WOMEN AND HEALTH
IN THE ESCWA REGION

Specific Health Problems

ESCWA

United Nations Economic and Social Commission for Western Asia

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Although the countries that comprise the Economic and Social Commission for Western Asia (ESCWA) region have experienced an overall improvement in the health of its population in recent years, women in the region still suffer as a result of certain conditions and practices, including female genital mutilation (FGM), fistula, lack of obstetric care, unsafe abortion, HIV/AIDS and high rates of anaemia, all of which can lead to high rates of both maternal and infant mortality.

I. Maternal Mortality

The ESCWA region has been characterized in recent years by an overall increase in life expectancy and a drop in the fertility rate. The total fertility rate in the region declined from 4.90 children per woman to 3.84 children per woman between 1990 and 2005 as a result of an increase in family planning and health awareness.[1] In terms of life expectancy, on average, women and men in ESCWA member countries outlive their counterparts in non-ESCWA Arab countries by some 10 years.[2] Between 1990 and 2005, the life expectancy of Arab women rose from 66 years to 69.3 years and that of men from 62.6 years to 65.7 years. In parallel, maternal mortality ratios (MMRs) declined throughout the region. It is estimated that MMRs in the ESCWA region are lower than the world average of 400 deaths per 100,000 live births.[3] MMR figures, however, vary significantly across the region. The countries of the Gulf Cooperation Council (GCC) have the lowest MMRs in the region, followed by the Mashreq region, then the least developed countries (LDCs). Both Kuwait and the United Arab Emirates, for example, have achieved or exceeded their target of reducing maternal mortality by three quarters; yet, MMR figures in Iraq and Yemen have worsened since the 1990s. In Iraq, between 1990 and 2003, the proportion of women dying during pregnancy, childbirth or within 42 days of termination of pregnancy rose from 117 deaths to 193 deaths per 100,000 live births, while in Yemen, it rose from 351 deaths to 365 deaths per 100,000 live births.[4]

The high rates of maternal mortality in the LDCs can be attributed to political instability and poor socio-economic conditions. Furthermore, the presence of skilled medical workers during childbirth can considerably reduce the risk of maternal mortality. During the period 1995-2001, only 67 per cent of Arab women gave birth in the presence of skilled health personnel. While over 90 per cent of deliveries in GCC countries during that period were attended by skilled personnel, only slightly more than half those in LDCs had such access. In the Arab Mashreq and Maghreb regions, the proportion of births attended by skilled health personnel were 67.1 per cent and 71.7 per cent respectively.[5]

(1) ESCWA. 2006. *The Status of Arab Women in the Light of International Instruments.* E/ESCWA/ECW/2006/WP.1.

(2) Ibid.

(3) ESCWA. 2007. *Health and Millennium Development Goals in the ESCWA Region.* E/ESCWA/SCU/2007/Technical Paper.2.

(4) Ibid.

(5) ESCWA. 2006. op. cit.

In addition to the unavailability of skilled medical personnel to supervise deliveries, unsafe abortion practices, FGM, early marriage, adolescent childbearing, and frequent and multiple pregnancies place women at a higher risk of maternal mortality.

II. Obstetric Fistula

a) What is obstetric fistula?

Obstetric fistula is a hole in the birth canal, which may occur when emergency obstetric care is not available to women who develop complications during childbirth. A prompt caesarean delivery, for example, would avoid the development of fistula. Adolescent girls are particularly susceptible to fistula, as their organs are not yet fully developed. If untreated, fistula can lead to chronic medical problems, including ulceration, kidney disease, and nerve damage in the legs. Furthermore, in most cases, fistula results in a stillborn baby.[6]

In addition to medical problems caused by fistula, women suffering from the condition frequently become social outcasts. As a result of their inability to control the flow of their urine and faeces, most of them are ostracized by their husbands, families and communities. If the condition is left untreated, the prospects for such women to work or lead a normal life are severely diminished.

The World Health Organization (WHO) estimates that over 300 million women currently suffer from short-term or long-term complications of pregnancy and childbirth globally, with 20 million new cases each year. According to WHO data, obstetric fistula accounts for 8 per cent of maternal deaths worldwide.[7] The United Nations Population Fund (UNFPA) estimates that at least 2 million women in Africa, Asia and the Arab region – mainly Djibouti, Somalia, the Sudan and Yemen – are living with the condition, and that some 50,000-100,000 new cases develop each year.[8] Obstetric fistula occurs disproportionately among poor rural women, especially those living far from medical services.

