregnant women's health. Nevertheless, despite the attention to MMR, MDG5 is "the furthest goal from being achieved."[3]

MMR should not be considered the only indicator of maternal health. As not all maternal deaths are reported, MMR is difficult to calculate. In addition, MMR is "useless for assessing quick changes, and for monitoring programs." Moreover, maternal health should not be limited to a mother's health. Maternal health means "that women shall survive their pregnancies and the outcome of the pregnancy, be it delivery or abortion, induced or spontaneous."[4]

Despite the problematic indicator of MDG5, a landmark Human Rights Council Resolution 11/18 was adopted in 2009. This resolution considered avoidable maternal mortality and morbidity a health, development and human rights challenge requiring cooperation and renewed commitment. It urged states to dedicate resources to tackle the issue and called on Office of the High Commissioner for Human Rights to prepare a thematic study on the human rights aspects of avoidable maternal mortality and morbidity (MMM). A follow-up resolution, 15/17, was adopted in 2010 asking states to collect disaggregated data on MMM and calling on the OHCHR to submit an analytical compilation of rights-based MMM policies. A best practices compilation of how to reduce MMM in line with human rights standards was presented by the OHCHR in 2011. A third resolution, 18/8, was adopted in 2011 asking states to address the root causes of MMM like poverty, malnutrition, harmful practices and especially violence against women. The resolution asked the OHCHR to provide technical guidance on the application of a rights-based approach on the policies and programs aimed at eliminating avoidable MMM, which was done by the High Commissioner in 2012.

In the upcoming section, we will discuss the magnitude of the problem of maternal mortality by examining two indicators: the maternal mortality ratio and adult lifetime risk. This is followed by a discussion of the prevention of maternal deaths by analyzing emergency obstetric care and skilled attendance at birth. Antenatal care will be used as an indicator to measure the promotion of maternal health, while inequalities in access to maternal health services will be displayed along with maternal morbidity.

i- The Magnitude of the Problem

Maternal Mortality

a. Measurements and Statistics
The WHO defines maternal death as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes."[5] According to the UNFPA, most maternal deaths are caused by hemorrhage, obstructed labor, unsafe abortion, infection (sepsis) and eclampsia (pregnancy induced hypertension). In addition, malaria, HIV and anemia are indirect causes of maternal death.[6]

The MMR is defined as "the ratio of the number of maternal deaths during a given time period per 100,000 live births during the same time-period."[7] A maternal death refers to a female death from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy. As mentioned above, MMR is difficult to calculate as not all maternal deaths are recorded.

In addition, data collected on maternal mortality is rarely disaggregated, and governments usually lack transparency in reporting maternal death and morbidity.[8] For instance, a study published in 2006 shows that monitoring of maternal deaths was not adequate in the West Bank in the OPT where notification sheets of maternal death were incomplete and notifications of maternal death were not reported immediately.[9]

The maternal mortality rate (MMRate) is another indicator for measuring maternal health. The MMRate is defined as "the number of maternal deaths in a population divided by the number of women of reproductive age." This indicator "captures the likelihood of both becoming pregnant and dying during pregnancy or the puerperium (six weeks after delivery)."[10]

Table 9: Maternal deaths per 100,000 live births, achievement of ICPD targets and lifetime risk of maternal death (1995, 2003, 2008/2011)

Country	1995	2000	2005	2010	Confidence intervals of MMR uncertainty (2010)	Adult lifetime risk
Egypt	150	100	78	66	40–100	490
Kuwait	10	9	8	14	8–23	2900
Palestine	72	64	67	64	28–150	330
Tunisia	110	84	68	56	29–110	860
Turkey	51	39	28	20	13–32	2200
Yemen	520	380	270	200	110–370	90

Source: Trends in Maternal Mortality: 1990 to 2010, estimates developed by WHO, UNICEF, UNFPA and the World Bank

"Countries should strive to effect significant reductions in maternal mortality by 2015: reductions by one half of 1990 levels by 2000 and further one half by 2015 . . . " (ICPD PoA, para. 8.21)

According to the WHO, in 2005, MMR in the MENA region was 200–210 per 100,000 live births with an estimated 15,000–21,000 maternal deaths, a decrease from 150–270 per 100,000 live births in 1990.[11]

In 2000, MMR was estimated at 100 per 100,000 live births in Egypt, falling to 66 per 100,000 live birthsin 2010. In 2010, MMR was estimated at 20 in Turkey and 200 in Yemen per 100,000 (see Table 9). Sadly, most of these deaths could have been prevented "if affordable, good-quality obstetric care were available 24 hours a day, 7 days a week."[12] Studies conducted in developing and developed countries indicate that "prenatal care is an important determinant of improved health outcomes among infants and that birth delivery assistance

from a trained and well-equipped provider is necessary to reduce maternal mortality." [13]

As one country that is on track to achieve MDG5, Egypt made an effort during past decades to lower the MMR, resulting in a decrease from 150 in 1995 to 82 in 2005. The government undertook a series of initiatives, most of them with USAID, aimed at upgrading maternal healthcare,[14] one of which was the National Maternal Mortality Surveillance System. The initiative documents and investigates each maternal death with a local office in every governorate. Although it looks good on paper, the results of the surveillance system are not publicly available.[15]

In Yemen, available statistics show an improvement in lifetime risks from 1995 to 2010. Risk was estimated at one maternal death for every 13 births in 1995, decreasing to one in 19 births in 2000, one in 39 births in 2005 and one in 90 births in 2010. Despite the obvious progress, adult life risk of maternal health is still high in Yemen. The total fertility rate and health facility conditions play a major role in the high risk of maternal death in Yemen.[16]

Yemen is a signatory to both the ICPD and the MDGs and is one of ten countries chosen for the UN Millennium Project. However, recent MDGs progress reviews suggest that it is unlikely that the maternal health MDG will be reached by the target date of 2015.

Kuwait has the lowest maternal mortality ratio in the countries examined in this report. In 2010, the MMR was only 14 per 100,000 live births (see Table 9). Obstetric hemorrhage and thromboembolism are the leading causes of maternal mortality, with thromboembolism causing 28.6% of maternal deaths. The proportion of deaths from puerperal sepsis (14.3%) was reported after the 1980s when substandard care was identified as a cause in 70% of direct and 55% of indirect deaths.[17]

Tunisia has succeeded at decreasing the MMR from 110 per 100,000 live births in 1995 to 56 per 100,000 live births in 2010 (see Table 9). Data shows that during this period, Tunisia achieved improvements in various aspects of maternity care, seen in more prenatal visits, fewer home deliveries and more deliveries assisted by skilled birth attendants. Some argue that such achievements are the result of strong political will to reduce MMR, in addition to pro-women political decisions.[18]

ii- Prevention of Maternal Deaths

a. Skilled Birth Attendance

One target of both ICPD+5 and the MDGs is ensuring that 90% of all births are assisted by skilled birth attendants, which include doctors, nurses, midwives and other health workers. Although pregnancy complications are not preventable, they are better handled in the presence of a skilled birth attendant.[19]

by skilled health staff.[20] Skilled birth attendance in Kuwait is universal, while Palestine comes in at a close second and

Table 10: Skilled health attendants at birth

Country	% of deliveries attended by skilled healthworker
Egypt	78.9 (2008)
Kuwait	100 (2007)
Palestine	98.9 (2006)
Tunisia	94.6 (2006)
Turkey	91.3 (2008)
Yemen	35.7 (2006)

Source: MDG Indicators (http://mdgs.un.org/unsd/mdg)

The data shows an improvement in the presence of skilled health attendants during deliveries performed in the MENA region. It has been estimated that in 1995-97, a total of 82% of deliveries performed in the MENA region were attended from 1999 to 2003.[21]

Turkey has a relatively high rate (91.3%). In Tunisia, there has been an increase in the number of deliveries assisted by skilled birth attendants, from 89.3% in 1999 to 94.6% in 2006, while the number of home deliveries decreased by 33%

In Yemen, skilled birth attendance is very low; less than 50% of women have undergone deliveries with trained personnel. Home deliveries are common in both urban and rural areas, but it has been reported that some women in urban areas give birth at home with a skilled attendant.[22]

In Egypt, according to the latest DHS (2008), medical assisted deliveries have steadily increased from 46% in 1995 to 61% in 2000, reaching 74% in 2005 and 79% in 2008.It has been reported that only 33% of delivery facilities have basic supplies needed for conducting normal deliveries. According to the Egypt Service Provision Assessment, this number has increased from 21% in 2002. Basic supplies include "an instrument to cut the umbilical cord, umbilical cord clamps or ties, a suction apparatus, antibiotic eye ointment for the new-born, and a disinfectant for cleaning the perinea area."[23] In facilities lacking such basic supplies, the provision of adequate obstetric emergency care cannot be ensured. As a result, emergency cases must be referred to other facilities, but only 10% of medical facilities have a system supporting transportation to another facility for obstetric emergencies.[24]

Education is an important factor in a woman's choice of where to give birth in Turkey. For instance, women with higher levels of education tend to choose a facility delivery over a home delivery and a modern home delivery over a traditional one.

b. Emergency Obstetric Care

Obstetric emergencies are not predictable. As a result, adequate delivery care is dependent on the availability of highly skilled staff. Emergency obstetric care can only be provided via investment in training, staff and equipment, which are not available in home deliveries.[25]

In 2007, the Palestinian Central Bureau of Statistics (PCBS) reported that 96% of women had access to comprehensive emergency obstetric care.[26] Due to the political situation in the OPT, adequate emergency obstetric care is not properly provided to women incurring obstetric emergencies. As a result of problems of mobility and security, Palestinian women in the West Bank often face delays in accessing needed medical care such as surgery. In a study conducted in 2006, it was reported that a "young woman with post-delivery bleeding needed hospital management and had to be referred to a hospital 20 km away. Because of a delay at a military checkpoint, it took her 3 times longer than normal to travel the distance and she died before she reached the hospital."[27]

In Turkey, a 2005 study assessing emergency obstetric care found several obstacles hindering women from accessing needed emergency obstetric care, including lack of needed skilled staff, equipment and supplies as well as insufficient managerial capacities. In addition, the study indicated that "low levels of awareness due to poor female literacy rates and a lack of empowerment reduced access to maternal health services."[28]

An assessment study was conducted in Yemen in 2008 to identify the main constraints in delivering emergency obstetric care. The findings pointed to the lack of adequately trained staff and service providers and poorly supplied facilities that lacked basic equipment (like a blood bank, and an intermittent supply of water and electricity).[29]

iii- Promotion of Maternal Health

In addition to the traditional elements of antenatal care (ANC), such as height, weight and blood pressure monitoring, antenatal care should include measures to predict potential health risks of pregnant women and improve maternal health. The WHO recommends "a minimum of four [antenatal] visits, with emphasis based on the mother's health, such as screening of HIV/syphilis, monitoring of sugar, blood pressure, urine protein, iron and folic acid supplementation, and at least two doses of tetanus toxoid in areas where neonatal tetanus is common."[30]

In MENA countries, like most developing countries, ANC is not properly provided to most pregnant women. In 2001, the WHO and UNICEF reported that while 98% of pregnant women in industrialized countries receive antenatal care, only 65% of pregnant women in the MENA region receive such care.[31]

Table 11: Antenatal care coverage in six countries in the MENA region

Country	At least one antenatal visit (%)	At least four antenatal visits (%)
Egypt	73.6 2008)	66.0 (2008)
Kuwait	100 (2007)	N/A
Palestine	98.8 (2006)	N/A
Tunisia	96.0 (2006)	67.5 (2006)
Turkey	92.0 (2008)	73.7 (2008)
Yemen	47.0 (2006)	13.9 (2003)

Source: MDG indicators (http://mdgs.un.org/unsd/mdg/Data.aspx)

Table 11 shows that more women have at least one antenatal care visit than have at least four visits. ANC coverage in Yemen are very low, with less than 50% of women having at least one antenatal care visit while only 13.9% of Yemeni pregnant women have at least four care visits. On the other hand, Turkey, considered one of the most developed countries in the region, managed to increase significantly the percentage of pregnant women who receive at least four visits. The Turkish Ministry of Health reported in 1993 that 37.7% of pregnant women do not receive proper antenatal care, but this number has declined over the past few years. One study found that the percentage of pregnant women who received at least four prenatal visits increased from 57.3% in 1999 to 67.5% in 2006.[32] In 2008, this percentage reached 73.7%, which is relatively high but not when compared to the percentage of pregnant women who receive at least one visit (92%).

Recent data shows an increase in the number of pregnant women receiving ANC especially in Tunisia, Turkey, Kuwait and Palestine. However, the number is not as high in Egypt, where only 74% of pregnant women receive antenatal care.[33] In Yemen, figures are far from promising and there has been little improvement, as less than half (47%) of pregnant women receive even a single antenatal visit.[34]

A comparison between one-visit and four-visit coverage reveals a huge gap in most of the countries under review. In both Turkey and Tunisia, coverage with four ANC visits is lower by almost 30% than one visit. In Egypt, the difference between the two figures is not high, as ANC coverage of at least four visits is 66%, but it is important to keep in mind that the one-visit indicator is not high in the first place. In Yemen, where less than half of the pregnant female population has at least one visit, only 14% of pregnant women have four visits. The low four-visit coverage represents missed opportunities for women and their babies for more evidence-based interventions.[35] The package of four ANC visits, called "focused ANC," includes among other services the identification and management of pregnancy complications, tetanus toxoid immunization, intermittent preventive treatment for malaria during pregnancy and identification and management of infections, HIV and other STIs during pregnancy. Moreover, the four-visit ANC package enhances the chances for skilled birth attendance, natural breastfeeding and better pregnancy spacing.

Providing tetanus vaccinations is an essential element of prenatal care. According to the Department of Making Pregnancy Safer at the WHO, all birthing women and their newborns should be protected against tetanus. The WHO calls for the availability of tetanus vaccines, equipment and supplies in addition to training antenatal care providers in tetanus immunization.[36]

MENA countries have made significant progress with immunizations. Neonatal tetanus elimination caught the attention of health professionals at international organizations in the 1980s, and in 1999, UNICEF, WHO and UNFPA agreed to set a goal to reduce neonatal tetanus cases to less than 1 per 1,000 live births in every district of every country by 2005. Maternal tetanus elimination was added later to the goal. In all cases, neonatal tetanus elimination has been used as a proxy for maternal tetanus elimination.[37]

Table 12 shows estimates of the proportion of live births protected through maternal immunization with at least two doses of tetanus toxoid. These estimates, from 2000 onward, were collected by the WHO in their efforts to eliminate tetanus in countries where the risk of neonatal tetanus is a significant public health problem.[38]

Table 12: Tetanus protection at birth in six countries in the MENA region

Country	1995 (%)	2003 (%)	2010 (%)
Egypt	76	82	86
Kuwait	37	80	95
Palestine	N/A	N/A	N/A
Tunisia	58	87	96
Turkey	42	53	90
Yemen	30	65	66

Source: WHO-UNICEF estimates [39]

According to the WHO, "all countries are committed to 'elimination' of maternal and neonatal tetanus (MNT), i.e. a reduction of neonatal tetanus incidence to below one case per 1000 live births per year in every district."[40]

In 2000, neonatal tetanus was still not completely eliminated in the countries of the MENA region. In Yemen, neonatal tetanus was eliminated in less than 10% of the country's districts, but it was eliminated in more than 50% of the districts in both Egypt and Turkey and was completely eliminated in Kuwait and Tunisia.[41]

By 2011, maternal and neonatal tetanus were eliminated from Egypt and Turkey. This leaves Yemen, in addition to Iraq and Sudan, among the few countries in the region that have failed to eliminate maternal tetanus.[42]

iv- Inequalities in Maternity Care Services

Data show a significant improvement in the status of maternal health in most MENA countries, but many women in the region do not have full access to proper maternal health due to their geographic location, ethnic background and/or socioeconomic status.

In Turkey, healthcare services are likely to be more accessible in the relatively developed regions in western Turkey compared to the regions in the east. A study shows that living in the western regions of Turkey was "positively and significantly associated with prenatal care utilization."[43] In addition, Kurdish women were more likely to have traditional home deliveries instead of facility deliveries. Interestingly, the study indicates that Kurdish women are unlikely to seek care provided by health professionals, suggesting that this might be due to cultural and economic factors or the poor quality of health services provided.

Similar to Turkey, Yemeni women suffer from inequality in accessing maternal health services. Studies show that "women have unequal access to services based on their place of residence, geographical distribution, wealth and educational level."[44]

In Egypt, most antenatal care (74%) is provided by the private sector, and limited data is available on the quality and conditions of this care.[45] The unavailability of antenatal care in governmental facilities raises serious concerns regarding unprivileged women's ability to seek and obtain needed maternal health. In addition, there is a high discrepancy between urban and rural women in receiving antenatal care. The DHS of 2008 shows that more than 80% of urban women aged 15-49 years had at least four health visits during pregnancy by any provider while only 57% of rural women aged 15-49 years received such care. [46]

In the OPT, disparities in access to maternal health services are considerably affected by the political situation. In a survey conducted in 2004, 20% of interviewed women stated that their childbirth location was not the preferred place of delivery. Of these, 13.7% reported that access to maternal health services was impeded by Israeli Defense Force (IDF) measures.[47]

In Kuwait, and unlike the rest of the countries examined in this report, the total population access to local health services in general was universal (100%). As 95% of the Kuwaiti population is urban, there is no gap between access to maternal health services in urban and rural areas.[48] The highly urbanized population of Kuwait can be attributed to high living standards.

Voice on Maternity Care from Palestine [49]

"After three hours of driving from one checkpoint to another to get to the Ramallah hospital, Fatima's labour pains were becoming unbearable. By the time the taxi reached Aljabá checkpoint, cars were lined up for 150 metres. Realizing the gravity of the situation, the driver urged Fatima and her mother to proceed on foot. 'Khayta (sister),' he said, 'Please walk to pass the checkpoint or you won't make it to the hospital.'

After taking a few steps, Fatima (not her real name) felt the baby dropping in her pants. Clutching her mother's wrist and leaning on her shoulder, Fatima cried out 'Yammah (mother), I think the baby is out. Please get help.'

Panicking, her mother asked Fatima to lie down and started screaming for help. She covered her daughter with her coat to protect her dignity, while women at the scene gathered around to shelter her from the curiosity of crowds passing by. In the midst of the crowd, without proper care, Fatima gave birth to her fifth child, a baby girl, whom she later named Najat (meaning salvation). In tears, the mother wrapped the newborn in a tiny blanket and held it as she waited for help to come.

