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WOMEN'S REPRODUCTIVE HEALTH IN THE MIDDLE EAST AND NORTH AFRICA

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About half of the 10 million women who give birth every year in the Middle East and North Africa (MENA)* experience some kind of complication, with more than 1 million of them suffering from serious injuries that could lead to long-term illness.[1] Millions more experience other reproductive health problems, such as reproductive tract infections.[2] These problems harm not just women but also children and families, affecting the quality of life in the region and impeding long-term economic and social development.

Although there is considerable variation in the region, MENA countries continue to face major challenges to meeting women's reproductive health needs, including the poor quality of health services, widespread ignorance about reproductive health issues, financial constraints due to competing priorities, and continuing gender inequality.[3] Women's reproductive health problems, which are often preventable, are compounded by social and economic conditions and gender roles. MENA governments' failure to address women's reproductive health needs increases both health care costs and social inequalities.

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Improving reproductive health care in the Middle East and North Africa would benefit not just women and their families, but also the region's social and economic development.

Background

In 1994, delegates at the UN International Conference on Population and Development (ICPD) in Cairo agreed on a definition for the term "reproductive health" (see Box 1, page 2). The participating governments agreed that family planning should be provided in the context of reproductive rights and reproductive health care and that population policies should address social development by going beyond family planning, especially by encouraging the advancement of women.

National governments and the international community have increasingly adopted language supporting reproductive health, but reorienting policies and programs has been more challenging. Since the Cairo conference, a common set of indicators for monitoring progress on reproductive health has been developed. These include the percentage of women using contraceptives, the maternal mortality ratio (defined as the number of maternal deaths per 100,000 live births), and the percentage of deliveries attended by trained personnel.[4] Reproductive health also incorporates mental and social well-being, but measurements for nonmedical indicators such as women's autonomy, control over their sexuality, and social status have been more difficult to establish.

This brief describes the key medical and demographic aspects of reproductive health in the MENA region for which data are readily available.

Maternal Mortality and Morbidity

Each year, roughly 13,000 women in the MENA region die of complications related to pregnancy and childbirth, although the maternal mortality ratios vary greatly by country. Three out of five maternal deaths in the region occur in four countries: Egypt, Iraq, Morocco, and Yemen. Yemen and Iraq have some of the highest levels of maternal death in the world, with around 300 maternal deaths per 100,000 live births. Morocco's maternal death ratio remains high, at more than 200 deaths per 100,000 live births, although there have been

* Countries and territories included in the Middle East and North Africa as defined here are listed in Table 1 (page 4).

Box 1

Reproductive Health and Rights Defined in the Cairo Programme of Action

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

SOURCE: United Nations, "Programme of Action of the International Conference on Population and Development," paragraph 7.2, accessed online at www.iisd.ca/linkages/Cairo/program/p07002.html, on Dec. 9, 2002.

improvements in maternal health in the country over the past 20 years. A recent survey of maternal mortality in Egypt showed that the number of women dying of maternal causes fell from 174 deaths per 100,000 live births in 1992 to 84 deaths per 100,000 live births in 2000.[5]

Not surprisingly, the lowest maternal mortality ratios in the MENA region are found in countries with the highest levels of health expenditure per capita and the smallest gender gaps in education.[6] Only Kuwait and the United Arab Emirates have managed to reduce their maternal mortality ratios to levels considered low by international standards (not more than 5 maternal deaths per 100,000 live births). Maternal mortality is fairly low in Oman, Qatar, and Saudi Arabia, but ratios in all three countries remain higher than those in countries outside the region that have comparable per capita incomes.[7]

Maternal deaths are strongly associated with the absence of good medical care before, during, and after delivery. More than half of all maternal deaths worldwide occur within 24 hours of delivery, mostly due to postpartum hemorrhage.[8] The most effective way to prevent maternal deaths is to have deliveries attended by skilled personnel who can recognize and treat or refer any complications that arise. (Skilled personnel include health professionals such as physicians, nurses, and midwives but do not include traditional birth attendants who have not been trained to perform emergency life-saving medical interventions.) Since women living in higher-income countries generally have better access to health services, higher percentages of their deliveries take place in health facilities with skilled attendants, although there is often a gap between rural and urban areas throughout the region (see Figure 1).