Although fistula was a common condition in Europe in the past, today it is almost unheard of in developed countries and is entirely preventable. A simple operation can repair the injury, with success rates as high as 90 per cent for experienced surgeons, according to UNFPA figures. The average cost of fistula treatment, including post-operative care, is just US$ 300.[9] Unfortunately, most women with the condition are either unaware of or unable to afford such treatment. The persistence of fistula in certain Arab countries is a clear indication that greater efforts are needed to mainstream gender in policymaking in general and in the health sector in particular. Furthermore, other harmful practices

(6) See http://www.endfistula.org/fistula_brief.htm.

(7) See http://www.who.int/mediacentre/news/releases/2006/pr45/en/index.html.

(8) See http://www.endfistula.org/fistula_brief.htm.

(9) Ibid.

carried out on women in the region and the high prevalence of women who were subjected to FGM as young children in such countries as Djibouti, Egypt, Somalia and the Sudan, all serve to increase the risk of birth complications and the development of fistula.

b) How can obstetric fistula be eliminated?

In recent years, United Nations agencies, including UNFPA and WHO, have doubled their efforts to end obstetric fistula. In 2003, UNFPA launched a global campaign to eradicate fistula in over 40 countries in Africa, Asia and the Arab region, including the Sudan and Yemen. In 2006, WHO published a guide entitled *Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development* to assist countries in formulating a national approach to eliminate fistula.

Prevention, treatment and rehabilitation are the cornerstones of any campaign to end obstetric fistula. Providing easy access to family planning services and open access to medical care for pregnant women alone is not sufficient to prevent the condition, since the underlying social and economic conditions of women living in poor and rural areas need to be tackled in parallel. Prevention has to deal with such issues as poverty, raising the minimum legal age of marriage and delaying pregnancy in young girls. Furthermore, there is a clear need to raise awareness in affected countries of the availability of treatment, not simply repairing the physical damage through medical intervention, but extending to emotional rehabilitation through the availability of and access to counselling services.

III. Female Genital Mutilation (FGM)

a) History of female genital mutilation

The history of FGM can be traced back as far as the second century B.C. among tribes residing on the western coast of the Red Sea. It is believed that the practice originated in Egypt and spread south and west. As the practice continues, it is generally believed that the dual intentions of its practitioners today are to control a woman's sex drive and to "cleanse" her genitalia by removing the clitoris, which is often seen as "impure". As a result of this association with purity, young women who have not been excised have little chance of getting married in the countries where FGM is practised. Efforts to eradicate the practice are therefore required to address the socio-economic dimension as well as the deeply-rooted cultural beliefs of the communities that carry out the procedure.

While male circumcision has proved to be beneficial to men, as it lowers their risk of acquiring the HIV/AIDS virus by some 60 per cent,[10] female circumcision,

(10) World Health Organization. 2008. *Eliminating Female Genital Mutilation: An Interagency Statement.*

in contrast, can actually increase the vulnerability of women to acquiring the virus and is associated with serious short-term and long-term physical and psychological health complications.

b) Prevalence of female genital mutilation in the ESCWA region: legal status and statistics

FGM, defined by WHO as "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons",[11] causes severe short-term and long-term health complications. Almost all those who undergo FGM experience severe pain during the procedure due to the cutting of nerve ends and sensitive genital tissues, and because proper anaesthesia is seldom used. Immediate health complications include haemorrhage, difficulty in passing urine, infection, unintended labia fusion and psychological consequences. Moreover, women and girls who undergo FGM are vulnerable to HIV infection as a result of repeated use of surgical instruments – mostly razor blades and scissors – without sterilization between patients. Death can also occur as a direct result of the procedure due to haemorrhage, infections (including tetanus) or shock.