At the sound of cries and pleas, according to Fatima's testimony, which was documented by the Women's Center for Legal Aid and Counselling, two good Samaritans crossing the checkpoint approached the women. One identified himself as a surgeon from Al-Makased hospital in Jerusalem. He tried to calm Fatima and her mother, and then proceeded to cut the umbilical cord. His companion called for an ambulance because Fatima was haemorrhaging.

Forty-five minutes later, the ambulance arrived at the checkpoint and was allowed to transport Fatima, her newborn and her mother to the hospital. Upon arrival, they were rushed to the emergency room where Fatima received two units of blood while the baby was taken to the nursery for a check-up.

In the days and months to come, Fatima tried to live a normal life, but found herself overwhelmed by shame, anxiety and depression. 'After what I have been through, I hated my body and that of all women,' she said. 'I cannot look at myself in the mirror and breastfeed my own daughter, thinking she was the cause in all of this'.

'For a long time I isolated myself fearing to face my family's and the neighbours' questions about the incident,' she added. 'I feel besieged and cannot mentally and psychologically overcome it. I need help.'"

Source: UNFPA

v- Maternal Morbidity

According to the UNFPA, maternal morbidity is a "serious disease, disability or physical damage such as fistula and uterine prolapse, caused by pregnancy-related complications. Maternal morbidity is widespread, but not accurately reported."[50] Lack of emergency obstetric care is a main cause of maternal morbidity. Due to lack of equipment, supplies and skilled staff in medical facilities, home deliveries without the assistance of trained attendants, and unsafe, clandestine abortions, many women fail to obtain necessary emergency care.

Maternal morbidity is one of many underreported reproductive health issues. As governments tend to focus only on reducing mortality without giving proper attention to improving health and avoiding morbidity, it is neglected. In many cases maternal morbidity is thus a "silent agony" for women.

Pregnancy-related complications include obstetric fistula, damaged pelvic structure, chronic infection, anemia, infertility, depression and impaired productivity. As a result of their medical conditions, women may be at risk of social isolation, shortened life spans and, in some cases, suicide. In addition to social problems, the costs of medical care are a major financial burden on these women and their families.[51]

Fistula is an injury in the birth canal that allows leakage from the bladder or rectum into the vagina, leaving a woman permanently incontinent and often leading to isolation and exclusion from the family and community.[52] Fistula can be avoided by adequate delivery care by skilled birth attendants as well as access to emergency obstetric care for women developing complications during delivery. Fistula is a major maternal morbidity problem in poor developing countries while it is rare in developed countries. The newly released Global Fistula Map shows a great disparity in the presence of fistula between developed and developing countries.[53]

Genital Tract Fistula (GTF) is neglected as an alarming health issue in Yemen, meaning that GTF cases are rarely documented.[54] Yemen is one of the few countries in the MENA region where "the prevalence of obstetric fistula is high, especially among rural areas."[55] Poverty, especially in rural areas, limits the access of many Yemeni women to adequate healthcare. In developing countries, obstructed labor is one of the main causes of GTF,[56] and early marriage is an indirect cause. Reduced pelvic dimensions due to early childbearing (when the female body has not fully developed) is one of the causes of GTF in Yemen.

Socioeconomic class and geographical location play a major role in a woman's ability to access proper medical care. In 2003, a study was conducted on maternal morbidity in rural areas in Upper Egypt (southern Egypt). It found that the literature on maternal morbidity in Egypt is limited and inaccurate and that a high percentage of women report cases of puerperal bleeding and puerperal fever after delivery. The study estimates that more than 50% of women in Upper Egypt experience such complications, but most of these women do not receive proper medical care.[57]

Maternal mortality and morbidity are still serious health concerns for women in the region. Many Yemeni women and girls forced into early marriage face pregnancy-related complications such as obstetric fistula. As seen time and time again in this report, a woman's maternal health is hugely affected by education, place of residence, socioeconomic conditions and employment status.

While the MENA region has made some notable achievements in reducing maternal mortality, there is more to reproductive health rights than the MMR. Women in the region still suffer from many pregnancy-related complications that are entirely preventable. It is important to applaud the efforts of the six countries studied in this report, but it is even more important to recognize that this progress is not satisfactory. The MENA region as a whole needs to make the overall health of the female population a main priority.

SUMMARY

In the countries examined in this report, attention has focused mostly on reducing the MMR. The governments of the six countries have neglected other important aspects of maternal health such as maternal morbidity and the improvement of pregnant women's health in general. Many women in the region do not have access to high quality, affordable and adequate maternal care services.

In the past few years, efforts have been made to eliminate maternal and neonatal tetanus. By 2011, tetanus was eliminated from Egypt and Turkey, but maternal and neonatal tetanus is still widespread in Yemen. Most countries examined in the report show progress in antenatal care coverage. Home births are still common in some countries in the MENA region especially Yemen.

Due to the absence of skilled health attendants during deliveries performed in homes and health facilities, women in the MENA region face a high risk of obstetric emergencies that could be prevented or, at the very least, better handled by the presence of adequately trained healthcare providers and necessary equipment.

II- ABORTION

Abortion has been internationally recognized as a serious reproductive health issue that raises significant human rights concerns. Among the key elements of a rights-based approach to abortion is to ensure a woman's autonomy in deciding whether to continue or terminate a pregnancy, to facilitate access to abortion services and to examine and reform laws hindering women from exercising their rights.[58] A discussion of abortion in the MENA region must lead "to a political discussion since the issue has come to concern national laws, international organizations, religious institutions, human rights concerns and the healthcare sector as well as the privacy of women's personal lives and bodies."[59]

International Commitments on the Issue of Abortion
Paragraph 8.25 of the ICPD states that abortion should not be used as a family planning method while acknowledging the role of governments, intergovernmental and non-governmental organization in addressing abortion as both a women's health issue and a public health issue. The paragraph clearly states the right of women to "have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family-planning services should be offered promptly, which will also help to avoid repeat abortions."[60]

However, the ICPD did not address the issue of women's access to safe abortion in cases where it is illegal. While the ICPD urged a consideration of reproductive health issues and fertility regulations as reproductive rights, it did not tackle the legalization or the safety of abortion, which is a major cause of avoidable mortality and morbidity of women. Negotiations among the states participating in the ICDP meeting in Cairo led to a compromise on abortion, which resulted in a contradictory approach: "safe abortion should be provided only if it is legal, on the one hand, and on the other hand, it should be prevented and resources to it should be reduced or better eliminated."[61] This demonstrates the conflict between a moral judgment on abortion and the perception of abortion as a serious public health issue. The contradiction is further illustrated on making the safety of abortion dependent on its legality, meaning that in countries where the law prohibits abortion, unsafe abortion should be tolerated.[62]

A further step was taken by ICPD+5 in 1999, stressing the importance of training and equipping health services providers to perform safe abortions in countries where it is legal.[63] The CEDAW (Article 16) guarantees women equal rights in deciding "freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights." In addition, the CEDAW Committee has addressed the issue of women's access to healthcare services and women's right to make decisions about the number and spacing of their children.[65] The Committee also has raised "general concerns about the lack of accessibility of safe abortion, particularly in cases of rape."[66] The Beijing Platform for Action states that "the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence." The CEDAW Committee has stated that "when possible, legislation criminalizing abortion could be amended to remove punitive provisions imposed on women who undergo abortion."
The Committee on the Rights of the Child has made the link between maternal mortality and high rates of illegal, clandestine, and unsafe abortions,"[67] and the Human Rights Council (HRC) has "discussed illegal and unsafe abortion as a violation of Article 6 of the Civil and Political Rights Covenant, the right to life, and has made the link between illegal and unsafe abortions and high rates of maternal mortality."[68] The HRC also "criticized legislation that criminalizes or severely restricts access to abortion [in addition to] laws that restrict access to abortion where a woman's life is in danger."[69]
The Special Rapporteur on the Right to Health presented a report in 2011 to the UN General Assembly on criminalization and other legal restrictions on reproductive health services, including abortion. He concluded that "states must take measures to ensure that legal and safe abortion services are available, accessible, and of good quality," calling on states to "decriminalize abortion" and "to consider, as an interim measure, the formulation of policies and protocols by responsible authorities imposing a moratorium on the application of criminal laws concerning abortion."[70] In addition, post-abortion medical services, regardless of the legality of abortion, must always be available, safe and accessible.[71]

Among the MDGs for 2015 are improving gender equality, empowering women and improving maternal health. Although abortion is not addressed directly in any of the MDGs, women's control of their own fertility is a key milestone in improving women's empowerment. At the same time, "unsafe abortion in many countries is a key obstacle to meeting the MDGs." [72]

i- Legal Status of Induced Abortion

Table 13: Grounds on which abortion is permitted

Country	Grounds on which abortion is permitted						
	To save the woman's life	To preserve physical health	To preserve mental health	Rape or incest	Fetal impairment	Economic or social grounds	On request
Egypt	×						
Kuwait	×	×	×	×	×		
Palestine	×	×	×				
Tunisia	×	×	×	×	×	×	×
Turkey	×	×	×	×	×	×	×
Yemen	×						

Source: UN, World Abortion Policies 2011

The MENA region has some of the most restrictive abortion laws in the world . Almost all MENA countries allow abortion to save a woman's life,[73] and countries such as Egypt and Yemen only allow abortions in this case; it is illegal and consequently unsafe in all other conditions. In Egypt, the law does not specify exactly when an abortion is permitted, but the physicians' code of ethics allows an abortion to save a woman's life and/or health. In the latter case, it requires the approval of two other specialized doctors and a detailed report submitted after the operation.

Tunisia and, until recently, Turkey were exceptions to the general rule of highly restrictive abortion laws in the MENA region.

In the middle stands Kuwait with some restrictions on abortion. Abortion is permitted to save the woman's life, preserve her physical and mental health and in the case of fetal impairment.

In the OPT, Jordanian and Egyptian criminal laws are in force in the West Bank and Gaza respectively.[74] Jordanian law, similar to the law in Kuwait, permits abortion to save women's lives or their physical and mental health and avoid giving birth to deformed children.[75] In Gaza, the very restrictive Egyptian law on abortion is applied.[76]

Kuwait was the first Arab country in the Gulf to permit abortion on less restrictive grounds. In 1981, abortion became legal if the pregnancy is of less than four months' duration and endangers the woman's life. Abortion is also allowed to avoid the birth of a child with a serious physical or mental malformation. Kuwaiti law requires the consent of both the woman and her husband for the abortion to be performed, although spousal consent has been considered a breach of a woman's right to control her own body.[77] After the first Gulf War, there was wide discussion on the rape of Kuwaiti women by Iraqi soldiers. Kuwaiti Islamic jurists concluded that rape was not a justification for abortion,[78] and, as a result, Kuwaiti law does not permit legal abortion for victims of sexual violence.

Tunisia, the first Muslim country to legalize abortion, allows abortion on request in the first trimester. The legalization process began in 1965 when the first law legalizing abortion was issued; it was subsequently liberalized in 1973. Initially, the law limited the right to abortion to women who already had at least five children and during the first three months of pregnancy. In the same year, the Office Nationale de la Familleet de la Population (ONFP) was successfully established for the purpose of promoting a strong family planning program. Simultaneously, the ONFP started creating access to safe abortion and other reproductive health services. In 1973, the law was further modified to allow abortion for all women, regardless of their marital status or number of children. The law permitted an abortion during the first three months of pregnancy, to be conducted in a hospital or health clinic or authorized by a physician lawfully engaged in his profession.[79]

It is worth noting that Tunisia is one of the few predominantly

Muslim countries—98% of the population is Muslim—to have legalized abortion, and the country has been at the forefront of adopting pro-women's rights laws in the region. Under President Habib Bourguiba, who ruled Tunisia 1957-87, access to safe abortion became a legal right of Tunisian women, along with the right to vote, work and divorce.[80]

In Turkey, abortion was legalized in 1983 when the population planning law allowed for abortion on request during the first ten weeks from conception.[81] Interestingly, the law did not provoke a wide public debate nor were there public pro- and anti-abortion campaigns. On the contrary, the law was discussed and debated at the highest levels of the Turkish government. Some argue that there is a lesson to be learned here—that progressive, pro-women decisions can be made if "the right policymakers are in power."[82] On the other hand, some Turkish feminists have criticized the 1983 abortion law, arguing that it was not motivated by concerns for the well-being of women. In fact, feminists noted that the law was a governmental population policy promoted at the expense of women's health, to satisfy the government's need for a voluntary population control mechanism instead of as a response to Turkish women's demands for reproductive rights.[83] Regardless of the logic behind the law, Turkey's more progressive approach to abortion is perilously close to collapse. In May 2012, Prime Minister Recep Tayyip Erdogan stated that abortion was murder, and his government is reportedly working on a law that would ban abortions after four weeks from conception, except in emergencies. With his statement and impending legislation come serious fears that such a law will only lead to more unsafe abortions and an increase in maternal mortality. If this legislation passes, it will surely be a step in the wrong direction for women's sexual and reproductive health rights in Turkey as well as the entire MENA region.[84]

ii- Abortion in Islam

Islam is a diverse religion and Islamic views on abortion are complex. Interpretation of Islamic law, or Sharia, with regards to women's issues in particular, is an ongoing contentious issue among Islamic jurists, state-sponsored religious institutions and women's rights advocates.

Islamic views of abortion are highly contested. While some argue that abortion is generally prohibited, "others stress on the fact that all Muslim authorities recognize the mother's well-being as the major exception to Islam's general prohibition of abortion."[85] The general prohibition of abortion is based on its similarity to infanticide. There is also a general consensus among Islamic jurists that it is forbidden to terminate a "pregnancy that results from illicit sexual activity, such as an extra-marital relation."[86] In countries such as Turkey and Tunisia, where abortion is legal, laws are more liberal toward women, including personal status laws. One of the reasons for the Tunisian abortion law is the adoption of more liberal interpretations of Islamic law on women's issues and related personal status and family laws.

However, Islamic law is not the only factor in national laws on abortion in predominantly Muslim countries. Studies show that current laws emerged from the interaction between Islamic law and colonial laws carrying restrictive Western attitudes toward abortion. For instance, the French colonial administration in North Africa enforced an anti-abortion interpretation that echoed France's own prohibition of abortion.[87] Thus, restrictive national abortion laws in the MENA countries "cannot be predicted based only on their use of Sharia or colonial law."[88] Islamic law is sometimes used as a justification to approve or disapprove of women-related issues perceived as sensitive cultural issues.

iii- Current Situation with Regards to Abortion in the Region

Unintended pregnancies occur to a great extent in the region due to many reasons, including lack of access to contraceptive methods and the failure and incorrect use of contraception. Women with unwanted pregnancies may seek to end these pregnancies by induced abortion. While induced abortion is still one of the most underreported reproductive health issues, available estimates can provide us with useful insight.

iv- Unsafe Abortion and Percentage of Maternal Deaths Attributed to Unsafe Abortion

The latest estimates from WHO indicate that more than three million unsafe abortions were performed in 2008 in the MENA region, accounting for 14% of maternal mortality.[89] The number of unsafe abortions almost doubled in less than a decade, up from 1.5 million in 2003.[90]

Lack of access to safe abortion services directly results in unsafe abortions, which is a significant health and human rights issue in most countries in the MENA region.

Table 14: Estimates of unsafe abortions and related maternal deaths

Region	Regional estimate of annual number of unsafe abortions (2008)			Maternal deaths due to unsafe abortions	% of total maternal deaths
	Number (rounded)	Number (lower estimate)	Number (high estimate)		
North Africa	900,000	890,000	910,000	1500	12
Western Asia	830,000	790,000	870,000	600	16

Source: Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008, sixth edition

According to the WHO, unsafe abortion is "characterized by the inadequacy of skills of the provider, hazardous techniques, and unsanitary facilities."[91] Unsafe abortion is defined based on inappropriate conditions in the processes before, during and after an abortion,[92] and it is separate from the issue of legality.[93] The lack of pre-abortion counselling, immediate intervention to respond to emergencies during the procedure and the lack of post-abortion care are some factors that lead to unsafe abortions. Unsafe abortion also includes inducing abortion by inserting an object into the woman's uterus, performing violent abdominal massage, ingesting traditional medication or hazardous substance and performing a medical abortion that is prescribed incorrectly or by inadequate provider. Another feature of unsafe abortion is women's reluctance to seek proper medical care because of legal and socio-cultural concerns.[94]

Global and regional estimates of the incidence of unsafe abortion are put together by WHO, where MENA countries are divided between North Africa and Western Asia. WHO estimated that in 2008, 900,000 unsafe abortions took place in North Africa and 830,000 in Western Asia. Legal conditions will continue to lead to unsafe abortion in North Africa, except for Tunisia with its liberal abortion law. In Western Asia, where the number of unsafe abortions is reported as lower than North Africa, similar contraceptive prevalence rates and total fertility rate patterns suggest that the data on unsafe abortion is underestimated.[95]

The WHO estimated that countries in North Africa, including Egypt and Tunisia, had an unsafe abortion rate of 22 of 1,000 women aged 15-44 in 2003 and 18 of 1,000 women aged 15-44 in 2008.[96] In 2003, WHO estimated that unsafe abortion contributed to 11% to maternal deaths. Since abortion is illegal in most MENA countries, it is likely underreported.[97]

At the same time, the percentage of maternal deaths due to unsafe abortion is at a high 12% in North Africa and a very high 16% in Western Asia. Unsafe abortion procedures in developing countries have tragic consequences for maternal mortality and morbidity, with a higher risk of death due to complications from unsafe abortion procedures. The WHO estimates the risk as several hundred times higher than that of an abortion performed professionally under safe conditions.[98] It is impossible to tackle maternal mortality without addressing unsafe abortion, especially since deaths resulting from unsafe abortion are totally avoidable.

Maternal deaths from unsafe abortions were estimated at 130 deaths per 100,000 unsafe abortions in 2003, which increased to 170 in 2008, accounting for 12% of maternal deaths.

Prevalence of Unsafe Abortions at the Country Level

Studies from the MENA region show that, in spite of the laws restricting abortion in most countries, married and unmarried women undergo abortion, but these cases are not officially reported nor openly discussed. Most of the time, such abortions are clandestine and unsafe. Due to the absence of national databases on unsafe abortions, accurate information is not available. Laws that penalize women and medical staff for performing abortions only add to the secrecy surrounding unsafe abortion.[99]

In Turkey, accurate data on unsafe abortion is not available. In 1997, a study at 615 hospitals in 53 provinces was conducted to determine the main causes of maternal mortality. This study indicated that 4% of women died from complications from unsafe abortion.
A study conducted in Egypt estimated that one of every five obstetric admissions is for post-abortion treatment.[100] A study conducted in 2009 on reported maternal mortality shows that 4% of maternal deaths in the West Bank of the OPT are

caused by post-abortion complications.[101] Comprehensive data on post-abortion care services in the MENA countries is not available.