Access to quality antenatal care and a good referral system can also improve maternal health. Although an increasing number of women in MENA countries are seeking antenatal care, rates in the region are still low: Less than 70 percent of pregnant women have at least one antenatal checkup, putting the region behind east Asia (excluding China) and Latin America.[9] Even fewer women in MENA countries receive multiple checkups. In Turkey, for example, 67 percent of pregnant women had at least one antenatal visit, but only 42 percent had at least four such visits.[10]

While nearly all women in industrialized countries receive antenatal care, many pregnant women in MENA countries seek antenatal care only when they have a complaint. According to one study of maternal health in Morocco, 50 percent of women who had not sought care during their pregnancies reported that they did not seek antenatal care because they had no problems; another 22 percent of those who did not seek care reported that such services were not available to them; and another 10 percent said the services were too expensive.[11] Women in other countries, such as Yemen and Algeria, also report difficulty accessing health facilities as a reason for not seeking antenatal care.

The relatively low rates of antenatal care in the region are due in part to the lack of public awareness about the importance of medical care during pregnancy. The widespread ignorance about anemia provides a good example. Anemia lowers women's tolerance of blood loss and resistance to infection, contributing to maternal illness and death. Although anemia is common throughout the MENA region (regardless of countries' income levels), few anemic women recognize the symptoms and seek treatment.

Cultural obstacles can also prevent women from seeking health services. For example, many women prefer to see female health care providers, but few such providers are available in many parts of the region. Often, pregnant women are not the

ones who decide whether to seek care, so educating husbands and other family members about reproductive health issues is particularly important. Reducing cultural, financial, and physical obstacles to reproductive health care services is necessary for improving maternal health.

Closing the gap between rural and urban areas' access to and use of reproductive health care is a major challenge for MENA governments. The rural-urban gap is particularly large in lower-income countries in the region. In Egypt, for example, only 42 percent of pregnant women in rural areas received any antenatal checkups, compared with 70 percent of those living in urban areas; in Morocco, the rates are 56 percent and 88 percent, respectively.[12]

Rates of postnatal care in MENA are even lower than those of antenatal care. Postnatal care is important for identifying and treating childbirth-related injuries and illnesses, promoting breastfeeding, and counseling couples about appropriate family planning methods for spacing births. Home visits by health personnel can help reach women who have difficulty leaving the home due to complications or to cultural beliefs that women should stay home following childbirth, but most practitioners in the MENA region do not offer home visits.

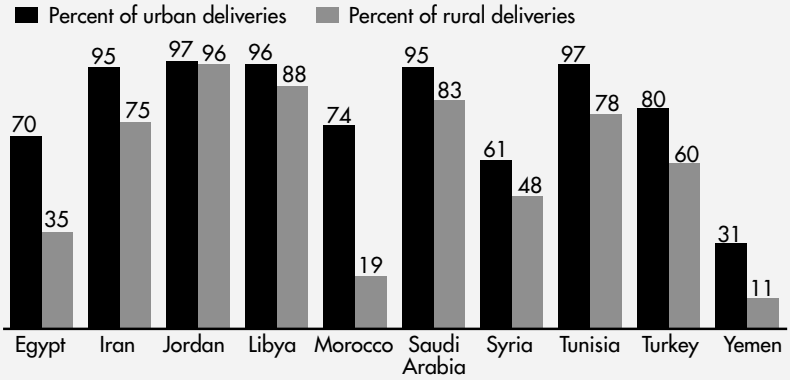
Maternal morbidity, or nonfatal illness or injury due to pregnancy and childbirth, is difficult to evaluate accurately in less developed countries, especially since women themselves may not recognize the symptoms. Prevalence of low birth weight is sometimes used to assess maternal health. Low birth weight is usually the result of the mother's poor health and nutritional status during pregnancy. In Yemen, which has the region's highest rate of low birth weight, 26 percent of babies born alive weigh less than 2.5 kilograms, the standard definition for low birth weight. Saudi Arabia has the region's lowest rates of low birth weight: Only 3 percent of babies born there weigh less than 2.5 kilograms.[13]

Complications from unsafe abortions—those that are self-induced or carried out by unskilled providers—are also a major cause of maternal death and disability. Abortion is a relatively safe procedure when performed by qualified doctors using correct techniques in sanitary conditions. But in countries where abortion is illegal or safe abortion services are not available, women with unwanted pregnancies may seek clandestine abortion services or drugs and other means of inducing abortion. Unsafe abortion may lead to serious complications, such as infection and injuries, that require emergency care. In the developing world, 16 percent of all maternal deaths are attributed to unsafe abortions, whether legal or illegal.[14] It is estimated that over 1 million unsafe abortions are performed in MENA countries each year.[15]