Long-term complications include recurrent reproductive and urinary tract infections, sexually transmitted infections and birth complications. Studies have revealed that infibulation, the most extreme form of FGM,[12] is especially dangerous during childbirth, since women would be at risk of prolonged labour, which may lead to foetal brain damage or foetal death. Furthermore, FGM is associated with sterility and it is estimated that 20-25 per cent of cases of sterility in northern Sudan can be linked to infibulation.[13]

FGM is practised in parts of Africa, Asia and in a number of Arab countries, including communities in Djibouti, Egypt, Ethiopia, Mauritania, Somalia and the Sudan. It is also practised among certain ethnic groups in Iraq, Oman, Palestine, United Arab Emirates and Yemen, and among certain immigrant communities from those countries in Europe, Australia, Canada and the United States of America.[14] In those countries where mutilation is common, it is practised by Muslims and followers of other religions.

United Nations agencies estimate that 100-140 million women and girls

(11) Ibid.

(12) The three broad categories of FGM are clitoridectomy, excision and infibulation. The mildest form of FGM, clitoridectomy, is the removal of all or part of the clitoris. Excision includes the removal of the clitoris and the cutting of the labia minora. The most extreme form of FGM is infibulation, the removal of the clitoris, labia minora, and the stitching together of the labia majora. Infibulation leaves just a small opening in the vagina for the passage of urine and menstrual fluid, and requires binding together of the legs until stitches adhere. Cited directly from Castledine, J., *Female Genital Mutilation: An Issue of Cultural Relativism or Human Rights*. Available at: http://www.mtholyoke.edu/acad/intrel/jc.htm.

(13) Ibid.

(14) See http://www.unfpa.org/gender/practices2.htm#12.

have been circumcised worldwide and at least 3 million are at risk every year.[15] In the ESCWA region, according to the WHO, the prevalence of FGM in Egypt was 95.8 per cent in 2005; in northern Sudan, some 90 per cent in 2000 and in Yemen, 22 per cent in 1997.[16] In 2005, the United Nations Children's Fund (UNICEF) reported that 97 per cent of Egyptian women aged 15-49 who were unmarried had undergone FGM; according to a Government study, 50.3 per cent of Egyptian children aged 10-18 have been circumcised.[17]

In Yemen, a health survey, conducted by the Government in 2003, showed that more than 21 per cent of Yemeni women have been exposed to this harmful practice. Yemen has five main governorates that still perform FGM: Hodeidah (97.3 per cent), Mahrah (96.6 per cent), Hadhramout (96.5 per cent), Aden (82.2 per cent), and the Sana'a Capital Secretariat (45.5 per cent).[18] Furthermore, studies conducted by the Yemen Ministry of Public Health and Population have revealed that trained medical personnel performed only 10 per cent of these operations. According to the study, on 95 per cent of occasions, the procedure is carried out at home and mothers are the primary decision-makers in determining whether their daughters should undergo the procedure.

According to a UNICEF report entitled *The Progress of Nations 2000*,[19] 89 per cent of northern Sudanese women and girls (totalling almost 10 million people) have been subjected to FGM. Furthermore, according to a survey conducted between 1996 and 2000 by the Sudan National Committee on Traditional Practices and Save the Children Sweden, FGM is performed on 87 per cent of urban women and 91 per cent of rural women.[20]

There are no national laws prohibiting FGM in the Sudan or Yemen. In November 2008, a single law was passed outlawing the practice in the state of Southern Kordofan in the Sudan. In Yemen, a ministerial decree which came into force in January 2001 prohibits the practice in both governmental and private health facilities. In July 1996, the Egyptian health minister issued a ban on FGM; despite an overrule by a junior administrative court in Cairo, the decision was taken on appeal to the Supreme Court, which ruled in favour of a total prohibition of FGM. The Egyptian Government has thus prohibited the procedure, even if it is done with the agreement of the parents and the child, although gynaecologists are still permitted to perform the surgery if it is necessary for health reasons. Enforcement mechanisms to ensure that the ban on FGM is respected are, however, still lacking in Egypt.

(15) Ibid.

(16) WHO. 2008. Op. cit. FGM prevalence data are derived from national survey data.

(17) Black, I., *The Guardian*, 30 June 2007. Available at: http://www.religioustolerance.org/fem_cirm3.htm.

(18) Al-Thaibani, 27 June 2008. *Yemen Times*. Available at: http://yementimes.com/article.shtml?i=1167&p=local&a=1.