In Yemen, data on abortion is very limited, and not only because of conservative theological and political opinions. Even when available, it may not be fully reliable, as questions on abortion in some Yemen national surveys do not distinguish between induced and spontaneous abortion. Nevertheless, research suggests that abortion might be used as a method to control family size, especially in countries where contraceptive methods are not available. In the case of Yemen, a study conducted to examine issues of fertility and contraception found evidence that use of "abortion as a method of birth control is widespread."[102]

Human Rights Watch has voiced its concerns over Jordanian and Egyptian laws that deny victims of sexual violence the right to a legal abortion. In the occupied Palestinian territory, where Jordanian and Egyptian laws are in force, they limit women's choices to either undergoing unsafe abortion or "bear[ing] the social and psychological burdens of an 'illegitimate' pregnancy and childbirth."[103]

In Egypt where abortion is only permitted to save a woman's life, clandestine abortion is a common practice, but the safety of the procedure depends on the woman's socioeconomic class. One study concluded that safety is expensive for women in Egypt, and thus only wealthy women can "literally buy safety."[104] The study identified the main abortion methods in Egypt and divided them into three levels of safety. The first is the use of indigenous methods, which are the cheapest and also the most dangerous. The second method is biomedical abortion at clandestine clinics; while safer than the first type, it is not without risk. Biomedical abortions administered by private gynecologists are the safest as well as the most expensive method available to women. The majority of Egyptian women cannot afford the cost of biomedical abortions administrated by private gynecologists nor can they afford the clandestine methods. This leaves poorer women to face the risks of the less expensive and more dangerous methods of abortion. Governmental data in Egypt shows the percentage of maternal deaths due to abortion, but it does not note whether the abortion is spontaneous or induced. According to the Egyptian Ministry of Health, abortion was the cause of 4.6% of maternal deaths in 2000, 4% in 2002 and 1.9% in 2006.[105]

Although all abortions performed should be reported to the Kuwaiti Ministry of Public Health, data on the incidence of abortion and maternal mortality due to abortion are not available. It might be that the maternal mortality associated with abortion is negligible, which often leads governments to ignore the seriousness of the issue.

v- Dangers of an Unsafe Abortion

Abortion services in clandestine clinics are not adequately provided. For instance, a study conducted in Egypt shows that women must leave immediately after the procedure and before recovery due to clinic physicians' fear of discovery. In addition, abortion services are usually provided with "a disrespectful and physically rough manner in these clinics." Although they felt mistreated, women reported that "they felt they had to submit to this treatment because they had no other alternative."[106]

In addition to economic inequality, geographic location might determine women's access to safe abortion. Studies show gaps in the availability of reproductive health services between urban and rural areas and between the poorer eastern regions in Turkey and the more affluent western regions.[107]

Although abortion is legal, in reality safe abortion is not accessible by all Turkish women who need it. Turkish law requires the procedures to be performed by or under the supervision of gynecologists, and in Turkey's socialized public health system, abortion services are restricted to the availability of obstetricians, who are less likely to be present in rural areas compared to mid-level healthcare providers and general practitioners. In addition, "healthcare facilities without obstetricians have to refer their abortion cases, even those with severe bleeding, to a higher level facility."[108] As a result, women living in rural areas have limited access to safe abortion services. It is worth noting that "properly trained paramedical personnel could also perform the procedure as safely and effectively as physicians [without] substantial difference[s] between complication rates of medical professionals and paramedics."[109]

These requirements also deny women in rural areas proper access to safe abortions performed in hospitals and clinics. Their alternative is to have the procedure performed at a private doctor's clinic. A study conducted in Turkey shows that the risk of death due to induced abortion procedures outside medical clinics is four times higher than the risk in a medical clinic or hospital. The legal obligations found in the Turkish abortion law thus increase the risk of death or maternal morbidity resulting from unsafe abortions in clandestine clinics or by traditional methods for women of low socioeconomic status.

Voice on Abortion from Egypt [110]

In a study conducted to explore Egyptian women's perceptions of abortion in Egypt, researchers interviewed a group of women who had undergone an abortion. The average age of the group was 29, and they had minimal or no formal education. Regarding the pain she experienced during and after the procedure, one study participant said:

"I was dying yesterday and I was dying before the operation...It was very painful to go through the operation. Afterwards, the pain has only got worse. I am still in pain now ... I feel like my body is broken into pieces. I cannot sleep, I cannot sit down and I feel severe pain with every move I make. I know it will be some time until this pain goes away. This has been the most painful experience I have ever had."
Speaking of blood loss during abortion, another one said:

"Our bodies are already tired... and going through an abortion affects the health tremendously. The blood that a woman loses makes her weaker than she was before. It also causes anaemia. As a result a woman has to rest for a long time to regain her strength..."
A third woman expressed her need for support during this difficult experience:

"Physical problems are the most important. I will still have to face some other problems, things like what people will say about me when they know that I have had an abortion. But I know that the most important thing I should concern myself about is resting for at least two months so that I can get back my original health. The only problem in doing that is there is no one to help me during that time."

Source: Women's Perceptions of Abortion in Egypt

Maternal morbidity is another common result of unsafe abortion. Complications include hemorrhage, sepsis, peritonitis and trauma to the cervix, vagina, uterus and abdominal organs. For example, in Egypt, the hospitalization rate for the treatment of abortion-related complications is high, about 15 hospitalizations per 1,000 women aged 15-44.[111] This data is in line with evidence showing that in countries where abortion is permitted on narrow grounds, thousands of women are hospitalized each year with serious complications from unsafe procedures.

Medical abortion is a non-surgical, drug-induced abortion associated with a decreasing percentage of unsafe abortions.[112] The pharmaceutical drugs needed for inducing medical abortions, such as misoprostol and mifepristone, vary in availability in MENA countries. Mifepristone is available in Tunisia and Israel only, while misoprostol is available in all countries under review in this report.

vi- Post-abortion Care

A post-abortion care package includes various elements, most significantly the emergency treatment of complications of spontaneous or induced abortion and family planning counselling in order to avoid unwanted pregnancies in the future. Linkages between abortion and other reproductive health issues or community mobilization should also be taken into consideration.[113]

Due to the "the politically charged atmosphere unique to abortion,"[114] improving post-abortion healthcare services has been one of the most difficult tasks for international and local advocates. As a result, post-abortion care is still a key cause of maternal mortality and morbidity. However, studies show that in countries where abortion is restricted, such as Egypt, the OPT and Yemen, data on diagnoses of women with post-abortion complications is limited.[115]

In spite of the restrictive laws on abortion and the difficult and unsafe conditions of clandestine abortion, desperate women resort to unsafe abortions, which lead to serious post-abortion complications. A study published in 2008 shows that post-abortion care was the cause of almost 20% of obstetrical and gynecological hospital admissions in Egypt.[116]

Unfortunately, despite the rising need for post-abortion care, high quality post-abortion medical services are absent in most developing countries. A study notes that in addition to medical services, women who undergo abortions are in need of emotional support from an adequate social network and health providers. The study stresses how this support system affects women's ability to cope with their health condition. In addition, the study notes that "listening to the concerns and needs of the patients themselves is a prerequisite to designing programmes for improving services and raising awareness of the public health consequences associated with restrictions on the provision of safe abortions."[117]

Family planning counselling is an essential part of post-abortion care. In order to avoid future unplanned and unwanted pregnancies, family planning and contraception counselling should be fully integrated within post-abortion care services. However, in many countries such as Egypt[118]

and Turkey,[119] family planning services are not offered to women before discharge from the hospital due to the physical and administrative division between the units providing post-abortion care services and others providing family planning counselling.[120]

The issue of post-abortion complications is more serious in countries where abortion is illegal as it is performed unsafely in clandestine clinics. Adequate post-operative monitoring is absent in procedures performed in these clinics. The clinics' failure to provide post-abortion care is not only because of the unavailability of needed equipment, but also that in many clinics, women are asked to leave immediately after the operation. A study shows that "physicians are afraid to have the woman stay after the procedure to recover, for fear of being discovered. Women with complications must seek care at a government hospital, where they cannot admit that they have had an induced abortion."[121]

Box 3: Post-abortion Care in Egypt

In the MENA region, Egypt has been a pioneer in research, training and advocacy on post-abortion care services. In early 1990s, the common practice in post-abortion care was dilatation and curettage (D&C) technique performed under general anaesthesia. Studies have shown that Manual Vacuum Aspiration (MVA) with local anesthesia is associated with lower complication rates and shorter patient stays than sharp curettage with general anesthesia.

In 1994, a pilot study on improving post-abortion care was conducted in two hospitals in Egypt. The study concluded that" upgrading post-abortion care (PAC) services and training physicians in MVA, infection control and counselling led to significant improvements in the care of post-abortion patients." Fortunately, the study did not cause a wide public debate. As a result, a larger study was conducted in 1997 to introduce improved post-abortion care services to university and Ministry of Health and Population hospitals in Egypt. The aim of Egypt's post-abortion initiatives was to institutionalize MVA as a safer and simpler method in treating post-abortion complications.

An analysis of Egypt's post-abortion care initiative shows that the initiative demonstrated significant achievement in its pilot phase in 1994 and initial expansion in 1997. In addition, the initiative caught the attention of innovative policymakers.

However, further expansion of the initiative has failed. Despite the positive results of the study in state owned university hospitals, MVA has not yet been institutionalized in most of the Egyptian hospitals providing post-abortion care services. MVA equipment is available in only 12% of hospitals offering delivery services. And it has been reported that the Egyptian government has "refused subsequent requests to import MVA devices." This represents a failure of the government to meet the commitments it has made in ICDP PoA and ICPD+5.[122]

SUMMARY

Most women in the MENA region do not have access to safe abortion. Among the countries discussed in this report, only two countries, Tunisia and Turkey, allow abortion upon request, although most countries in the region allow abortion to save the mother's life. Abortion is a contested issue in Islamic law and it is not widely accepted in the region for social and cultural reasons.

Due to the criminalization of abortion and the cultural sensitivity of the issue, many women in the region face serious health risks and sometimes death while undergoing unsafe, clandestine abortions. In some MENA countries, induced abortion, mostly unsafe, is being used as a method of birth control. In addition, victims of sexual violence who become pregnant must choose between two equally undesirable paths: either face possible legal action for undergoing an illegal procedure as well as the dangers of an unsafe abortion, or endure the stigma associated with their pregnancy.

Most women in the region, largely unprivileged and rural, do not have access to affordable, adequate post-abortion care services. In most countries, post-abortion care services do not provide family planning counselling, which is essential for avoiding unwanted pregnancies. As a result, many women face the risks associated with unsafe abortions more than once.

III- FERTILITY AND FAMILY PLANNING

In order to better understand overall reproductive health rights in the MENA region, it is important to examine fertility and family planning policies in the region. These two areas shed light on some of the issues already discussed, like abortion. Furthermore, fertility and family planning raise serious concerns regarding couples' and individuals' rights to decide freely and responsibly on the number of children they want to have and their spacing. As has been demonstrated time and again in this study, the issues discussed in this report are interconnected—high fertility rates and inadequate family planning options result in higher unsafe abortion rates.[123]

i- Total Fertility Rate

Table 15: Total fertility rates in six countries in the MENA region

Country	Total fertility rate		
	1995	2003	2008+
Egypt	3.6 (EDHS)	3.1 (EDHS2005)	3.0 (EDHS2008)
Kuwait	3.1 (HDR 1995)	2.7 (HDR 2003)	2.3 (HDR 2013)
Palestine	6.24 (PCBS)	5.2 (PDHS)	4.3 (2012)
Tunisia	3.2 (HDR 1995)	2.0 (HDR 2003)	1.9 (HDR2013)
Turkey	2.6 (TDHS 1998)	2.2 (TDHS2003)	2.15 (TDHS2008)
Yemen	6.5 (DHS 1997)	7.0 (HDR 2003)	5 (HDR 2013)

Source: Country DHSs, HDRs, PCBS

The total fertility rate (TFR) is defined as the average number of births per woman. In other words, it is the age-period fertility rate for a synthetic cohort of women, measuring the average number of births a group of women will have if they reach 50 according to the current age-specific fertility rates. At present, the estimated TFR falls below 2.5 births per woman in Tunisia, Kuwait and Turkey. At the other extreme, Yemen and Palestine have TFRs in excess of 4.5 births per woman. Egypt lies in the middle with a TFR of 3 births per woman. Since the late 1980s, most countries in the region have experienced TFR declines of 50% or greater. Of the more populous countries, only Yemen did not undergo a rapid fertility decline in this period (with TFR falling about one-third or more).[124]

Egypt and Tunisia began their fertility transition at almost identical fertility levels and at roughly the same time, but the difference in the pace of decline has been such that the TFR in Tunisia reached replacement level by 2001, whereas the TFR in Egypt remains above 3 live births per woman.[125]

Demographers attribute Tunisia's achievement of replacement fertility to the modernization efforts of the era of President Bourguiba, which restricted polygamy, liberalized abortion laws, encouraged education and lowered female illiteracy and provided governmental subsidies to the first four children only.[126] While Egypt lowered its TFR during 1980s and 90s, the decline stopped since the government did not change its target audience as it should have done. This will be discussed below in population policies.

In Palestine, high fertility levels remain a demographic puzzle for many population specialists who believed that improved educational attainment and favorable socioeconomic conditions would lower fertility rates.[127] Some demographers find the answer in "political fertility": the Israeli-Palestinian conflict plays an important role in encouraging Palestinians to have more children, as the population in OPT is used as a weapon against the occupation. This proved to be true during the Intifada years.[128] During conflict years the child survival hypothesis also came into play, as people tended to have more children to compensate for expected deaths. Other researchers oppose the political fertility theory and attribute high TFR in Palestine to unmet needs of contraception.[129] In recent years, TFR decreased significantly to reach 4.3 due mainly to an increase in the age of marriage.

Scarce data on TFR in Kuwait suggest that lowering the TFR to

near replacement rate is due to an increase in the marriage age, which is adversely proportionate to the number of children women have. In addition, the percentage of single women of reproductive age doubled from 16% to 31% between 1965 and 2000.

By 1965, Turkey started a strong family planning multi-sectoral program and the TFR started to slowly drop. The rate then quickly dropped during the 1990s when rural areas were targeted. The decline in TFR has been explained by increased urbanization, increased female literacy and the liberalization of abortion laws.[130]

The persistence of high fertility rates in Yemen comes as no surprise. High female illiteracy, and high unmet needs levels and low prevalence rate of contraception explain how the lack of investment in human development is reflected on fertility rates.

Disparities in TFR remain significant within the same country. In some countries those disparities have regional characteristics, as is the case in Egypt. According to the 2008 DHS, the TFR for women in rural Upper Egypt is 3.6 while in urban governorates it is 2.6. On the other hand, differentials in TFR in other countries like Turkey are associated with geography and, more importantly, ethnicity, with higher TFRs and bigger families more common among Kurdish women. Only Egypt and Turkey have recent DHSs that enable us to study inequalities and disparities within the same country.

Lack of data on targeted fertility rates for many countries under examination in this report precludes a comparative discussion, which again points to the problem of states that do not conduct DHS.

ii- Population Policies

Population policies are laws and policies that deal with fertility, mortality and migration.[131] For the purposes of this report, we will focus on those that address fertility. The ICPD PoA represented a paradigm shift in population policies, where states were urged to focus on people's choice instead of states' optimal growth rate. Investing in reproductive health and rights was encouraged to replace governments' goals for fertility rates. The PoA calls for making family planning services available, affordable, accessible and of good quality for couples and individuals.

While Egypt and Yemen adopt anti-natalist population policies that aim to lower fertility rates, Turkey and Kuwait now encourage pro-natalist policies due to their low TFR. In Palestine, the Israeli-Palestinian conflict remains central in the issue of political fertility as discussed above. The dominant interpretation of Islamic law is pro-natalist in the matter of fertility, which prevents many governments from applying disincentives on larger families, although Tunisia in the 1960s exceptionally withdrew governmental subsidies for the fifth child.[132]

Egypt has given some attention to population policies since the 1950s when it identified population increase as a major obstacle to development.[133] The government adopted anti-natalist policies through provision of subsidized family planning methods. Although Egypt made major strides in lowering the TFR from the mid-1980s to the mid-1990s, it reached a plateau in the late 1990s when TFR leveled. While the government blames rural Upper Egypt for this stagnation, many demographers argue that it is the responsibility of the high- and middle-income strata.[134] Egypt now struggles with a TFR of 3 (2008), which is still far from the replacement rate. Achieving replacement level fertility will be very difficult without addressing the middle or high classes and focusing only on fertility among the rural women of Upper Egypt. Kuwait's population policy concentrates mainly on regulating migration, since Kuwaitis are considered the largest minority in their own country.[135] The details of migration policy in Kuwait will not be discussed here, as it is irrelevant to our topic. The focus on migration may have affected the production of a proper analysis in various studies for fertility determinants.[136]

For a long time, the Yemeni government did not have an official population policy, but attempted to resolve its population problems through the improvement of socioeconomic conditions. The government also provided family planning services and population information and education. The Yemeni Family Care Association was established to provide prenatal services and information on birth control with the government supporting the provision of contraceptives and the training of family planning volunteers. In 1990, after the Yemen Arab Republic and Democratic Yemen united to become the Republic of Yemen, the government recognized that the future development of the country relied heavily on the link between population and development. With a renewed interest in population policy, in 1991, Yemen held its first national conference on population, adopted a national population strategy and established the National Population Commission. The government set a target of 35% contraceptive prevalence rate and a total fertility rate of 6.0 births per woman by 2000. By 1997, the contraceptive rate rose from 6% to 10%. Despite Yemen's efforts, the TFR for the 1995-2000 period remained high at 7.6 children per woman, while the population growth rate remained steady at 3.7% during the same period. In 1996, Yemen held the Second National Conference on Population Policy, which focused more on female education, the reduction of girls' illiteracy and gender discrimination. In 2007, Yemen still had one of the highest population growth rates in the world at 3.2% per year.[137]

Population policies in Turkey witnessed serious changes over the past decades. In the early years of the republic, a pro-natalist policy was employed to encourage people to have more children to compensate for the loss of life during WWI in order to produce more manpower for the utilization of various development plans.[138] In those years, the distribution of contraception was prohibited and abortion was illegal. Only after the military coup in 1960, when concerns over rapid population growth were rampant, did population policies shift to family planning and small family sizes.[139] Turkey is now almost at the replacement fertility rate, and recently the government called on Turkish families to have more children out of fear of an aging population.[140]

iii- Contraceptive Prevalence Rate

Table 16: Contraceptive prevalence rates and method selection

Country	Any method	Any modern method	Not currently using	Pill	IUD	Injectables	Norplant /implant	Condom	Female sterilization	Male sterilization	Any other traditional method
Egypt 2008	60.3	57.6	39.7	11.9	36.1	7.4	0.5	0.7	1.0	0.0	2.7
Kuwait* 1999 WCU 2012	52.0	39.3	N/A	23.4	8.8	N/A	N/A	2.9	4.1	N/A	12.9
Palestine 2006/7 WCU 2012	50.2	38.9	N/A	7.0	24.8	N/A	N/A	N/A	N/A	N/A	11.3
Tunisia 2006 WCU 2012	60.2	51.5	N/A	14.5	27.8	1.4	0.3	1.3	5.6	N/A	8.7
Turkey 2008 DHS	73	46	26.9	5.3	16.9	0.9	0.0	14.3	8.3	0.1	27
Yemen 2006 WCU 2012	27.7	12.9	N/A	9.0	4.0	3.5	0.0	0.4	2.3	0.0	8.4

Source: Country DHSs and UNDESA, World Contraceptive Use, 2012. Data are for ever-married women in reproductive age
*Data pertains to Kuwaiti women only

WHO defines the contraceptive prevalence rate (CPR) as" the percentage of women between (15-49) years who are practicing or their sexual partners are practicing any form of contraception."[141] The CPR is among the MDGs indicators used to monitor progress in achieving MDG5.B: universal access to reproductive services by 2015.[142]

Turkey ranks first with the highest regional CPR of 73%. Both Egypt and Tunisia share a very similar CPR of around 60%. Kuwait and Palestine are also similar with a CPR of around 50%. Yemen has the lowest CPR among the countries in this study, at 27.7%. Modern methods of contraception represent almost more than two-thirds of total contraceptive usage in all countries except Yemen. In Tunisia and Egypt, married women mainly use modern methods, whereas in Turkey married women rely heavily on traditional or folk methods (27%).