Data on abortions in MENA countries are rarely collected and analyzed, although more data are available in countries where abortion is legal. In Turkey, where abortion is legal, abortions are available at government hospitals for a nominal fee and at private clinics for a larger fee. The results of Turkey's 1998 Demographic and Health Survey reveal that 23 percent of all pregnancies that occurred in the five years prior to the survey were terminated by abortion. In two-thirds of those cases, the women reported that they had been practicing a family planning method when they became pregnant (see Figure 2).[16]

Figure 1

Share of Rural and Urban Deliveries Taking Place in Health Facilities

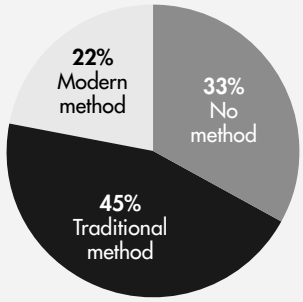


NOTE: Data are provided for the following years: Morocco and Libya, 1995; Saudi Arabia, 1996; Yemen, 1997; Turkey, 1998; Egypt and Iran, 2000; Syria and Tunisia, 2001; and Jordan, 2002.

SOURCE: ORC Macro, Demographic and Health Surveys for Egypt, Jordan, Morocco, Turkey, and Yemen; United Nations Population Fund et al., *Demographic and Health Survey of Iran* (2002). Data for Libya, Syria, and Tunisia are taken from the *Pan-Arab Family Health Survey*. Data for Saudi Arabia are from the Arab Gulf Cooperation Council, *Gulf Family Health Survey*.

Figure 2

Abortions in Turkey by Contraceptive Method Used in Month Before Pregnancy



SOURCE: ORC Macro, *Turkey Demographic and Health Survey, 1998*: table 5.5.

Table 1

Selected Reproductive Health Indicators in the Middle East and North Africa

	Women 15–49 Years Old			Percent of Women Who Are Married		Total Fertility Rate	Percent of Married Women 15–49 Years Old Using Contraceptives		
	Number in 2002 (thousands)	Number in 2015 (thousands)	Percent Increase 2002–2015	15–19 Years Old	20–24 Years Old		Any Method		
							Total	Urban	Rural
Middle East and North Africa	100,046	129,944	30	12	47	3.3	59	64	52
Algeria	8,438	10,553	25	4	30	2.8	64	67	62
Bahrain	162	186	15	3	30	2.5	62	—	—
Egypt	18,157	22,862	26	12	53	3.5	56	61	52
Iran	18,789	24,242	29	16	—	2.0	74	77	67
Iraq	5,842	8,423	44	—	—	5.3	—	—	—
Jordan	1,251	1,807	44	8	38	3.6	56	57	50
Kuwait	485	658	36	5	40	4.2	52	—	—
Lebanon	1,022	1,176	15	—	—	2.4	63	—	—
Libya	1,479	1,888	28	1	12	3.9	45	48	36
Morocco	8,300	10,207	23	10	37	3.3	58	—	—
Oman	584	939	61	15	58	6.1	24	28	16
Palestine[a]	748	1,228	64	24	62	5.9	51	—	—
Qatar	114	136	19	4	31	3.9	43	—	—
Saudi Arabia	4,638	7,465	61	7	39	5.7	32	37	21
Syria	4,345	6,131	41	11	42	3.8	47	54	38
Tunisia	2,728	3,058	12	1	14	2.1	63	65	58
Turkey	18,264	21,276	16	15	59	2.5	64	67	58
UAE	497	616	24	8	40	3.5	28	30	22
Yemen	4,202	7,094	69	26	70	7.2	21	36	16

[a]Palestine inclues the Arab population of the West Bank and Gaza.
— = data not available.

NOTE: GNI PPP per capita is gross national income in purchasing power parity (PPP) divided by midyear population. GNI PPP refers to gross national income converted to "international" dollars using a purchasing power parity conversion factor. International dollars indicate the amount of goods and services one could buy in the United States with a given amount of money. Data are from the World Bank, *2002 World Development Indicators*.