(19) Available at http://www.state.gov/g/wi/rls/rep/crfgm/10110.htm.

(20) Ibid.

c) *United Nations mandate, resolutions and activities to eliminate female genital mutilation*

Through the legal standards set by its conventions and resolutions, as well as its operational activities in the field, the United Nations has, in association with local communities and national Governments, been leading the efforts to eradiate FGM. In the early 1980s, UNICEF launched the first of its many anti-FGM campaigns and in 1989, WHO adopted a resolution to end the practice. The principal United Nations legal framework on combating FGM is set out in the following instruments and documents:

- The Convention on the Rights of the Child (CRC) (1989)
- The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (1979)
- The Beijing Declaration and Platform for Action (in particular, the fourth critical area of concern, violence against women, and the twelfth critical area of concern, persistent discrimination against and violation of the rights of the girl child) (1995)
- The Millennium Development Goals (2000)
- The Programme of Action of the International Conference on Population and Development (1994)
- The Declaration on the Elimination of Violence against Women (1993)
- The Special Session of the General Assembly on Children (2002)
- The recommendations of the 2005 World Summit Outcome Document (2005)
- The General Comments and Recommendations of the CEDAW Committee The recommendations ending female genital mutilation of the Commission on the Status of Women (2008)

d) *The holistic approach to eliminate female genital mutilation*

A holistic approach to end this deeply-rooted practice should include three components: legislation; capacity-building activities involving all stakeholders; and awareness campaigns targeting the public at large.

The enactment of legislation banning FGM alone will not be sufficient; it must be coupled with the creation of efficient enforcement mechanisms. Furthermore, FGM must be combated in a systematic manner through the

creation of action plans and allocation of sufficient resources to end the practice. Combating violence against women in general and FGM in particular is at the core of United Nations conventions and resolutions; member States are therefore additionally encouraged to respect their international obligations through the implementation of such related human rights instruments as CEDAW and the CRC.

Capacity-building activities should target all key actors in a community, including Government officials, law enforcement and judicial personnel, health care providers, religious and community leaders, teachers and media professionals. Furthermore, Governments should double their efforts to eradicate illiteracy among women, since there is a lower incidence of FGM in families with an educated mother. This should be supported by the amendment of school curricula, including the elimination of discriminative images of women and girls.

Member countries should also ensure the quality and accessibility of their health care systems and measures to improve health, including sexual and reproductive health, should be undertaken. Women and girls who have undergone FGM additionally require social and psychological support, and this should be provided by both the State and their communities.

The final essential component in any holistic approach to ending FGM is the launch of campaigns to raise awareness of the human rights of women and girls. Involving men and boys in advocating an end to this practice is a strategy that has been used with success by many United Nations organizations, and regional and local non-governmental organizations.

IV. Women and HIV/AIDS in the ESCWA Region

Half of those living with HIV/AIDS in the world are women. They are more prone to infection by the disease because they are often ignorant of sexual matters and have limited access to information on safe sexual practices. Moreover, power imbalances, economic dependency and fear of physical violence all too frequently make it difficult for women to negotiate safer sexual practices with their partners (both inside and outside marriage).

While there is insufficient data in the ESCWA region on HIV/AIDS prevalence among women, reports reveal that in 2003, an estimated 83,000 new HIV/AIDS cases (both women and men) were registered in the ESCWA region, compared with some 5 million globally.[21]

Underreporting or failure to report is widespread in the region due to the sensitivity of the issue, which is still considered taboo in most communities.

(21) ESCWA. 2007. *Health and Millennium Development Goals in the ESCWA Region*. E/ESCWA/SCU/2007/ Technical Paper.2.

It is therefore essential that Governments integrate a gender perspective into their policies when tackling the issue of HIV/AIDS, acknowledging that poverty, gender discrimination and violence against women, especially in war zones, are fuelling the pandemic. Furthermore, since it is primarily women who care for the sick and the elderly and who lose income when a male member of the family is sick, analyzing the consequences of HIV/AIDS reveals a disproportionately gendered aspect to the disease, which needs to be addressed by member countries. Women are inordinately affected by the consequences of HIV/AIDS, even when they themselves are not actually infected with the disease.