The MENA region is one of the few regions that does not advocate for sterilization as a method of family planning, which might be due to the lack of such services, legal restrictions and/or religious opposition.[143] This is demonstrated in Table 16, where male sterilization is almost negligible in the countries in this report. In contrast, female sterilization is growing, especially in countries where abortion is legal, like Tunisia and Turkey. The very low percentage of sterilization in Egypt is due to an informal policy that does not encourage such methods.[144]

Among modern contraceptives, IUDs and pills are the most prevalent form of contraception. In Egypt, Tunisia, Palestine and Turkey, IUD predominates while pills are utilized more in both Kuwait and Yemen. Research suggests that reliance on a specific method may be attributed to socioeconomic status or government population policy. In Kuwait, which is a small oil-rich country, oral contraceptive pills are available over the counter[145] and high socioeconomic conditions enable many women to purchase them, while Egyptian women rely on IUDs due to unfavorable socioeconomic conditions. Some researchers suggest that this is due to economic incentives for physicians who prescribe IUDs rather than other contraception methods.[146]

iv- Male Contraception as Percentage of Total Contraception

The ICPD PoA states that the objective is to promote gender equality in all spheres of life, including family and community life, and to enable men to take responsibility for their sexual and reproductive behavior and their social and family roles.

Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; the recognition and promotion of equal value of children of both sexes. Male responsibilities in family life should be included in the education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children.

Table 17: Male contraception as percentage of total contraception

Country	Condom	Male sterilization
Egypt (DHS 2008)	0.7	0.0
Kuwait (WCU 2012, 1999)	2.9	N/A
Palestine (WCU 2012)	N/A	N/A
Tunisia (WCU 2012)	1.3	N/A
Turkey (DHS 2008)	14.3	0.1
Yemen (WCU 2012)	0.4	0.0

Source: Country DHSs and UNDESA, World Contraceptive Use, 2011

Table 17 indicates that a very low proportion of men use contraception, which burdens women with the sole responsibility for contraception. Strikingly, condom use in Turkey is uncommonly high. Condoms in Turkey are considered the second most prevalent modern contraceptive and account for 14.3% of all contraception use. Part of this unusual preference is due to the use of social media to reach young people and convince them to utilize condoms.[147] Using social media to market condoms was a smart move by private sector companies, and it allowed young people to discuss taboo sexuality issues in a friendlier environment. Furthermore, it has proved a good channel to disseminate information and raise awareness.

v- Male Involvement

In a study conducted in Yemen to assess male involvement in family planning, the results indicate that male involvement was relatively low, and despite the positive attitude toward family planning, there were issues concerning decision making about family planning and who should be practicing it.[148]

Studies in both Egypt and Turkey recommend more male involvement in family planning programs through mass media and communication.[149] It was recommended to change the system in current family planning clinics in Egypt to allow the presence of husbands and integrate the services they need in the clinics. The importance of educating young men about contraception was emphasized in both countries. When men are substantially involved, the chances for a more stable family increase tremendously—the couple will share the family planning responsibility, will know ahead of time how many children to have and can decide if they want to promote traditional or altered gender roles. More stable families lead to more stable communities, which has a positive effect on the entire country.

vi- Informed Choice

"Recognize that appropriate methods for couples and individuals vary according to their age, parity, family size preference and other factors, and ensure that women and men have information and access to the widest possible range of safe and effective family planning methods in order to enable them to exercise free and informed choice."[150]

Ensuring that potential contraceptive users have the information they need to make informed choices is a vital component of family planning programs. Users should be informed of the range of methods that are available so they can make decisions about the contraceptive method that is most appropriate for their situations. Family planning providers should also inform potential users of the side effects they may experience when using specific methods and what to do if they encounter any of the effects. This information both assists the user in coping with side effects and decreases the unnecessary discontinuation of temporary methods.

The reality in most countries, however, is far different. Most countries offer only a limited choice of contraceptive methods, and couples cannot easily choose the method that best suits their reproductive needs.[151]

According to Egypt's latest DHS in 2008, the exchange of information about contraception between users and providers was fairly limited. Around 60% of users were informed about other methods, while only 56% were told about the side effects they may encounter with the method they use and 46% were told what to do in these cases. It was found that obtaining contraceptives from the pharmacy decreases the possibility of women receiving adequate information regarding the method, other contraceptives and side effects.

The UNFPA conducted an evaluation study to assess the quality of family planning services in eight countries, among them Turkey, and to improve contraceptive and family planning services. It was found that it was hard for clients to make informed decisions about the type of contraceptive they prefer for a number of reasons: the inaccuracy of information they receive from providers, providers' disregard for the reproductive health goals and needs of their clients and the inadequate provision of a wide range of modern contraception. Clients were pressured to adopt specific methods like the IUD, which is provided by the government (thus explaining why IUD is the most prevalent contraceptive in Turkey). Alarmingly, providers sometimes gave the users wrong information, and a discussion of side effects was not a common practice.[152] Moreover, male contraceptives were not favored or promoted by providers in public sectors.

Since Yemen is one of the poorest countries in the world, it is necessary to examine the socio-cultural conditions of women there and their mobility and how this affects their access to contraception and decision making about family planning.[153] There are several obstacles facing Yemeni women's ability to access contraception and make informed decisions. Those obstacles include lack of information about their bodies and their reproductive needs, an inability to access information due to high female illiteracy rates and a lack of universal access to media outlets like television and radio. Aspects of decision making greatly influence women's reproductive autonomy since husbands have the upper hand in all decisions and own financial resources. Finally, freedom of movement is not attainable for most Yemeni women. Yemeni women have little inexperience in expressing their reproductive goals, and for some, their location inrural areas makes it much more difficult to access service providers.

In Palestine, UNRWA clinics play an important role in providing women with access to modern contraception in the West Bank and Gaza. According to some demographers, this access was behind the recent decline in fertility.[154]

vii- Unmet Need

Unmet need for contraception, a term used in the international population field since the 1960s, is defined as the proportion of women who do not want to become pregnant but are not using contraception. It is one of several frequently used indicators for monitoring family planning programs and it gives an estimate of the proportion of women who might potentially use contraception.[155]

The percentage of unmet need is sometimes interpreted as evidence of lack of access to a source of contraception. However, there are many reasons why women do not use contraception, and unmet need should not be equated with the lack of access to contraception due to supply constraints or the financial costs of family planning.

Table 18: Unmet need for contraception 1995, 2003, 2008

Country	Unmet need		
	1995	2003	2008+
Egypt	16.0	9.5	9.2 (2008)
Kuwait	N/A	N/A	-
Palestine	N/A	N/A	20.1 (2010)
Tunisia	N/A	N/A	12.1 (2001)
Turkey	N/A	9.5	6.2 (2008)
Yemen	N/A	N/A	38.6 (2006)

Source: Egypt DHS 2008, Palestinian Family Survey 2010, World Contraceptive Use, 2012

Egypt has not witnessed a real decline in unmet need over the past decade, as unmet need remains around 9%. The highest age group with unmet need is 30-34 followed by 40-44.

Unmet need in Turkey is relatively low (around 6%). Many studies suggest that this number could be misleading, since traditional methods are widely practiced in Turkey. As traditional methods are considered met need, women who wish to shift from traditional to modern contraceptives are not counted.[156] In 2005, a study counted women seeking to shift to modern contraceptives and found an increase in unmet need from 7.1% by traditional calculation to 18.9% when those women are considered. Reproductive health advocates thus suggested focusing on improving the current use of family planning rather than increasing overall use.[157]

In Kuwait data obtained from small-scale studies indicates that the absence of family planning programs represents a huge barrier to reducing unmet need. Although unmet need is relatively low, there are still negative attitudes toward contraceptives among couples who think family planning methods are forbidden by Islam. These views are hard to change without a formal family planning program.[158]

Data from Yemen is old and the numbers are disturbing. In a 1997 survey, unmet need was 38.6%. Poverty is still a key factor that hinders women from access to contraception.[159] Women who have not used contraception before and do not intend to do so, occupy a large area in the overall unmet need picture in Yemen. This poses a special challenge for the government since this group requires both motivation and supplies. A very high unmet need is observed among young people, especially aged 15–19 and 20–24.[160] This is not surprising given the prevalence of early marriage in Yemen and poor access to reproductive health information and services for young people specifically.

Unmet need in the OPT has been rising rapidly over the past decade from 12.4% in 2000 to 20.1% in 2010. Reasons for the increase have not yet been identified. Further research is needed, especially since there is a marked difference between unmet need in the West Bank and Gaza Strip.

Country averages of unmet need may be good indicators, but at the same time they conceal disparities and dynamics in every country.[161] We therefore need to further disaggregate data according to residence, education and wealth. In Egypt, place of residence, education and wealth seem to influence the unmet need rate, where rural, uneducated and poor women have a higher unmet need than urban, educated and wealthier women.[162] The same disparities in unmet need remain valid in Turkey where rural areas and eastern settlements have higher unmet need than urban and western settlements.[163] Educational attainment is inversely proportional with unmet need in Turkey.

Voice on Unmet Need from Turkey

"My husband wants neither a child nor to get protected" Esmanur, is a 31-year-old Kurdish woman and a mother of five who voluntarily migrated from Gevas in 1977. She had 1 miscarriage, 4 abortions and 5 childbirths during her 16 years of married life. She tried the pill, IUD, injectables, withdrawal and condoms, but she became pregnant again and again. She took abortive herbs almost every pregnancy, but they did not work. When she became pregnant twice consecutively after two abortions, her husband told her: "Why didn't you get protected? Why did you do this? Go and get a coil fitted!"

Soon after the birth of the fifth child, she went to a hospital for tubal ligation but was refused by the doctor because she was still young. She had two more abortions the same year. Her husband was furious with her after her fourth abortion and sent her back to her father's house.

"Go to your father's house! I don't want you. I struggle this hard. I work this hard. I cut expenses for myself. I cut expenses for my kids. I cut expenses for home. Do you give all to abortions?! Pity me a bit, "Esmanur's husband said.

She considered his accusation unfair, but endured his fury and insults to save the marriage. The situation was very tense because there was little money.

"I sometimes acknowledge him to be right...' It's as if I collect money with a broom!' he always tells me... but he didn't pity me."

Esmanur had a D&C four times but she could not afford to buy medicine.

"He didn't think that way. I had to bear this. What can I do? But still, because I love him and for my children, I endure this."

Source: Reproductive Practices: Kurdish Women Responding to Patriarchy [164]

SUMMARY

Since the late 1980s, most MENA countries have been experiencing rapid fertility decline. Population growth and policies differ across the countries in the MENA region. For instance, Tunisia successfully achieved replacement rates in a few decades, and Turkey has almost achieved the replacement fertility rate. Recently, the Turkish government began advocating larger family sizes out of fear of an aging population.

Sterilization is not commonly used as a contraceptive method in the region while IUDs and pills are common. Among the countries examined in the report, Turkey has the highest contraceptive prevalence rate.

Many women across the MENA region do not have adequate access to modern contraceptive methods due to poverty, geographic location, ethnicity and political conflict.

IV- REPRODUCTIVE CANCER

The ICPD PoA states that referrals for the diagnosis and treatment of breast cancer and other cancers of the reproductive system should always be available as required.[165] Reproductive cancers are one of the least prioritized issues among reproductive and sexual health issues, and male reproductive cancers are even more overlooked. SRHR advocates call for population-based screenings and the enhancement of prevention, diagnosis and treatment techniques. Activists also urge attention to the high cost of cancer treatment, especially since reproductive cancers are an epidemic in most developing countries.[166]

National cancer registries play an important role in providing statistics on the burden and extent of cancer for epidemiological and public health purposes. Data generated from cancer registries is useful in evaluating cancer control programs and their efficiency.[167] Most of the countries in this report have some form of a cancer registry, though coverage of these registries and accuracy of their data differ from one country to another.

Kuwait has one of the earliest cancer registries in the MENA region. It was established in 1970 and intended to cover the whole country including natives and non-nationals. An evaluation of the registry found it to be reliable and precise in data collection, particularly for demographic information; however, data collected about the tumor stage and provided care was less accurate.[168]

Turkey began its first population-based cancer registry program in 1991 with the Izmir cancer registry.[169] Since then, other cancer registries have been established, but there is no nationwide coverage for cancer registries.[170]

Egypt has a national cancer registry program. Still in progress, it covers 20% of the Egyptian population in four governorates—Aswan, Minia, Damanhour and Damietta[171] —and there are plans to integrate the Gharbia governorate cancer registry center, the oldest population-based cancer registry in Egypt. Coordination

between the National Cancer Registry Program and other registries like the hospital-based National Cancer Institute and the Ministry of Health registry is slated for the near future.

Palestine has cancer registries in both the Gaza Strip and West Bank. Evaluation indicates that data is accurate and reliable, but the lack of economic support from different stakeholders jeopardizes the sustainability of reliable and accurate information.[172]

Tunisia has two main population-based registries, one for the northern governorates and the other for the southern ones, covering nearly two-thirds of the population combined. Yemen established the Aden Cancer Registry in 1997 to cover the Aden population, and is a member of the Gulf Cancer Center for Cancer Registration.[173]

i- Breast Cancer

Global cancer statistics show that breast cancer is the most diagnosed cancer and the leading cause of cancer death among women, accounting for 23% of total cancer cases and 14% of cancer deaths. Moreover, breast cancer is the leading cause of death among women in developing countries. This is a shift from the last decade when the leading cause of death among women in developing countries was cervical cancer.

In Palestine breast cancer ranks first among women, accounting for 30% of female cancers with a high mortality rate. Problems concerning lack of awareness and delayed detection are still widespread.[174]

Tunisia has relatively low breast cancer incidence (around 30 per 100,000 women in 2008, or 1,543 cases) with 728 mortality cases,[175] but breast cancer is the most common female cancer. As a public health problem, it requires the development of more responsive policies for early detection and control, especially in the absence of a population-based screening program for breast cancer among women in Tunisia.[176]

Turkey has a relatively high incidence of breast cancer with 1,065 cases in 2008 and 4,311 mortality cases.[177] Although breast cancer has increased over the past few years, Turkey still lacks a nationwide screening program and most women are diagnosed at stage II. More concerning are the disparities based on socioeconomic conditions, with earlier diagnosis and higher incidence more likely in western Turkey.[178]

In Kuwait, breast cancer is the leading cancer among the Kuwaiti population, increasing threefold over 33 years (1974-2007).[179] Data indicates that incidence number in Kuwait is 337 and the mortality number is 94 for 2008. [180]

Breast cancer is the most widespread cancer among women in Egypt as well.[181] Egypt has the highest incidence among countries under research in this report, with 12,621 cases in 2008 and 6,546 deaths the same year.[182] In 2007, Egypt launched the Women Health Outreach Program, hoped to be the first national program designed to offer all Egyptian women free breast screening and mammograms, but it continues to face many economic, cultural and availability of information challenges.[183] In a study conducted in the Minia governorate to assess the effect of socioeconomic characteristics on the survival rate of women with breast cancer, it was found that mortality is more likely to occur among rural, less educated and non-working women and that survival rates are higher among women with higher levels of education, skilled women and women in urban areas. [184]

Yemen recorded 1,253 breast cancer cases and 665 mortalities in 2008.[185] A study conducted in 2009 in Sana'a, the capital, to assess female doctors' attitude and the practice of mammography screening found that the economic barrier is the main factor for doctors' reluctance to refer women to routine screening. The study recommended making mammography free for women over 40. [186]

Table 19: Cervical cancer risk, mortality and incidence in six countries in the MENA region

Country	Population of women aged 15+ at risk of cervical cancer (millions)	Cervical cancer mortality (new deaths) (absolute number)	Cervical cancer incidence (new cases) (absolute number)
Egypt	25.76	299	514
Kuwait	0.758	16	45
Palestine	N/A	3	5
Tunisia	3.68	148	314
Turkey	25.43	556	1443
Yemen	5.6	99	162

Source: International Agency for Research on Cancer, Globocan 2008 and WHO/ICO Information Centre on HPV and Cervical Cancer, 2010 [187]

ii- Cervical Cancer

Cervical cancer is the second most common cancer among women in developing countries, while screening programs and early detection make it less prevalent in developed countries. Although Turkey has the highest incidence among the countries under review in this report, it is still a relatively low incidence rate. This can be explained by widespread monogamy and higher age for first sexual relations. A universal screening program has also been recommended.

Almost none of the researched countries have a high incidence rate. Turkey is the highest with an incidence rate of 1,443. Egypt's incidence rate is 514. Palestine and Kuwait have the lowest incidence rate, 5 and 45 respectively.

Cervical cancer is not a significant problem in Kuwait. According to the latest estimates of the Kuwait Cancer Registry, cervical cancer accounts only for 4.6% and 4.7% of female cancers among Kuwaiti and non-Kuwaiti women respectively.