SOURCES: United Nations, *World Population Projections: The 2000 Revision* (2001); United Nations, *World Population Monitoring 2002—Reproductive Rights and Reproductive Health: Selected Aspects* (2002); League of Arab States, *Pan-Arab Project for Child Development: Arab Mother and Child Health Surveys* (Algeria 1992, Lebanon and Libya 1995) and *Pan-Arab*

Fertility and Family Planning

MENA's total fertility rate (TFR) has declined from an average of 7.0 children per woman in 1960 to 3.3 children in 2002—still well above the world average of 2.8 children per woman. Although the region's overall TFR has declined, fertility rates in some MENA countries remain above 5.0 children per woman (see Table 1).

A growing number of MENA countries are including family planning programs in their national development plans, although rates of family planning are still uneven. In Iran, which reintroduced family planning in the late 1980s, 74 percent of married women practice family planning, the highest rate in the region.[17] In Yemen, which adopted its national population policy in 1991, less than 25 percent of married women practice family planning, the lowest level in the region.[18]

Use of family planning contributes to maternal and infant health and survival by reducing the number of unplanned pregnancies. Reducing the number of deliveries and increasing the time between births help save the lives of both women and their infants. International data suggest that siblings born three to five years apart are about 2.5 times more likely to survive to age 5 than siblings born less than two years apart.[19] In MENA countries, many brothers and sisters are born close together: 44 percent of babies in Jordan are born less than two years after their older sibling.[20]

On average, about 60 percent of married women in MENA countries practice family planning.[21] Still, surveys throughout the region show that there is a large unmet need for family planning, as measured by the number of women who report that they would prefer to avoid a pregnancy

Percent of Married Women 15–49 Years Old Using Contraceptives			Percent of Births Attended by Skilled Personnel			Percent of All Deliveries Conducted in Health Facilities			Maternal Deaths per 100,000 Live Births	Percent of Births With Low Birth Weight	GNI PPP per Capita, 2000 (US$)	
Modern Methods												
Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural				
45	47	41	70	88	54	64	81	45	130	11	—	Middle East and North Africa
50	53	48	78	88	69	76	84	68	140	7	5,040	Algeria
31	—	—	98	—	—	98	—	—	46	10	—	Bahrain
54	59	50	61	81	48	48	70	35	84	10	3,670	Egypt
56	55	57	90	96	79	88	95	75	37	7	5,910	Iran
—	—	—	54	—	—	—	—	—	290	23	—	Iraq
39	40	31	98	99	97	97	97	96	41	10	3,950	Jordan
39	—	—	98	—	—	98	—	—	5	7	18,690	Kuwait
40	—	—	89	94	84	88	92	84	100	6	4,550	Lebanon
26	28	19	94	97	89	94	96	88	75	7	—	Libya
49	—	—	40	80	20	37	74	19	230	9	3,450	Morocco
18	22	12	91	93	88	89	91	85	14	8	—	Oman
37	—	—	97	—	—	—	—	—	—	9	—	Palestine[a]
32	—	—	98	—	—	98	—	—	10	10	—	Qatar
29	33	19	91	95	84	91	95	83	23	3	11,390	Saudi Arabia
35	42	28	89	96	83	55	61	48	65	6	3,340	Syria
53	53	54	91	98	79	90	97	78	70	5	6,070	Tunisia
38	41	31	81	88	69	73	80	60	130	15	7,030	Turkey
24	25	20	99	100	99	99	99	99	3	—	—	UAE
10	21	6	22	47	14	16	31	11	350	26	770	Yemen

Project for Family Health (Syria and Tunisia 2001); Council of Health Ministers of Gulf Cooperation Council States, *Gulf Family Health Surveys* (Bahrain 1995, Kuwait 1996, Oman 1995, Qatar 1998, Saudi Arabia 1996, UAE 1995); POPIN Population Information Network, Western Asia, "Country Data and Population Pyramids" (www.escwa.org.lb/popin/indicators/main.html, accessed Aug. 14, 2002); ORC Macro, *Demographic and Health Surveys* (Egypt 2000, Jordan 1997 and 2002, Morocco 1995, Turkey 1998, Yemen 1997); Palestinian Central Bureau of Statistics, "Selected Statistics" (www.pcbs.org/inside/selcts.htm, accessed July 17, 2002); United Nations Children's Fund (UNICEF), *Multiple Indicator Cluster Surveys—National Reports* (www.childinfo.org/MICS2/natlMICSrepz/MICSnatrep.htm, accessed Aug. 20, 2002), *The State of the World's Children 2003* (www.unicef.org/sowc03/, accessed Jan. 2, 2003), and UNICEF Global Database (www.childinfo.org, accessed Jan. 2, 2003); Ministry of Health and Population, *National Maternal Mortality Study, Egypt 2000* (2001); United Nations Population Fund et al., *Simaie Jameeat va Salamat dar Jomhorie Eslamie Iran, Mehrmah 1379* (2000 DHS report in Farsi); and World Bank, *2002 World Development Indicators*.