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CHAPTER 4:

Sexual Health and Sexual Rights

This chapter will discuss sexuality-related services provided to young people, whether sexuality education and information, scanning and treatment of sexually transmitted infections (STIs) or family planning services.

To better understand the problems and needs of the MENA region, this chapter explores specific country approaches to HIV/AIDS and other STIs, the stigma associated with such diseases and infections, access to anti-retroviral drugs (ARTs) and the significance of the most at-risk populations.
In the sexual rights section, marriage, domestic violence, trafficking, sexual violence and sex work will be highlighted and discussed.

Although there is not an approved definition of sexual rights, we endorse the working definition frequently utilized in international agreements and consensus papers, which includes, but is not limited to, the following rights: the right to sexual health; to consensual sexual relations; to choose one's partner; to sexuality education; the right to seek and impart information related to sexuality; to choose whether or not to be sexually active; to consensual marriage; to bodily integrity; and the right to pursue a safe and enjoyable sexual life.

I- YOUNG PEOPLE SEXUALITY

According to the United Nations, the youth population comprises individuals between the ages of 15 and 24, [1] while adolescents are defined as persons between the ages of 10 and 19, or those in the second decade of their lives.[2] In this section, we will focus on adolescent sexuality, since sex education sometimes starts during the early years of adolescence and older adolescents might encounter risky sexual behaviors. SRHR are very important issues for the adolescent population in the MENA region. Not only do these youths face a high risk of exposure to the traditional, harmful practice of female genital mutilation (FGM), but they are also extremely susceptible to risks associated with unprotected sexual relations, such as unsafe abortions due to unwanted pregnancy, HIV/AIDS and STIs.

In the MENA region, youth constitute the majority of the population and, according to UNFPA, in 2007 one in five persons in the MENA region wasaged 15–24. Striking similarities persist between the young people across the region. Most youth in the region share an increasing level of education, high percentages of unemployment especially among university graduates and delay in the age of marriage. While waiting for employment and marriage opportunities, youth in the MENA region enter into a phase of waiting adulthood or "wait-hood."[3]

In this wait-hood phase, youth are more vulnerable to risky behaviors such as drug use and unsafe sexual practices. At the same time, youth engaging in safe sex often lack information on various issues of sexuality. Carrying the pressures of their family's expectations on their shoulders, young married couples in the region usually start marital life without proper preparation. Furthermore, they are usually persuaded to have children early in their marital life.

i- Comprehensive Sexuality Education

ICPD calls on governments to collaborate with NGOs when addressing issues of adolescent sexuality. Education and access to reproductive and sexual health services are among the issues highlighted in the ICPD.

Sex education programs should include the following components: 1) human development, including reproductive anatomy and physiology; 2) Information on relationships, in particular relationships in dating and marriage; 3) personal skills helping adolescents to make autonomous decisions regarding their sexuality; 4) sexual behavior, including abstinence; 5) sexual health including STI and HIV prevention and information on contraception and abortion; and 6) knowledge of gender roles and sexuality in adolescent communities.[4] In addition to providing factual information and social support, comprehensive sex education should teach young people to respect the right to consent to sexual acts and to combat violence and sexual coercion. Such programs should be provided in a safe environment that fosters diversity and enhances youth confidence.[5] In order to be effective, sex education programs should be tailored to the needs of different age groups.

Comprehensive sex education (CSE) provides information on self-protection if young people are sexually active. Unlike comprehensive sex education, abstinence-only approaches do not provide young people with the knowledge needed to make informed decisions about their own sexuality.[6] Unfortunately, most countries in the region do not provide CSE programs for political or religious reasons.

Lack of CSE is a common characteristic among different countries in the region. Evidence shows that school curricula include limited information on reproductive health, and teachers usually disregard even this information during classes. Most the sex education initiatives have adopted an abstinence-only model instead of taking a comprehensive approach. Moreover, NGOs bear the brunt of raising youth awareness of issues related to puberty, body changes, contraception and the prevention of STIs and HIV, but efforts implemented by NGOs are limited and cannot be replicated on a national level unless their initiatives are adopted by governments. NGOs also have limited access to schools, and permission to research and communicate with young people is extremely hard to obtain since the government places many barriers on working with youth, particularly adolescents.

Tunisia stands as a rare example that maintains a national policy to address young people's reproductive and sexual health rights.[7] Reproductive health information, though not comprehensive, was integrated in science curricula in the Tunisian public schools in the 1990s.[8]

Educational curricula in Egyptian schools contain basic information about the anatomy of the reproductive system and information on STIs including HIV/AIDs; however, this information is usually very basic and is frequently skipped by teachers due to embarrassment and/or lack of preparedness to tackle such issues with students. Many studies have found that youth know little about their sexuality and there is a serious need to improve the quality of sexuality education programs in Egyptian schools.[9]

There is no school-based sexuality education in Turkey, but issues of family planning, maturation and human reproduction are being introduced to students in science, biology or health classes.[10] Most sexuality education initiatives are being led by NGOs and international organizations. Recently, a state-led initiative, "the puberty project," has been launched to address adolescents' need for SRHR information, but there is no evaluation as yet of that project.

In Yemen, researchers have identified many barriers hindering the implementation of effective sexuality education, including the popularity of the abstinence-only approach, social resistance to sex education, the absence of qualified teachers and classroom over-crowding. However, limited information on SRHR in school curricula is sometimes better than the total absence of such information. In addition, a high percentage of Yemeni girls are deprived of access to proper education. In 2004, 73% of boys were enrolled in schools, but only 32% of girls were.[11] Therefore, only a very small segment of the population receives the already scarce SRHR information provided to students, while the rest of the population is left uneducated, more vulnerable to unwanted pregnancy and disease and generally less informed.

In Kuwait, there is no sex education in schools, but the government has established sex education programs as part of the family planning package offered to couples considering marriage.[12] It was reported that there was a decision to include a sex education component in Kuwaiti high schools, but the Ministry of Health dropped this decision in 2007.[13]

In Palestine, the Ministry of Health reportedly supported the inclusion of sex education in the Palestinian Health Plan, a program to provide formalized sex education in primary and secondary schools.[14] At the same, however, there was often a negative reaction to sex education initiatives sponsored by NGOs such as the Balata Camp Women's Center, established by the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) in 1975 in the Balata refugee camp. In a study published in 2001, the director of the center spoke of her experience in introducing sex education to the women in the camp. She noted that most people in the camp agreed about the importance of sex education, suggesting this was motivated by the limited knowledge young brides have on sex and sexuality, but when the center attempted to organize a lecture on the importance of sex education for women, the camp "was in an uproar.[15] As a result, the lecture was cancelled. In recent years, there has been heated discussion over the formal inclusion of sex education in schools.[16]

ii- Sexual and Reproductive Health Services for Young People

In terms of services, medical staff in the MENA region is generally reluctant to introduce services such as contraception to unmarried youth.

There are eight youth-friendly clinics in Egypt run by NGOs and another nine clinics placed in teaching governmental hospitals,[17] whose main activities providing information to youth about sexual and reproductive health, including premarital counselling, prevention of STIs, combating smoking and drug addiction and the provision of laboratory tests. Information, education and communication (IEC) is the principal technique used in these clinics, which limits their ability to provide sexual health services, and the youth uptake rate is low. The clinics face many challenges, including the embarrassment of the youth to go and the strict association of family planning with married women, which cause them to be underutilized.[18] In light of the limited knowledge of these clinics, one can identify two concerns: 1) these clinics do not provide contraceptives to youth and 2) the clinics do not

cover the large population spread across various geographical areas.

Similar to the situation in Egypt, Yemeni NGOs take the lead in small-scale projects to deliver services to young people. For instance, the Yemeni Women Union in cooperation with Extending Service Delivery launched an initiative to reach out to girls and encourage them to delay marriage until the age of 18 by educating them about the harmful effects of early marriage. There is a national policy to address the needs of young people concerning reproductive health, but information on these topics remains limited, weak and accessible mostly to educated youth.[20]

In Turkey, knowledge about reproductive health among youth remains limited. Young people are usually confronted with various barriers when they try to seek SRH services, so they tend to go to the private sector for the treatment of STIs and the termination of unwanted pregnancies. Led by UNFPA, services such as Youth Friendly Clinics, peer education and anti-violence against women campaigns are underway to a certain extent.

In Palestine, the World Bank reported that in 2001, sexuality counselling was very limited among youth, in particular young girls. It is also noted that unmarried Palestinian youth faced difficulty in accessing family planning services.[21]

SUMMARY

Many young people in the MENA region face the challenges of the "wait-hood" phase as they are waiting for employment opportunities and marriage prospects. Youth in wait-hood are more vulnerable to high-risk behavior.

In the countries examined in this report, comprehensive sex education is not provided to youth populations. Formal schools in some countries in the region provide information on anatomy and reproductive systems, but issues of sexual violence, contraception and unintended pregnancy are rarely addressed.

Youth in the Middle East do not have proper access to reproductive and sexual health services. Most of the efforts to provide youth with access to reproductive and sexual health services are non-governmental initiatives.

II- SEXUALLY TRANSMITTED INFECTIONS

Until recently almost all adults spent most of their sexually active lifetime married. Yet, it will soon become the exception rather than the rule. In large part, the demographic transition in MENA is driven by stark changes in nuptiality.[22]

Women endure a large share of the STI burden through exposure to infected husbands. Sex with an infected partner was found to be a significant predictor of women's exposure to STIs in Egypt. Youth contribute disproportionately to the disease burden of STIs in MENA. Some 59% of STI cases in Egypt were among young and predominantly single adults.[23] STI incidence has steadily increased in Kuwait where the most reported STIs among STI clinic attendees were aged 21-30.[24] The dominant profile of STI clinic attendees in Tunisia was young single men with multiple sexual partners.[25] In Yemen, it is estimated that there are 150,000-170,000 new STIs per year.[26] In Turkey, 2.9% of sex workers tested in 2010 were seropositive for active syphilis.

One of the biggest problems associated with STIs is the lack of general awareness of the various infections and how to protect oneself against them. The 2005 Demographic and Health Survey (DHS) in Egypt revealed that only 18% of married women aged 15-24 had heard of gonorrhea, syphilis or chlamydia. Of the sample, 22% of women reported experiencing abnormal genital discharge, genital sores and genital ulcers, which are symptoms of a potential STI.[27] Furthermore, 30% of boys and approximately 20% of girls aged 16-19 had no knowledge of any STIs, even HIV/AIDS. For youth in that age range without any schooling, the numbers were as high as 38% for girls and 31% for boys.[28]

Data shows variations in knowledge about STIs among Tunisian youth. In 2001, more than 85% of young peopleaged 18-29 knew about HIV/AIDS, while 40% knew about candidiasis. Less than 30% knew about syphilis while only 20% of young Tunisians knew about genital warts. One can assume that this is due to limiting knowledge of reproductive health solely to HIV/AIDS.

Egypt and Palestine reported having a national strategy for STIs, but neither country has a national action plan to implement these strategies or allocate required funds from the national health budget for an adequate response. There are no policies or interventions for people who inject drugs in Egypt, such as needle and syringe exchange programs or opioid substitution therapy. In Tunisia, six interventions have been adopted as policies exclusive of other needle/syringe or opioid substitution programs.[29]

III- HIV/AIDS

i- HIV Prevalence

The prevalence of HIV in the Middle East and North Africa remains the lowest among all other regions worldwide. The national HIV prevalence among adults is low at 0.2% throughout most of the region except for Djibouti, Somalia and South Sudan (classified by UNAIDS as part of MENA), where the epidemic is becoming generalized (national HIV prevalence exceeds 1%).

There is no evidence of a substantial HIV epidemic in the general population in any of the MENA countries, but available evidence on HIV epidemics indicates a persistent rise in the number of people newly infected with HIV, the number of people living with HIV and the number of people dying from AIDS-related causes (see Table 20).

The estimated 59,000 (40,000-73,000) people newly infected with HIV in 2010 was the highest annual number yet, 36% more than the 43,000 (31,000-57,000) people estimated to have been newly infected in 2001. In the same period, the estimated number of people living with HIV rose steeply, from 320,000 (190,000-450,000) to 470,000 (350,000-570,000), as did the number of people dying from AIDS-related causes, which increased by 60% from 22,000 (9,700-38,000) in 2001 to 35,000 (25,000-42,000) in 2010.

Overall, the number of children under 15 living with HIV almost doubled from 24,000 (9,400-45,000) to 40,000 (27,000-52,000) between 2001 and 2010. The number of children newly infected rose from 5,400 (2,700-7,600) to 6,800 (4,800-8,800), and the number of children dying from AIDS-related causes increased from 2,600 (1,100-4,300) to 3,900 (2,700-5,000) in the same period. This reflects an accelerating epidemic and comparatively high proportions of women among the population living with HIV (44-45% in 2001-2010), as well as the generally inadequate provision of services to prevent mother-to-child transmission of HIV.

Table 20: HIV and AIDS estimates and data, (2001 and 2009)

Country	Estimated number of adults and children		Estimated prevelance among adults and children		Women (15+)	
	2001	2009	2001	2009	2001	2009
Egypt	3300	11,000			<1000	2400
Kuwait						
Palestine						
Tunisia	<1000	2400			<500	<1000
Turkey	1700	4600			<1000	1400
Yemen						

Source: 2010 Report on the Global AIDS Epidemic

a. Vulnerable Most-at-Risk Behaviors

Young people aged 15-24 are at increased risk for HIV in MENA due to risk behaviors such as unprotected sex, transactional sex and injecting drug use. Other factors that contribute to HIV vulnerability include limited access to HIV testing, prevention and treatment; armed conflict, resulting in disrupted healthcare services and refugees living in poor conditions; and lack of accurate HIV informational materials in Arabic. Stigma, discrimination and human rights abuses against HIV-positive people and most-at-risk populations are common, driving people living with HIV/AIDS (PLHIV) underground and preventing them from seeking needed support services.

HIV data in the region has improved but remains limited. Current research indicates that unprotected sex (including between men) and the sharing of non-sterile drug-injecting equipment remain the primary drivers of HIV infection in the Middle East and North Africa.

Exposure to contaminated drug injecting equipment is prominent in the Egyptian epidemic where 7% of men who inject drugs in Alexandria and 8% of those in Cairo tested HIV positive in 2010. The concentrated HIV epidemic among people who inject drugs in Egypt has increased during the past few years; HIV prevalence was only 0.6% in 2006, but it has increased to 6.7% in 2010. A study among Egyptian youth found that more than half of injecting drug users (IDUs) use non-sterile needles or syringes.[30] Moreover, multiple sexual partnerships were reported by 73% of IDUs in Egypt, and 38% of female IDUs in Egypt were previously convicted for prostitution. Levels of HIV/AIDS knowledge among IDUs in MENA appear to be variable. A report from Egypt indicated a higher level at 43%, but with 40% reporting that they were unaware that HIV/AIDS could be transmitted through the reuse of non-sterile needles.[31]

This indicates the potential for an expanded epidemic among key populations at higher risk within a short timeframe if adequate services with appropriate coverage are not in place. The brutal efficiency of HIV transmission from unsafe injecting practices—estimated to be up to ten times more transmissible than through sexual contact—is often underestimated by country responses.[32]

In Palestine, it is estimated that 52% of HIV transmission occurs via heterosexual sex, 1% via homosexual sex, 4.7% via injecting drug use and 17.6% via blood and blood products transfusion.

In many ways, the response to HIV in the MENA region is only beginning to emerge. In particular, social movements to encourage the greater involvement of PLHIV have been slow to take hold. This poses the challenge of reaching marginalized, isolated HIV-positive people in the region as well as the opportunity to adopt lessons learned and best practices from previous efforts in other regions.

b. Men Who Have Sex with Men

Sex between men is heavily stigmatized in the region and is deemed a criminal offence in many countries. High-risk sexual practices, low levels of condom utilization and generally low levels of HIV knowledge have been observed in several countries among men who have sex with men (MSM). In surveys in Egypt, 5% of MSM in Cairo and 7% in Alexandria tested HIV-positive. In Tunisia, as in Cairo, 5% of MSM tested HIV-positive. There are signs of expanding investment in HIV prevention programs for this high-risk key population in some countries, but service coverage remains limited.[33]

Various studies have documented same-sex anal sex among MENA populations. In Egypt, 77.4% of male street children reported ever having sex with males and 37.1% reported being forced to have sex with males.

Evidence of sexual partnership formation among MSM indicates substantial risk behavior. In Egypt, 90% of MSM reported more than one sexual partner, with 82% of MSM being insertive and 51% being receptive. About 67% of MSM reported having five concurrent sexual partners, and 80.8% had ever had sex with multiple partners per act. Approximately 6.3% of the MSM population reports being forced into having anal sex with their partners.[34]

Commercial sex among MSM ranges between 20% and 42%, according to various studies in Egypt. According to these studies, 19% of MSM used condoms consistently, and 9.2% used condoms during their last commercial sex experience. Some 22% of MSM in Egypt reported difficulty in obtaining condoms and 38% reported difficulty using them, but three-quarters of MSM had heard of male condoms.

The latest global report on HIV indicates that the level of coverage of prevention programs among MSM is 75-100%, while the level of coverage of HIV testing is 50-74%, but condom use is still very low, at less than 25%.[35]

In Tunisia, the prevalence of HIV among MSM versus the general population is about 10%, while prevention program coverage is 25-49% and the HIV-testing coverage is less than 25%; condom use among MSM is relatively high at 25-49%.[36]

Coverage for both prevention programs and HIV testing among MSM in Yemen is reported at 25-49%. HIV prevalence stands at about 7% and condom use is less than 25%.[37]

c. Feminization of HIV/AIDS

In 2012, UNAIDS issued a report titled "Standing Up, Speaking Out: Women in the Middle East and North Africa," which documents the experience of 140 women living with HIV from ten MENA countries, among them Egypt, Tunisia and Yemen. Findings reveal that economic insecurities seen in high levels of female unemployment, gender-based violence, rare use of condoms and societal norms which enforce stigma and discrimination against PLHIV make women much more vulnerable to HIV. Among women, sex workers and IDUs suffer the most from societal prejudices and benefit the least from social support, even from family members.

According to USAIDS estimates, in 2010 women constituted half of the adult population (15 years and older) living with HIV. That proportion has shifted very little in the past 15 years and it has hardly changed in the MENA region, from 45% (24-57%) in 2001 to 45% (31-50%) in 2010. The burden of HIV on women, however, varies considerably by country, with Tunisia estimating that proportionally more women live with HIV than in Egypt and Turkey.[38]

Most people newly infected with HIV are men and live in urban settings (except in Sudan, where more women and people living in rural areas are acquiring HIV infection). Some evidence indicates that many returning migrants are living with HIV and transmit HIV to their spouses. Indeed, many women living with HIV are believed to have acquired the infection from their spouses who partake in high-risk behavior. Women comprised an estimated 41% of adults living with HIV in the Middle East and North Africa in 2010. In Egypt, 19% of HIV infections occur among women. Most of the risky sexual behavior appears to be practiced by men rather than women.

d. Pregnant Women

The majority of women living with HIV in MENA were infected through their husbands or partners, who were mostly unaware of their infections. HIV infections are repeatedly found among pregnant women with no identifiable high-risk sexual practices, suggesting that the risk factor is heterosexual sex with the spouse. There is little data about the availability of specialized medical care for pregnant women living with HIV and infants born to them in Egypt, Yemen, Tunisia and Turkey.

Providing anti-retroviral medicine to pregnant women living with HIV is key to any programs aimed at preventing mother-to-child transmission of HIV. The 2001 Declaration of Commitment on HIV/AIDS set a target of 80% coverage of anti-retroviral medicine to reduce mother-to-child transmission by 2010. Coverage remained low in MENA, where only 4% of pregnant women living with HIV receive anti-retroviral therapy, mostly a single dose of nevirapine instead of the most effective regimens recommended by WHO. In 2010, anti-retroviral therapy coverage among children living with HIV in the MENA region was 5% (3-7%).

Voice of Women from Tunisia

"The doctors told me you've got AIDS, this means you are not a good person."
WLHIV from Tunisia

Source: "Standing Up Speaking Out: Women and HIV in the Middle East and North Africa" [39]

e. Female Sex Workers

The data on the nature of commercial sex networks is limited. In most countries, the prevalence of HIV among female sex workers remains relatively low, but up to 2-4% of female sex workers in parts of Algeria, Morocco and Yemen are believed to be living with HIV.

In parts of MENA, such as in Egypt, female sex workers (FSWs) do not appear to form strong networks and do not have close ties. About 6% of FSWs always used condoms, 56% have ever used condoms and 6.8% used condoms with non-commercial partners during the last sexual encounter. A total of 44.2% of FSWs reported difficulty in getting condoms and 88.5% reported difficulty in using them.[40] In Yemen, 57.1% of FSWs used a condom during the last paid sexual experience, 28.8% used a condom during the last unpaidsexual experience, 50% used condoms consistently with non-regular clients and 58% used condoms consistently with regular clients.[41]

In the 2012 UNAIDS global report, the prevalence of HIV among sex workers versus the general population in Tunisia is less than 0.5%. The reported coverage for the prevention programs reportedly cover 25-49% of sex workers.[42]

ii- HIV/AIDs Programs for Voluntary Counselling and Testing and Anti-Retroviral Therapy

Despite the crucial need to improve the response to the HIV/AIDS epidemic throughout the region, MENA countries have made progress toward addressing the epidemic in their strategies and programs, including the development of standardized protocols for conducting behavioral surveys. All six countries have approved national strategies and programs to address HIV/AIDS.

Egypt developed a national HIV surveillance plan in 2004, and in 2008 a national disease surveillance system was created in 13 governorates to collect and analyze data on 26 priority infectious diseases, including HIV. These databases are still under development.

Although HIV/AIDS is still not a phenomenon in Egypt, the Ministry of Health has, as a preventive and awareness raising measure, established a hotline to receive and respond to related enquiries. The ministry sponsors some activities to raise awareness about HIV/AIDS, and several NGOs are active in this field. While 98% of women in Egypt know of HIV/AIDS, only 21.8% know of other STIs.[43]

Tunisia's National Strategic Plan (2006-2010) aims to intensify prevention and treatment programs by increasing political engagement, collaborating with civil society and improving monitoring and evaluation efforts.

Although efforts to combat HIV/AIDS started early in Yemen, it was not until 2005 that Yemen adopted a national strategy to prevent HIV/AIDS and provide care for PLHIV. In 2010, National Aids Program, along with civil society organizations, made strides in providing testing and counselling to people, increasing anti-retroviral therapy (ART) services coverage, promoting condoms and enhancing preventing mother-to-child transmission. The political transition in 2011 affected HIV efforts heavily; since HIV was not among the government's priorities, service provision has diminished and civil society has not remained a key player.[44]

a. Access to Anti-Retroviral Therapy

UNAIDS concluded that the AIDS response in MENA remains weak. Treatment coverage rate in the region was less than half the global average for low- and middle-income countries. The pace of service expansion is also slower in the Middle East and North Africa than in other regions. While global anti-retroviral coverage increased more than fourfold between 2004 and 2008, a more modest expansion was reported in MENA, with coverage rising from 11% to 14% in the same four-year period.

In 2010, still only 10% (8–13%) of regional ART needs were met, the lowest among world regions. Data available from five of the six countries under review showed a wide variation between Egypt and Yemen with 11% and 9% respectively, and Palestine (100%), Turkey (62%) and Tunisia (53%).

The number of facilities providing anti-retroviral therapy increased from 117 in 2009 to 124 in 2010 across eight reporting countries in the region, an increase of 6%.

Table 21: Adults and children with advanced HIV infection receiving ART, (2009)

Country	Adults and children with advanced HIV infection receiving ART for 2009 (%)
Egypt	11 (of which 6% are children)
Kuwait	N/A
Palestine	100
Tunisia	53 (of which 36% are femalesand 5% are children, boys and girls)
Turkey	62
Yemen	9 (of which 38% are females and 7% are children, boys and girls)

Source: MDG indicators; Palestine Country Profile 2009, WHO Eastern Mediterranean Regional Health System Observatory AIDS and Sexually Transmitted Diseases; and Yemen UNGASS 2010 Narrative Report

Some countries in the region face HIV epidemics that are concentrated among key populations at higher risk for HIV infection, who often have relatively greater difficulty in accessing treatment and care services.[45]

b. Access to Counselling and Testing

Fewer than two facilities were providing testing and counselling services per 100,000 adults in both 2009 and 2010, according to reports from 12 countries in the region. The median number of tests per 1,000 adults in the region remained stable overall.

In 2010, there were 127 testing and counselling facilities all over Egypt with more than 14,000 people aged 15 years and older receiving HIV testing and counselling throughout the year. In Tunisia, 261 testing and counselling facilities served almost 25,000 people in 2009-2010. There are 1,362 facilities in Turkey, but it is not clear how many people have been tested or counseled. Less than 20 facilities in Yemen provided their services to 7,500 people in 2009 and 11,000 in 2010.

Information from some countries in the region suggests that recent efforts to increase HIV testing and counselling—including through national campaigns, implementing provider-initiated testing and counselling policies and improving integration between HIV and maternal and child health services—have provided greater benefits to women than men.

iii- Laws and Policies Pertaining to People Living with HIV/AIDS

There is a huge stigma associated with HIV in the MENA region that raises several human rights issues. Fear of stigmatization and feelings of anxiety, hopelessness and depression are frequently reported by PLHIV. High-profile violations of basic rights of PLHIV have been widely reported. Due to a conservative societal mindset that deems human sexuality to be unacceptable except in very limited circumstances, rights to confidentiality and consent are repeatedly violated. Attitudes toward PLHIV depend strongly on the social acceptability of the transmission mode by which people become infected. Religiosity has been associated with both positive and negative attitudes toward PLHIV.

Programs and policies engaging sex workers are severely limited in the region. The most available intervention is HIV testing and counselling, followed by anti-retroviral therapy and care.

The countries under examination vary significantly with respect to the restrictions they impose on the movement, entry or deportation of PLHIV. While Turkey and Tunisia have no such restrictions, Yemen maintains a complete ban on the entry of people proved HIV positive and deports people discovered to be HIV positive. Kuwait and other Gulf countries also impose severe restrictions on the entry, stay and residence of immigrant workers according to their HIV status. Egypt has restrictions as well and it deports HIV positive people but it does not have a complete ban.[46]

iv. Integration of SRH Services, Including HIV/AIDS

Stigma, discrimination and phobia among healthcare workers are some of the most complicated challenges facing those with HIV/AIDS, and risk exaggeration is common in dealing with PLHIV.[47] For example, Egyptian nurses and over half of Kuwaiti physicians reportedly avoid contact with PLHIV. These negative attitudes have been documented in many other studies.

Such attitudes may be due in part to the invisible nature of the epidemic. As a consequence of low HIV prevalence, most people have never been in contact with a patient who hasan AIDS-related illness. For example, in Egypt, 99% of the general population did not accept all four positive attitudes toward PLHIV, including caring for patients with AIDS-related illness, buying from HIV-positive shopkeepers, allowing HIV-positive women to teach and being willing to disclose the infection of a family member. However, the increasing visibility of HIV in the MENA region may lead to improved attitudes toward PLHIV.

Few organizations or support groups for PLHIV exist in the MENA region. As demonstrated in other regions, such organizations play a key role in providing psychosocial support and referrals, advocating for improved policies and services, overcoming internal stigma and empowering PLHIV.

PLHIV from the MENA area have taken the first steps to establish a regional network of people living with HIV, and they have created a private website and chat room for women and men living with HIV. These resources help PLHIV gain access to information, share experiences and broadcast news about HIV in the region. However, due to the continuing stigma and discrimination in the region, information about the network and website is shared mostly with PLHIV circles and trusted partners and is not widely publicized.

SUMMARY

In the MENA region, young people are among the most at-risk populations for STIs. For instance, more than 50% of the STI cases in Egypt are young single adults.

Combating HIV/AIDS has been one of the most highlighted issues in the work to contain STIs. The MENA region has the lowest HIV prevalence among all regions worldwide, but there are indicators of increasing numbers of people newly infected with HIV.

The most at-risk populations of HIV infection include males having sex with males, injecting drug users and female sex workers. Recently, serious concerns have arisen about the feminization of HIV/AIDS in the MENA region.

In recent years, the number of facilities with counselling and testing services has increased in various countries in the region. However, in reality, people living with HIV/AIDs still suffer from limited access to adequate counselling and testing.

Due to the social stigma, individuals living with HIV/AIDS often face discrimination from the general public. Unfortunately, the most problematic form of discrimination comes from those who are in the best position to help HIV/AIDS patients—health services providers, including physicians and nurses.

IV- SEXUAL RIGHTS

i. Marriage

a. Legal Age of Marriage

The legal marriage age varies in the six countries examined in this report. In Kuwait, the legal age is 15 for women and 17 for men, while in Yemen, it is 15 for women and 16 for men. In Tunisia, the highest legal age in the six countries, both men and women are required to be at least 20 years old.

Table 22: Age of marriage in six countries in the MENA region

Country	Women	Men	Observations	Median female marriage age (ages25-49)
Egypt	18	18		21.2 (EDHS 2008)
Kuwait	15	17		25.2
Palestine	15 (West Bank) 16 (Gaza)	16 (West Bank) 17 (Gaza)	The legal marriage age in Palestine is 18, but the law is regularly ignored. Two different versions of law are currently practiced in Palestine: in the West Bank, Jordanian lawis followed, whereby the minimum age of marriage for girls is 15 and 16 for in boys; in Gaza, Egyptian law is followed, and the ages are 16 and 17 for girls and boys respectively.	21.7
Tunisia	20	20		26.6
Turkey	17	17		22.0
Yemen	15	16		20.7

Source: United Nations Statistics Division, UNdata Gender Info 2007, Early Marriage in Palestine report [48]

In the six countries under review, there are no stark differences in the median age at marriage for women aged 15-49. Data gathered from these countries in 2007 shows that in Yemen the median marriage age for women is 20.7 years, the lowest of the six countries examined in this report. In contrast, the median age at marriage for Tunisian women is 26.6. The median marriage age in Palestine, Turkey, Egypt and Kuwait 21.7, 22.0, 22.3 and 25.2 respectively.

Due to the increasing financial burden of marriage on young men and women, youth in the MENA region have been facing issues of delayed marriage resulting in, as explained above, "wait-hood." While waiting for proper employment opportunities and the financial capability to get married and start a family, MENA youth become trapped between childhood and adulthood. Among the factors causing the rapid increase in the cost of marriage is the high cost of housing, high demands by families and high expectations by women, in particular women with high levels of education.

b. Early Marriage

While not as common as in regions such as South Asia and Sub-Saharan Africa, early marriage is a serious issue in the MENA region, as marriage at the age of puberty is common.[49] The UN Convention on the Rights of the Child defines a child as "every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier." Using that definition as a foundation, CEDAW, in its General Recommendation 21, calls for the prohibition of marriage before the age of 18 since most children do not have the "full maturity and capacity to act" as recognized by the expert body that monitors CEDAW.

Article 16.2 of CEDAW states, "The betrothal and the marriage of a child shall have no legal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage."[50] Interestingly, the legalization of early marriage depends largely on the definition of 'child' in the country's law. Reporting of early marriage is rare and data is limited. In addition to traditions, poverty is one reason for the high rate of early marriage, especially among rural women.

Child marriage usually results in range of violations of children's human rights, since it is broadly connected with lack of education and deteriorating health, and in many cases it constitutes child exploitation and is not in the best interest of the child.[51]

A study conducted in the 1980s in Upper Egypt discovered that more than 40% of rural women enter into an early marriage.[52] In 2011, UNICEF reported that 17% of Egyptian women experienced child marriage in 2000-2009. UNICEF used the percentage of women aged 20-24 who were married or in a union before they were 18 years old as an indicator of the status of child marriage in the country. The data shows a high gap between the prevalence of child marriage in rural Egypt (22%) and urban Egypt (9%).[53]

Data from the Palestinian Central Bureau of Statistics in 2009 indicates that 5.8% of ever-married women are married by the age of 14 or less, 8.7% by 15 years old, 11.7% by age 16 and 13.2% by the age of 17. This means that more than one-third of ever-married women are married before they reach 18.[54] More recent reports from the bureau do not include disaggregated information on the age of marriage, but the final published percentage of ever-married women under 18 is steadily decreasing, from 22.9% in 2009 to 21.8% in 2010.[55] Published in 2011, UNICEF's report on the state of the world's children asserts that 19% of women aged 20-24 years old in the OPT were married before the age of 18 in the period of 2000-2009.[56]

Tunisia was one of the first countries in the region to take legal action against early marriage in the 1950s. In 2004, only 3% of girls aged 15-19 had entered into an early marriage.[57]

According to UNICEF, in Turkey, there is a lower percentage of child marriage—approximately 14% of women experienced early marriage. While 13% of Turkish women in urban areas have been through child marriage, 17% of women in rural Turkey experienced child marriage in 2000-2009.[58]

In comparison with other countries examined in the report, the median age at marriage for Kuwaiti women is high at 25.2. Data on the prevalence of child marriage among the Kuwait population is not widely available. In 2004, it was estimated that 5% of Kuwaiti girls aged 15-19 had been married.[59]

In 2006, a study conducted by the Yemeni Ministry for Public Health and UNICEF found that 19% of women aged 14-19 were currently married and in 16% of these marriages, the husbands were ten years older than the women.[60] Data also shows that 14% of women aged 15-19 were married by the age of 15 and 52% of these women are married by the age of 18.[61] A 2011 Human Rights Watch report on child marriage in Yemen said that young girls aged 12 and 13, and sometimes as young as 8, may be wed.[62] While Yemeni hospitals have received several cases of girls with injuries stemming from forced sexual encounters, these cases are rarely reported.[63] In 2010, the case of Elham Mahdi El-Assi brought international attention to the issue of child marriage in Yemen. Elham, who

was only 12 years old, died "from internal bleeding following intercourse, three days after she was married off to a man at least twice her age."[64] Sadly, recent numbers show limited progress on combating child marriage in Yemen.

In addition to the sexual violence young brides face, early marriage is usually associated with high fertility and early childbearing, which frequently endanger women's life and/or health.

Voice on Early Marriage from Yemen

Young women tell their painful stories about child marriage: "Najla did not know exactly how old she was, but she said that she was married soon after completing her second year in secondary school, which would have made her about 15 or 16 at the time of her marriage. She has been married for seven years and has two children who were likely born before she was 18 years old. She explained how she was denied medical treatment by her in-laws.

'I was pregnant with the second child when my firstborn was only five months old. For five days, I bled severely and I thought it was just my period. My mother-in-law knew what was happening to me, but she wouldn't tell me anything. They [my in-laws] wouldn't let me go to the hospital and wouldn't tell my husband what was going on with me. When I became very dizzy, they finally took me to the hospital, but at the hospital they didn't stop the bleeding and didn't give me any treatment. I had to lie on my back for six months during my [second] pregnancy and I needed 500 cc of blood. The doctor told me it's because I married early.'"

Source: Human Rights Watch, How Come You Allow Little Girls to Get Married? Child Marriage in Yemen, 2011

c. Other Forms of Marriage

Besides legal registered marriage, other forms of marriage are common in different MENA countries. Urfi (common law or customary) marriage, an unregistered form of marriage that is usually secretive, is most common among young couples in urban areas, often chosen by young couples due to the high cost of marriage in some countries. Although urfi marriage provides a sexual relationship with some legitimacy, it is still socially unacceptable.[65] On the other hand, urfi marriage is valid if it "meets the requirements of the pillars of the contract, the conditions of conclusion and the requirements of publicity."Significantly, Islamic law does not require an official document to consider the marriage valid.[66]

Cases of urfi marriage are under-reported due to the secrecy surrounding it and the unavailability of official records on its occurrence. It is also under researched.[67] Hence, there is limited data by which to estimate its prevalence. In 1998, around 10,000 cases of contested paternity in urfi marriages were being considered in Egyptian courts.[68] In a study conducted by UNDP and published in 2006, it was reported that journalistic and anecdotal evidence shows that urfi marriage has been reported in other countries besides Egypt. The UNDP study reported incidents of urfi marriage among university students in Jordan. In Yemen, the study shows that urfi marriage is rare and occurred mostly in cases of marriage to non-Yemenis.[69]

Similar to informal and unregistered forms of marriage, women's legal rights in "tourist" marriages are endangered. In Egypt, while data on tourist marriages are limited, there have been efforts to focus governmental, non-governmental and public attention on the issue. The Egyptian Center for Women's Rights defines tourist marriage as a "short-term marriage between an Egyptian woman and non-Egyptians for the duration of the summer."[70] Recent reports show that young girls in poor families, in particular girls under 18, are being forced into tourist marriages by their fathers and male guardians.[71] In Yemen, cases of tourist marriage have been reported in which young girls are married to older wealthy men, mostly from the Gulf countries. After being sexually exploited for a temporary period of time, young wives are usually abandoned by their husbands.[72] Similar cases of "summer marriages" were reported in Egypt. Recent data show that majority of these "husbands" are from Saudi Arabia, the United Arab Emirates and Kuwait.[73]

ii- Gender-Based Violence

In 1993, the United Nations Declaration on the Elimination of Violence against Women defined violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."[74]

a. Rape and Marital Rape

In the Middle East, under tribal laws in particular, rape was traditionally perceived as an act of hostility toward the tribe, the clan, the women's family or husband. As virginity was a major factor of a woman's worth in the marriage market, it was regarded as an act of physical damage and theft of sexual

Table 23: Anti-rape laws in six countries in the MENA region

Country	Anti-rape laws
Egypt	The law prohibits non-spousal rape and punishment is either life imprisonment or the death penalty, according to the latest amendment in March 2011; however, spousal rape is not illegal. Article 290 of Law 214 introduced a death sentence for rapist-kidnappers. In 1999, the People's Assembly passed legislation to repeal Article 291 of the Penal Code, which permitted an abductor to marry his victim to avoid punishment.[77]
Kuwait	Articles 186-194 of the Penal Code (Law 16/1960). [78]
Palestine	Article 308 of the Jordanian Penal Code (West Bank) allows legal proceedings to be dropped against a rapist who marries his victim. Similar types of Egyptian law are enforced in Gaza.
Tunisia	Under Article 227 of the Tunisian Penal Code, sexual assault accompanied by acts of violence or threats with a weapon is punishable by death, while for other cases of rape, the prescribed punishment is life imprisonment (Tunisia 1 Oct. 1913).
Turkey	In Turkey, the Penal Code was amended in 2004 to consider sexual assault to be a crime against the person rather than Turkish society or the victim's family. Provisions that allowed rapists to avoid punishment by marrying their victims were changed. Marital rape is criminalized in Turkey. [79]
Yemen	N/A

Source: UN Secretary-General's database on violence against women, SIGI 2012 and UNHCR 2008.

property.[75] Most modern laws in the MENA region frame rape as a crime against public order.[76] Victims of rape carry the burden of social stigma and alienation, and raped women face serious, life-threatening risks, especially if they are pregnant. While most women in the MENA region do not have access to safe, legal abortion, pregnant victims of rape have limited options. In addition to non-spousal rape, CEDAW has included marital rape as a form of sexual, physical and psychological violence occurring in the family. In reality, little has been achieved to protect women from marital rape in the MENA region.