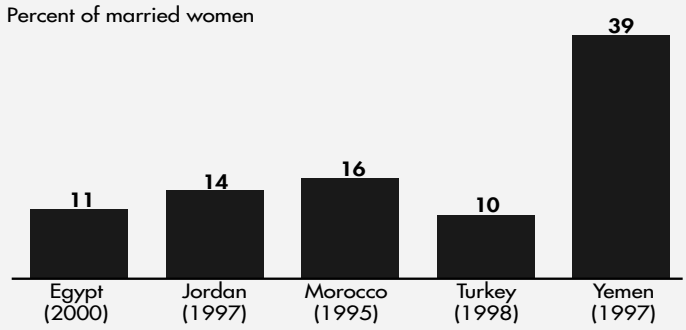
but who are not using contraception (see Figure 3, page 6). A recent pregnancy, fear of contraceptives' side effects, and opposition from husbands and relatives are issues commonly cited by women with unmet need. Some women report having tried to use contraceptives in the past but finding it difficult; women who are not satisfied with a particular method may stop using contraception entirely. Some family planning providers also fail to meet women's reproductive health needs.

Increasing access to high-quality family planning information and services can reduce the number of unintended pregnancies. One study has shown that if no women experienced contraceptive failure or stopped using a method, Egypt and Jordan's total fertility rates would drop to 2.0 births per woman, Morocco's to 2.4, and Turkey's to 1.5.[22] Providing a range of contraceptive methods to meet women's changing needs as they go through the life cycle is important; for example, mothers with infants need contraceptive methods that do not interfere with breastfeeding. It is also important that access and services be provided to hard-to-reach populations, such as women in rural areas and those with little or no education.

Approximately 10 percent of couples worldwide experience problems conceiving children.[23] Although there is nothing to suggest that infertility is more prevalent in MENA countries than elsewhere, the issue is especially important in the region. Cultural values in the region praise motherhood and stigmatize childless women, pressuring women to start families soon after they marry. Those who do not become pregnant usually seek medical treatment, often at great expense. Assisted reproductive technologies are increasingly becom-

Figure 3

Married Women Who Would Prefer to Avoid a Pregnancy But Who Are Not Using Contraception



SOURCES: ORC Macro, *Demographic and Health Surveys*.

ing available in the region, mainly through private providers, but the degree of reliability varies. Governments in the region need to establish standard protocols for infertility treatment, both to ensure the quality of care and to contain costs.

Sexually Transmitted Infections and Reproductive Tract Infections

More than 12 million people in the MENA region suffer from sexually transmitted infections (STIs) such as syphilis, gonorrhea, and chlamydia.[24] Although the prevalence of STIs in MENA countries is relatively low, reflecting cultural condemnation of sexual relationships outside of marriage, it is increasing rapidly. In addition, STIs are significantly underreported in the region, as they are elsewhere. For the most part, MENA countries are not equipped with effective systems for detecting and reporting these infections.[25]

Despite the cultural values condemning sex outside of marriage, high-risk sexual behavior, such as sex with multiple partners, does occur in MENA countries. The public is generally unaware of the extent of high-risk behaviors and of measures for preventing infections. Men who are away from their families, such as migrant laborers, are the most likely to put themselves at risk. Infected men can then transmit STIs to their wives, who become victims of their husbands' ignorance. A study in Jordan showed that between 3 percent and 7 percent of men who participated in the survey had had sexual contact outside of marriage.[26]