In Egypt, the Supreme Council of the Armed Forces amended provisions in the Penal Code related to sexual violence in March 2011, aggravating most of the penalties and making non-spousal rape punishable by life imprisonment or death (see Table 23). Law 214 introduced the death sentence for rapist-kidnappers, and in 1999, the death sentence was expanded to include other cases of rape without kidnapping.[80] Until 1999, when it was repealed, Egyptian law permitted an abductor to marry his female victim to avoid legal punishment.[81] In Egypt, marital rape is one of the most sensitive gender-based violence topics[82] ;spousal rape has not been addressed by Egyptian law and is not criminalized.[83] The recent Penal Code amendments of 2011 also stiffened penalties for sexual assault, child abduction, incitement of debauchery and public obscenity.[84]

In Kuwait, the law prohibits non-spousal and incest rape, with punishment ranging from life imprisonment to death. Rape of girls younger than 15 is punishable by life imprisonment, but the death sentence is mandatory if the rapist is a member of the girl's patrilineal family, a person with a guardianship over the girl or a domestic servant working in the household. Marital rape is not illegal under Kuwaiti law.[85]

In the Occupied Palestinian Territory, Egyptian law is enforced in Gaza while Jordanian law is enforced in the West Bank. In the West Bank, the 1960 Jordanian law considers rape and incest to be crimes against public morals and ethics.[86] Punishment of rape ranges from seven years imprisonment to death.

Under the same law, a more severe sentence for rape may be imposed if the victim lost her virginity[87] or was infected with an STI due to the rape. At the same time, rapists who marry their victims are exempt from criminal prosecution.[88] Similar to Egypt and Kuwait, marital rape is not illegal in the OPT. Articles 292 and 293 of the Penal Code explicitly allow an exception for non-consensual sex within marriage, limiting criminal penalties to a man who "has sex with a female (other than his wife) without her consent."[89]

In Tunisia, the law prohibits non-consensual sex and sets the age of consent at 13. Under Tunisian law, rape is punishable by as little as five years imprisonment and up to life imprisonment. Similar to Jordanian law, Tunisian law allows rapists to avoid criminal punishment by marrying their victims.[90]

In Turkey, the Penal Code was reformed in 2004 to make sexual assault a crime against the person rather than Turkish society or the victim's family. Among the reforms was the amendment of the provisions that provided rapists with an opportunity to avoid punishment if they marry their victims.[91] According to the Turkish Criminal Code, violation of sexual immunity is punishable by a two-seven year prison sentence, and inserting an organ or instrument into the body is punishable by up to twelve years imprisonment.

In addition, Turkish law prohibits spousal rape.[92] Human rights organizations have argued that cases of rape are underreported due to the victims' embarrassment and untrustworthiness of the country's slow justice system.[93] At the same time, some argue that the 2004 reforms were introduced to enhance Turkey's image as a "European" country, rather than being motivated by a recognition of women's rights.[94]

The Yemeni Penal Code criminalizes rape, but Yemeni law perceives rape as a form of adultery, punishable by Islamic laws on adultery. The law provides for a maximum penalty of seven years imprisonment for rape cases that do not meet the requirements of the Islamic punishment. A study published by a Yemeni women's organization argued that current rape law must be reformed to define rape separately from adultery.

Table 24: Anti-marital rape laws in six countries in the MENA region

Country	Anti-marital rape
Egypt	The law prohibits non-spousal rape with punishment ranging from three years to life imprisonment; spousal rape is not illegal.
Kuwait	Kuwait has no laws prohibiting domestic violence, sexual harassment or marital rape.[97]
Palestine	Articles 285 and 286 of the Jordanian Penal Code stipulate that if a woman wants to file a complaint for violence or abuse, the complaint must be filed by a male relative.[98]
Tunisia	Legislation in Tunisia provides a very high level of protection for the physical integrity of women. The legal framework includes specific punishments for violence against women. Under Articles 227 and 227 (bis) of the Penal Code, marital rape, like all other forms of rape, is a crime.[99]
Turkey	Any person who attempts to violate the sexual immunity of another person is subject to two-seven years imprisonment upon complaint from the victim. If the victim is a spouse, commencement of investigation or prosecution is bound by complaint from the victim and the offender is subject to 7-12 years imprisonment.
Yemen	The law does not recognize the concept of spousal rape. Under Article 40 of the Personal Status Act, a woman is legally required to provide her husband with "sexual access."

Source: UN Secretary-General's database on violence against women 2012, SIGI 2012, UNFPA 2005,UNHCR 2008 and the Human Rights Watch World Report 2012

It also urged the introduction of a minimum sentence for convicted rapists in order to avoid judicially reduced sentences.[95]

In Yemen, where early marriage is common, the inability to prosecute marital rape cases substantially endangers the lives and well-being of many Yemeni females. Among the many cases of child marriage and marital rape, one particular case caught the media's attention in 2011, involving a 12-year-old bride who was drugged and raped by her 50-year-old husband.[96]

b. Female Genital Mutilation/Cutting

FGM/C (female genital mutilation/cutting) is one of the most alarming traditional practices found in the MENA region, as well as other parts of the world. The WHO states that FGM includes "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons."[100] In 1990, the CEDAW Committee issued a general recommendation on FGM, calling on governments to include FGM as a public health issue and support women's organizations in their work combating

Table 25: Anti-FGM laws in six countries in the MENA region

Country	FGM law
Egypt	After two ministerial decrees banning FGM/C, the child law (Law 12/1996, amended by Law 126/2008) criminalized FGM/C and incorporated the article into the Penal Code (Article 242bis).[105]
Kuwait	N/A
Palestine	N/A
Tunisia	N/A
Turkey	N/A
Yemen	There is no law against FGM/C in Yemen. A ministerial decree effective 9 January 2001, however, prohibits the practice in both government and private health facilities.[106] The government banned the practice of FGM in official hospitals, but it is known to continue in private clinics.[107]

Source: SIGI 2012

the practice.[101] In 1994, ICPD called on governments to work on the elimination of FGM.[102]

During the ICPD in 1994, CNN aired a video on the practice of circumcision in Egypt, directing international attention to the issue but also sparking a legal and societal debate on the practice.[103] In 1997, FGM became illegal in Egypt. In 2007, a 12-year-old girl died due to the procedure, and the case was reported in local and international media, which caught public attention.[104]

In the countries examined in this report, FGM is widely practiced in Egypt and Yemen only, although cases have been reported in Gaza in the OPT.

Recent studies show extremely high prevalence of the practice of FGM in Egypt. Despite criminalization and the wide range of governmental and non-governmental campaigns against it, according to the 2008 DHS, 91.1% of Egyptian women aged 15-49 have been subjected to the procedure. Such a high percentage raises serious concerns regarding the prevalence of FGM among Egyptian women across classes, religions and geographic areas. Data gathered on FGM/C in the period of 2005-2008 show that 43.6% of women aged 15-49 were aged

Table 26: Percentage of women subject to FGM in six countries in the MENA region, 1997-2007

Country	Women aged 15-45 (%)
Egypt	96
Kuwait	FGM is not practiced in Kuwait (SIGI)
Palestine	FGM is known to be practiced in Gaza, but there are no reports on the number of women affected.
Tunisia	FGM has never been a general practice in Tunisia.
Turkey	N/A
Yemen	23

Source: Progress for Children: A Report Card on Child Protection, no. 8, September 2009, and SIGI 2012

Voice on FGM from Egypt

"The women come to my home early in the morning. They got hold of me and forced me to lie down. My hands and legs were held firmly and I could hardly move. They then spread my legs and the daya (village midwife) started cutting. The pain was excruciating, and I was screaming uncontrollably."

Naglaa's black eyes burn not with shame but something quite different: a kind of pride and self-assurance, fueled, perhaps, by memories of the horrific, life-changing experience that she went through many years ago.

"The daya continued cutting for what seemed like an eternity," she continues. "I don't remember how long it took, but I never imagined that I could experience such unbearable pain."

Naglaa was circumcised at the age of 11. She willingly volunteered for a procedure which—in much of Egyptian society—is culturally accepted and often encouraged. Her family told her it was her moral duty and the only way for her to become a real woman.

"The day before it happened, I went to collect ashes from an oven. People told me the ashes would help heal my wound, and I wanted to play a part myself in this important milestone in my life."

A few days after the circumcision, Naglaa found out that the ashes had not healed her wounds. Instead, infection had set in.

Source: UNICEF, Egypt [110]

9–10 when circumcised; in contrast, the majority of women circumcised in Yemen by 1997 underwent the procedure sometime in the early stage of life, at a few weeks or few months old.[108] UNICEF has reported that FGM is typically performed on Egyptian girls at age 9–12. While in the past the procedure was often conducted by traditional health attendants using unclean knives and razors, in recent years the EDH notes that 71.6 % of FGM/C procedures are being performed by health practitioners such as doctors and nurses, in a phenomenon called "the medicalization of FGM/C."[109]

A study conducted on FGM/C in Yemen and published in 2008 showed that more than 70% of Yemeni women and 48% of Yemeni men support the practice.[111] Interestingly, research in Egypt in the late 1990s showed similar trends for women's attitudes toward FGM.[112]

In addition to culture and traditions, religion has been used to justify this harmful practice against women, but FGM/C should be viewed only as a cultural practice rather than a religious practice justified by Islam.[113] In 2007, Al-Azhar, Egypt's highest Islamic authority, issued a statement that condemned the practice and clarified that it is not justified under Islam.[114]

c. Sexual Harassment

Table 27: Anti-sexual harassment laws in six countries in the MENA region

Country	Anti- sexual harassment laws
Egypt	Three bills on sexual harassment were drafted for discussion in the Egyptian parliament in the coming session (UNFPA 2012).
Kuwait	There are no laws that explicitly address sexual harassment in the workplace (SIGI).
Palestine	The Palestinian Criminal Code, passed by the Legislative Council in 2003, has no provisions to protect women from gender-based violence and allows offenders to use a variety of excuses to avoid prosecution (UNFPA 2005).
Tunisia	Law 2004-73 of 2 August 2004 amending and supplementing the Penal Code on the repression of indecency and sexual harassment.
Turkey	Person performing such act is subject to punishment from three months to two years imprisonment upon complaint of the victim.
Yemen	The country has yet to establish any laws against sexual harassment in the workplace (SIGI).

Source: SIGI 2012, the UN Secretary-General's database on violence against women 2012, UNFPA 2005 and 2012

Sexual harassment is defined as "any unwelcome sexual advance, request for sexual favor, verbal or physical conduct or gesture of a sexual nature, or any other behavior of a sexual nature that might reasonably be expected or be perceived to cause offence or humiliation to another, when such conduct interferes with work, is made a condition of employment or creates an intimidating, hostile or offensive work environment."[115]

In Egypt, the sexual harassment of women, in particular in public spaces and on the streets, has received much attention in the past few years. In 2005, a non-governmental study was conducted on the prevalence of sexual harassment in various Egyptian governorates. Some 83% of Egyptian women participating in the study reported experiencing sexual harassment, including inappropriate touching, verbal harassment of a sexually explicit nature, stalking, cat calling and indecent exposure.[116] Various non-governmental initiatives were launched to address the problem, among them a 2010 campaign to end sexual harassment in Egypt, led by the Egyptian Center for Women's Rights and supported by UNFPA.[117] At the same time, Human Rights Watch reported that the Egyptian government took a positive step to combat sexual harassment in 2009 by distributing informational materials on the issue to mosques across the country.[118] Unfortunately, anti-sexual harassment laws are still absent from the Egyptian legal code; while many attempts have been made to introduce laws combating sexual harassment, none have been successful. In February 2010, Egyptian Member of Parliament Dr. Georgette Kellini submitted a bill to deter sexual harassment through an amendment to the Penal Code. The proposal was presented to the parliament in at least three different forms, largely with the same purpose but divergent details such as the level of fines imposed. Due to the transition period Egypt has been undergoing since the January revolution of 2011, these bills were placed on hold. The recent rise in the number of sexual harassment incidents in Egypt has renewed interest in the topic and will hopefully bring the bills back into the political arena. Significantly, the March 2011 amendments to sexual violence provisions in the Penal Code ignored sexual harassment.

In Kuwait, there are no laws that explicitly address sexual harassment.[119] In a Human Rights Watch report on migrant domestic workers in Kuwait, it was reported that many non-Kuwaiti domestic workers, mostly women, experienced daily sexual harassment in the household in which they work. The report quoted the ambassador of a labor-exporting country in Kuwait who told Human Rights Watch that in 2009 his embassy received 290 claims of sexual harassment and rape.[120] In recent years, the media has highlighted cases of sexual harassment in Kuwait, in particular at workplaces. Women facing sexual harassment in workplaces are usually torn between seeking justice by reporting the incident and the fear of the loss of their jobs.[121]

Voice on Sexual Harassment from Kuwait

Migrant domestic workers in Kuwait narrated their stories of sexual abuse at their places of employment: Moulu T. faced the dangers of sexual assault for seven months at an employer's house. She said:
"My employer has three sons [...]They treated me in a bad way ... they tried to rape me."

Another domestic worker, Latha M. Talked about her first employer:
"She hit me and scratched me. One day she beat me, locked me inside, and locked the outside door."After escaping this employer's house, Latha was sent to another employer whose sons sexually abused her.

Source: Human Rights Watch [122]

In Turkey, the 2004 law defines sexual harassment to include all forms of harassment with a sexual intent.[123] Turkey is one of the few countries in the region that criminalize sexual harassment.

Tunisia, too, has a law that explicitly addresses sexual harassment. The current law criminalizes sexual harassment and carries a sentence of six months to one year imprisonment. The anti-sexual harassment law of 2004 increased the penalty if the victims of the harassment are women or children.

Many Palestinian women have reported that sexual harassment on the street is a daily threat to personal security in the Occupied Palestinian Territories.[124] Unfortunately, in most cases, victims of sexual harassment and abuse are blamed for these tragic events.[125] After the Israeli attacks on the West Bank in 2002, followed by a renewed intifada, there was an increase in the sexual harassment of women.[126] In addition, Palestinian women must also deal with constant sexual harassment from Israeli soldiers at the various checkpoints.[127]

A non-governmental study conducted in Yemen in 2010 found that 99% of Yemeni women living in Sana'a face street sexual harassment.[128] Yemeni law does not explicitly address sexual harassment.[129] Due to the increasing verbal harassment on the street and to avoid embarrassment, Yemeni families often

prohibit their daughters and female family members from going out.

d. Honor Killing

Honor killings have been one of the most serious issues facing women in different countries in the MENA region. An honor killing is the "murder of a woman by her male family members for a perceived violation of the social norms of sexuality, or a suspicion of women having transgressed the limits of social behavior imposed by traditions."[130] A 2009 report by the UN Special Rapporteur on Violence against Women listed Turkey, Egypt and Yemen among the countries where honor killing takes place.[131] Honor killing is one of the most important obstacles to achieving human security in the Arab states.[132]

In Egypt, a non-governmental study shows that the murder of women due to suspicion of improper behavior constituted the majority of honor crimes from 1998 to 2001.[133] The study stated that 41% of the reported cases were husbands killing wives, while 34% of the cases were fathers killing daughters. Egyptian law does not explicitly address the issue of honor killing.

In Turkey, the Penal Code after 2004 criminalized honor killings,[134] but despite the law, Turkish culture, similar to other countries in the region, perceives the control of women's sexuality and family honor as interconnected.

Voice on Honor Killing from Turkey

In 2006, BirgulIsik was murdered in the name of her family's honor.

Isik was gunned down by her 14-year-old son Ramazan for bringing shame on her family after she appeared on a Turkish talk show to discuss her abusive marriage.

She had fled her violent, bigamous husband several times before. Ignored by the authorities and dismissed by her family, she agreed to appear on the Women's Voice show.

But in Turkey, domestic violence is an issue few women dare discuss outside the family, let alone on national television. Back in her hometown, many believed Isikhad crossed the line.

She had just returned to Elazig in eastern Turkey by bus, accompanied by four of her five children after taking part in the program in Istanbul.

Ramazan was waiting for her at the bus stop. When he saw her, he shouted that she had shamed the family, pulled out a gun and shot her five times.
Isik died in the hospital three weeks later.
Ramazan was placed in a juvenile detention center and Isik's four other children in orphanages. Isik's husband was put on trial for incitement, but was later acquitted.

Source: BBC [135]

In Palestine, honor crimes are committed against women suspected of improper behavior as well as those who have been victims of sexual violence. In a report published in 2006, Human Rights Watch mentions the unfortunate story of a 16-year-old girl who was murdered after getting pregnant due to repeated rape by her brothers. After the imprisonment of her brother for incest and to avoid public shame, the girl was killed by her mother. Despite the Palestinian police's prior knowledge that the girl was in jeopardy, they failed to arrive on time due to Israeli checkpoints.[136]

In Yemen, the law provides reduced sentences to men convicted of murder of their wives or female relatives who commit adultery.[137] In tribal Yemeni society, accurate numbers on honor crimes are not available. One non-governmental study reported that families rarely disclose the real reasons for honor crimes.

Similar to other countries in the region, honor crimes against women are committed in Kuwait. Kuwaiti law provides reduced punishment of imprisonment for men who kill their female relatives in the name of honor. Honor crimes are rarely reported in Kuwait, with only one case reported from 2002 to 2009: the murder of a young woman by her brothers in 2006.[138]

iii- Status of the Lesbian, Gay, Bisexual and Transgender Community

In general, traditional societies in most countries of the MENA region do not provide safe and comfortable atmospheres for lesbian, gay, bisexual and transgender (LGBT) groups. Across the globe, transgender individuals are more vulnerable to various health risks like HIV infection.[139]

In Egypt, while there is not a clear law against sodomy, consensual, non-commercial homosexual conduct is criminalized under the law against debauchery (fujur).[140] In 2001, issues of homosexuality caught the attention of national and international media when the police raided a discotheque and arrested more than 50 men, who later faced criminal prosecution. The case became known as the Queen Boat case. In addition to social humiliation, gay men risk arrest and torture by the police. It has been reported that thousands of men were arrested in the period of 2001–2004 for homosexual sex. In 2007, Egypt started targeting people living with HIV/AIDS.[141] Similarly, while gender re-assignment surgery is allowed in Egypt, police arrest and torture transgender people.

Despite harassment from the public and police, it has been reported that transgender women in Kuwait are generally able to move around freely. However, in 2007, the law was amended to criminalize imitating the opposite sex.[142] While gay men face the danger of public assault and police arrests, Human Rights Watch has noted that transgender women are being arrested more frequently than gay men.

In comparison with other countries in the region, LGBT groups are more visible in Turkey, but visibility has been followed by stigmatization and physical and sexual violence. A small number of LGBT victims of violence seek help or report to the police.[143] Turkey has adopted European practices on gender re-assignment surgeries,[144] but at the same time, the Turkish state has closed down LGBT groups and the police harass transgender people.

In Yemen, sodomy is criminalized. According to the law, men who have sex with men are subject to the death penalty.[145]

iv- Trafficking

The United Nations Convention against Transnational Organized Crime, adopted by the General Assembly in 2000, addresses human trafficking and includes the Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children. The anti-trafficking protocol defines trafficking in persons as "the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of

Table 28: Anti-trafficking laws

Country	Anti-trafficking laws
Egypt	The Egyptian Penal Code does not prohibit all forms of trafficking, but some efforts have been made since June 2008, when the government enacted amendments to the Child Law (Law 126/2008), which include provisions prohibiting the trafficking of children for commercial sexual exploitation and forced labor. The sentences prescribed are equal to other grave crimes, with the minimum term of imprisonment set at five years.[147]
Kuwait	Articles 178–185 of the Penal Code (Law 16/1960) criminalize abduction, detention and the slave trade with penalties ranging from imprisonment to fines and a life sentence. Article 185 criminalizes the slave trade nationally and transnationally. Article 49 of Law 31/1970 amending some provisions of the Penal Code criminalizes forced labor in the public sector.[148]
Palestine	N/A
Tunisia	"The Government of Tunisia made limited anti-trafficking law enforcement efforts during the reporting period; one known trafficking offender was brought to justice. Tunisian laws do not specifically prohibit human trafficking, though trafficking offenders could be prosecuted under several laws that prohibit specific forms of trafficking in persons. The Penal Code prescribes a 10 years imprisonment for capturing, detaining, or sequestering a person for forced labour and up to a five years imprisonment for forced prostitution of women and children."[149]
Turkey	Persons convicted of human trafficking are subject to 8–12 years imprisonment and a fine of up to 10,000 days.
Yemen	Yemen does not have an anti-trafficking law, but it has provisions in its criminal code to prosecute and punish traffickers.[150]

Source: The UN Secretary-General's database on violence against women 2012 and Trafficking in Persons Report 2005 and 2009.

the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs."[146] The convention explicitly addresses the issue of trafficking of children, defined as all persons under 18, in Articles 3.c. and 3.d. Egypt, Tunisia, Turkey and Kuwait have ratified on the protocol.

Most countries in the MENA region have largely neglected introducing legal reforms to combat trafficking in persons.

In Kuwait, the system of kafala (sponsorship) leaves migrant domestic workers vulnerable to trafficking, as it gives employers with significant control over workers. In addition, Kuwaiti immigration law does not protect workers. The law allows for criminal charges against workers who leave their jobs.[151]

Egypt is considered to be a source, transit and destination country of trafficking in women and children.[152] The US trafficking report considers "summer marriages" of young Egyptian women to wealthy older men from the Gulf to be a form of trafficking. A non-governmental report, released in 2011, shows evidence that organ traffickers have been exploiting Sudanese refugees and asylum seekers. In addition, the report shows that organ brokers have been trafficking refugee women for sex.[153]

In Turkey, women and child sex trafficking victims are predominately from the former Soviet Union and Eastern Europe.[154] While there is little information on sex trafficking in Turkey, available data shows frequent trafficking routes and schemes from the Eastern Bloc to Turkey. Some of the trafficked women engage in the sex work industry in Turkey while others leave Turkey and go to other countries in Western Europe.[155]

In Yemen, a non-governmental study released in 2005 sheds light on underreported issues of trafficking. The study shows that children are among the most at-risk populations for trafficking, in particular for sexual purposes. The study points out a loophole in Yemeni law that punishes traffickers of female children exclusive of male children.[156]

A recent study on trafficking in Palestine shows four main trafficking routes: from Israel into the West Bank, from the West Bank into Israel and East Jerusalem, within the West Bank and from the Gaza Strip into Israel. The study shows that the age of trafficked women ranges from 12 to over 40, but most of the trafficked women are in their 20s.[157]

Voice on Trafficking from Palestine

Profile of a trafficked woman from the West Bank into Israel
Place of residence: Nablus; Age: 24; Marital status: Married; Number of children: 3

After S was raped by her husband's uncle, she ran away. She met a man who was trafficking women from the West Bank into Israel, mainly into Tel Aviv. Taking advantage of the vulnerability of the woman, he convinced her to work for him. A fake Israeli identity card made it possible to pass through Israeli checkpoints.

After a period working in prostitution, S used drugs and became pregnant by the same man. After a dispute, she stabbed him and ended up in jail, where she had her child. After her release, she was sent back to the West Bank.

Source: Sawa

v- Sex work

Sex work has been one of many battlefields for feminists and women's rights advocates across the globe. Some take the position of complete opposition to sex work, advocating the criminalization of prostitution based on the belief that no woman would voluntarily choose to engage in it. On the other hand, others argue that a distinction between voluntary and forced prostitution must be made. Groups adopting this perspective argue that forced prostitution, including sex trafficking, is a violation of women's human rights while voluntary prostitution as a sex worker should be a legitimate labor practice.[158]

As long as the sex worker is registered, sex work is allowed by Turkish law In Turkey.[159] In Egypt, prostitution was legal until the late 1940s. In the 1980s, anti-prostitution laws and anti-debauchery laws were revived due to the expanding prostitution industry serving Gulf tourists. A non-governmental report, published in 2010, raised the issue of limited data on sex work in Egypt. The report found that most women engaging in sex work come from underprivileged socioeconomic backgrounds. It identifies street children as one of the most at-risk groups for abusive behavior within forced prostitution.[160]

In Yemen, prostitution is criminalized. In addition to legal risks and social stigmatization, Yemeni male sex workers face serious health risks. Available limited research shows that most Yemeni male sex workers decide to engage in sex work due to poverty and economic necessity.[161]

In Tunisia, both forced prostitution and child prostitution are criminalized.[162] In early 2011 after the Tunisian Revolution, a group of Islamist protesters gathered near a neighborhood known for its brothels in the capital, Tunis, calling for closing down the brothels. The police blocked of the street until the demonstrators were dispersed.[163]

SUMMARY

All countries examined in the report set a legal minimum age of marriage for men and women. However, early marriage is still a sexual rights issue in the MENA region. Other forms of marriage are common in the region, such as urfi marriage and touristic marriage.

Rape is criminalized in all countries. In Palestine and Tunisia, rapists can avoid punishment by marrying their victims. Marital rape is criminalized in Turkey and Tunisia.

Several forms of gender-based violence are common in all countries examined in the report. Laws addressing domestic violence are absent from most of the countries in the region. Among the countries discussed in the report, FGM/C is common mostly in Egypt and Yemen. Sexual harassment is a serious gender-based violence issue. Tunisia is one of the few countries that have laws explicitly addressing sexual harassment. Due to traditional cultures in the MENA countries, many women fall victim to honor killings.

In general, the MENA region is not safe or comfortable for LGBT individuals and groups. In addition to social stigma, laws in some countries prohibit the representation and actions of LGBT sexualities.

Limited efforts have been made by governments in MENA countries to combat trafficking in persons, but the focus on anti-trafficking has increased in the past few years. Except Turkey, sex work is criminalized in all countries discussed in the report.

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CHAPTER 5:

Voices from the Region

This section includes a summary of a collection of interviews with different national NGOs from the region.

Interviews based on a closed questionnaire were used to gather qualitative information for a report on the status of sexual and reproductive health and rights in the Middle East and North Africa. We worked with a small sample of 11 interviewees recruited from representatives from the region: ten NGO staff members and one activist from Kuwait, all working in the field of SRHR in their respective countries.

We interviewed two people per country, with the exception of Kuwait, where we only managed to contact one person. We identified people to be interviewed by seeking individuals falling in the category of activists, experts and practitioners who have good knowledge on the issues explored here. Data analysis was performed after identifying the main themes that emerged during the interviews.

The main ideas for each topic were identified and illustrated with quotes from interviewees whenever possible. The objective of the study was to supplement other qualitative and quantitative data collected for the report, and to reflect the real situation on the ground to verify information documented in reports and studies.

The persons/NGOs interviewed for the report were asked about, inter alia, factors affecting sexual and reproductive health and rights in their countries, trends and emerging issues, the main challenges facing work on SRHR and how the upheavals in the region will affect SRHR.

The organizations that participated in the survey include: Al-Qaws for Sexual and Gender Diversity in Palestinian Society and the Health Work Committees (Palestine); KAOS GL, Women for Women's Human Rights (WWHR) and New Ways/the Coalition for Sexual and Bodily Rights in Muslim Societies (Turkey); the Center of Arab Woman for training and Research (CAWTAR) and the Association of Tunisian Woman for Research and Development (AFTRUD) (Tunisia); Aid Association and Yemen Family Care Association (YFCA) (Yemen); and Friends of Life Association and Nazra for Feminist Studies (Egypt). In addition, one male-to-female transgender person from Kuwait was interviewed.

- Interviewees from all countries noted that the rise of political Islam and conservative governments post-Arab Spring are likely to have a negative effect on SRHR.

- Positive developments noted by interviewees include a small increase in awareness on LGBT issues and an increase in the number of NGOs working on LGBT rights and HIV/AIDS. However, most interviewees could not see any significant improvement in the lives of women, youth, people living with HIV/AIDS or the LGBT community in past years.

- Challenges facing SRHR work and current issues of concern mentioned were, among other things: closed social traditions and customs (Yemen, Kuwait, Egypt); high levels of illiteracy and poverty, absence of awareness (Yemen); funding difficulties for work with the LGBT community and on HIV/AIDS (Yemen, Egypt, Palestine); low prioritization of SRHR-related issues by the government (Yemen, Egypt) and civil society (Egypt); FGM (Yemen, Palestine, Egypt) and early marriage (Yemen, Palestine, Egypt, Turkey); violence against women and children (Palestine); and honor crimes (Turkey).

- Interviewees noted that further legislative reforms were needed to ensure the rights of women and marginalized groups such as LGBT and minorities (Tunisia, Turkey). Cultural beliefs and practices still limit women's participation in SRHR and public life in Tunisia, and cultural beliefs and practices lead to stigmatization and discrimination of people with HIV/AIDS in Egypt. Furthermore, unequal access to services, depending on geographic location and social/economic status, was noted as a problem (Egypt, Tunisia).

- Specific challenges for Palestine that were mentioned were blockades and extremely limited access to basic health and medical services, even in emergency situations and especially for people living near the separation wall (17% of Palestinians), due also to the high cost of transportation and limited access to health insurance due to high costs, as well as a lack of skilled workers due to restrictions on movement and daily obstacles linked to the occupation.

CHAPTER 6:

Conclusion and Recommendations

CONCLUSION

With the new political changes in the region, there is growing concern about women's gains, relevant laws and commitments to international obligations. The Middle East and North Africa region has made tangible progress in some aspects of reproductive health, especially maternal health services and access to contraception, as a result of renewed international consensus on these obligations, the availability of funds and the individual country's political will. On the other hand, issues like abortion are still highly stigmatized and women's access to abortion is very limited in the region. Other reproductive health issues, such as reproductive cancers, are overlooked.

While some achievements have been made regarding reproductive health and rights, sexual health and rights are lagging behind in the region. Despite the availability of HIV funding, stigma and discrimination are still major barriers to tackling the growing incidence rate of HIV. The vulnerability of young people and their limited access to resources make youth sexuality a controversial topic in the region, where comprehensive sexual education programs are very limited and SRHR services are not provided to unmarried young people.

Given the social and political context of the region, the way forward for women's rights and people's reproductive and sexual health and rights can only come through the adoption of a much more progressive agenda and a renewed commitment by countries to respect, protect and fulfill human rights.

RECOMMENDATIONS

1. States are obligated to formulate, design and implement laws, policies and programs that respect couples' and individuals' reproductive and sexual health and rights:

   a. Policies should be consistent with states' international SRHR obligations under CEDAW, ICESR and other consensus documents.

   b. Women, young people and marginalized groups have the right to participate in shaping policies and laws that affect their daily realities and influence their reproductive and sexual health.

   c. SRHR policies should be centered around people's right to chooseand reproductive self-determination, not the state's demographic goals.

   d. National machineries for women and youth should be strengthened and their independence reinforced. National machineries should operate on a rights-based approach, not development-oriented only. These apparatuses should be a tool to monitor and enhance government transparency and accountability.

   e. Governments should prioritize issues of sexual and reproductive health on the national and sub-national levels, identifying the most pressing problems for different communities.

   f. States are called upon to enact laws that protect women from violence in the private and public spheres. Trafficking and harassment in the workplace should be on the legal agenda of the states beyond ICPD negotiations.

   g. States are encouraged to remove their reservations to the CEDAW convention and sign the optional protocol to prove their political will to achieve gender equality and realize women's rights.

   h. States are called upon to recognize the concept of "multiple discrimination" where factors of gender, age, ethnicity, gender identity and sexual orientation can foster certain types of discrimination. States should activate anti-discrimination laws and policies.

2. States are obligated to guarantee access to a full range of affordable, acceptable and high quality sexual and reproductive services. States should exert more effort to enhance service delivery to rural and marginalized areas:

   a. Couples and individuals should have access to a full range of affordable, good quality contraceptives, family planning methods and the full range of SRHR services, including condoms and emergency contraception. Men should be encouraged to share responsibility for contraception and family planning in a positive, participatory way. At the same time, barriers obstructing women and youth access to contraceptives and SRHR services, like prior consent from husbands, parents or third parties, should be removed. Health systems should be reformed in a way to avoid provider bias in family planning services and ensure proper counselling for couples and individuals.

   b. States are encouraged to continue their efforts to eliminate avoidable maternal mortalities. More importantly, states should be committed to prioritize maternal morbidity and disabilities resulting from pregnancies and have efficient strategies to decrease maternal morbidity. Numerical indicators should also be adopted to track states' progress in this regard. Governments are called upon to adopt a comprehensive approach to maternity health and not only maternal mortality; governments are obligated to enhance the healthcare, nutrition and lifestyle of pregnant women.

   c. States are encouraged to identify abortion as a human rights issue, not only as public health concern. States should seek to reform abortion laws and at least guarantee access to safe abortion when pregnancies threaten women's lives and health. Safe abortion should be provided to victims of rape and incest. States should be held accountable for deaths resulting from unsafe abortions if abortion is illegal in these countries. States are obligated to enhance post-abortion care and integrate family services in post-abortion care. Women should have the right to access information and counselling on medical abortion, and penalties on women seeking abortion should be eliminated.

   d. Reproductive cancers for men and women should be on the top of the beyond-ICPD agenda. States are encouraged to raise awareness of reproductive cancers and implement strategies to combat them. Screening, early detection and access to chemotherapy, radiotherapy and surgery should be important elements in states' strategies to combat reproductive cancers.

   e. HIV/AIDS should continue to be a priority in the beyond-2014 agenda. Issues of access to ARTs, the feminization of HIV/AIDS, how to deal with the most at-risk populations and stigma and discrimination should dictate the international debate on HIV. Prioritizing HIV/AIDS should not prevent states from being attentive to other STIs and maintaining solid policies and services to combat their incidence. Testing, treatment and awareness of STIs should be primary elements in states' policies.

   f. Young people should be a target group for the beyond-ICPD agenda. States are obligated to provide young people with comprehensive, rights-based sexuality education that enables them to make empowered, informed and free decisions concerning their sexuality. Young people's access to SRHR services, like contraception, testing and treatment for STIs, is crucial for the full realization of their right to health. States are encouraged to develop programs and initiatives that are friendly to youth and help them to access SRHR services.

3. Data are vital in informing decision makers, NGOs and practitioners on emergent issues and priorities. States are obligated to provide robust, valid and accurate data on the wide range of SRHR issues:

   a. Standardized, gender-disaggregated data should be available on maternal mortality and morbidity, the prevalence and incidence of STIs and HIV/AIDS, abortion, reproductive cancers, gender-based violence, trafficking and other SRHR issues.

   b. Data on illegal SRHR matters are of the utmost importance, and the legal status of any practice should not be a justification to conceal data on it.

   c. Detailed national health accounts are important to track states' obligations on health finance. States are encouraged to provide sub-accounts for reproductive health.

   d. Age groups and target groups in data collection on national levels should be inclusive of unmarried young people and marginalized groups like ethnic and religious minorities.

International donor agencies have the obligation to prioritize SRHR issues. Vertical funding should be avoided, and instead comprehensive reproductive and sexual services should be supported and funded. Also, donors should develop their agenda after consultations with states and NGOs to be more sensitive to national contexts and priorities.

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