The conservative social mores that discourage extramarital sex also discourage open discussion of sexuality, condoms, STIs, and HIV/AIDS. But open, frank dialogue is key to addressing STIs and other reproductive health needs and should be initiated in order to save lives throughout the region. HIV/AIDS, for example, is still relatively rare in MENA countries, but it is becoming more prevalent. An estimated 70,000 adults and children in MENA countries were living with HIV/AIDS at the end of 2001.[27]

Many women in MENA countries also suffer from other reproductive tract infections (RTIs) caused by lack of clean water for bathing and unclean practices during delivery or abortion. RTIs can cause persistent pain and discomfort, diminishing women's productivity and quality of life. Severe RTIs may lead to infertility or even death, especially if left untreated. Many women do not realize they have a treatable RTI, because they have been taught to accept the symptoms as part of being a woman. More than half of the women who participated in a small community-based study in rural Egypt reported having symptoms indicating RTIs.[28] Women's low social status plays an important part in keeping women's suffering from being recognized and addressed.

A recent pilot study of another rural community in Egypt found that reproductive health problems were hidden and women rarely, if ever, sought care for such problems. Although half the women who received a cervical biopsy were found to suffer from female genital schistosomiasis, the women considered the problems "normal" and rarely discussed them with their husbands or female relatives. The study found that interventions designed to improve women's reproductive health must involve men, since men are often key decisionmakers about women's health care.[29]

Adolescent Reproductive Health

Young people between the ages of 10 and 24 make up one-third of the region's population, or about 125 million people. While adolescence is generally a healthy period of life, young people may be exposed to the risks associated with sexual activity, including STIs, unintended pregnancies, and complications from pregnancy and childbirth. Social and health care services in MENA countries are ill-equipped to address young people's repro-

ductive health care needs, although some countries in the region are now trying to reach out to youth. For example, Iran requires that prospective brides and grooms take a class on reproductive health and family planning, and all university students in Iran are required to take a course on population and family planning.

High teenage fertility, the result of the high incidence of early marriage, is a reproductive health concern in a number of MENA countries. Although the average age at first marriage has increased overall, it is still common for women in some social groups to marry before age 20. In the MENA region, around 4 million young women under age 20 are married. Women who become pregnant while their bodies are still developing are at a greater risk of complications that threaten themselves and their babies.

Female genital cutting (FGC), the practice of removing all or part of young girls' external genitalia, is a major reproductive health issue in Egypt and Yemen and, to a lesser extent, in the coastal areas of the Arabian peninsula. FGC is almost universal in Egypt, where 97 percent of women of reproductive age have undergone the procedure; Yemen has the second-highest prevalence, at 23 percent.[30] FGC can lead to health complications such as infection, severe bleeding, and obstetric complications, as well as psychological trauma.[31] In addition, when performed on young girls and nonconsenting women, FGC violates a number of recognized human rights.

The Need for Action

Governments can take a number of steps to improve reproductive health within their countries. These steps can, in turn, improve quality of life throughout the region.[32]

- Raise awareness of health problems and provide information that people can use to change their behaviors. Target audiences for such efforts include women, husbands, elders, community leaders, and policymakers.
- Focus on priority issues, such as high fertility and maternal mortality.
- Target the underprivileged, especially the poor and those living in rural areas, and decrease disparities within countries.
- Improve quality of care by establishing standard protocols, setting up systems for monitoring and regulating quality, training and deploying skilled health professionals, and securing essential equipment and drugs. It is also important to improve managerial capacity at all levels.
- Develop sustainable financing mechanisms, possibly through private-sector involvement and community financing, to ensure that women have access to essential health services.
- Promote women's participation in decisionmaking and the overall development process.

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Since they are often key decisionmakers about women's health care in MENA countries, it is important to educate men about reproductive health issues.

Conclusions

Investing in women's reproductive health not only advances human rights and improves the health and well-being of individual women and their families, but it also benefits societies and national economies. According to the United Nations Population Fund, countries that have made social investments in health, family planning, and education have slower population growth and faster economic growth than countries that have not made such investments. While there have been significant improvements in women's reproductive health in many parts of the MENA region, further changes are crucial to achieving social equity and economic development in the region.

Addressing women's reproductive health needs, particularly in conservative societies, requires strong commitments on the part of governments as well as nongovernmental health and human rights advocates. Although reproductive health issues are sensitive topics for many people, it is important that

culturally appropriate discussions of public policy be initiated. Failure to pay attention to and invest in improving reproductive health today will only result in greater health and social costs in the future.

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