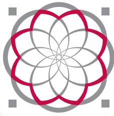

WOMEN AND THE RIGHT TO HEALTH IN THE ARAB REGION

Fatima Moussawi

INTRODUCTION

Three factors intersect in the Arab region impacting the status of women's health: 1) The deterioration of the general health landscape,[1] which affects all members of society;[2] 2) The accumulation of various aspects of oppression to which women are subjected,[3] and the fact that they are deprived of most of their rights; and 3) Requiring women, directly or implicitly, to provide care and healthcare, both physically and psychologically, to others while neglecting themselves, in line with a recurring normative social and cultural system (Morgan et al. 2018). "Gender" or the concept of "social construction"[4] of the roles of individuals is a main factor in determining people's access to protection and gains; thus, impacting women's access to their right to health within a human rights system. Gender factors also determine and

[1] The health landscape is advancing in some Arab countries but deteriorating in others. However, it remains behind in data that does not reflect the global development rate, the 2030 Sustainable Development Goals, or even the long- or short-term local government schemes. According to the study by Morgan et al. (2018), this includes low- and middle-income countries.
[2] Certainly, by taking into consideration the educational, social, and economic differences that form the basis of access to the right to health and the ability to discuss all conditions that would guarantee the right of individuals, including women, to health rights within the human rights system.
[3] We particularly mean oppressive practices that are initially manifested in social and gender norms and through regimes and laws that foster discrimination and work to institutionalize it for a long time until it becomes a pillar of the regime.
[4] It is referred to in other reviews as gender as well as in several accompanying publications and reports. I choose to use the term gender or social construction because it is closer to the concept of what impedes access to health as a right and in the current framework as a privilege on a discriminatory basis based on roles.

shape access to health services and information, and their effectiveness and ease, and contribute to paving or obstructing the way for women in need to use and resort to this right (Dejong & Al-Haidari 2017). On the other hand, health systems in the Arab region, as in all countries around the world, are "gendered" (Habib et al. 2022). The degree of ease, effectiveness, and availability with which services are provided differs between men and women, as well as between women of different socioeconomic backgrounds, in terms of the way health services are provided or received (Al-Dosari 2017). This contributes to the emergence of gender disparities in health services, in a context where aspects of health governance and political agendas are manifested in health services and social protection for all individuals (Van Ullman et al. 2012).

The health status reality of women and girls in the Arab region cannot be separated from their economic, educational, and professional participation. The deteriorating status of women in these areas leads to a great decrease in women's awareness of their health needs and rights and their ability to claim them. Similarly, they are unable to face the systems hindering their access to the right to health on an equal basis with men or even with other women of different educational and socioeconomic conditions. In most Arab countries, women's health lacks essential material and often logistical and knowledge resources as well. Additionally, many issues related to women's health are not openly discussed, or remain overlooked even in their private lives, due to the lack of a safe space and adequate awareness to discuss these issues (Assi 2020). Women in the Arab region face multiple obstacles in accessing the right to health under both the legal and political frameworks, as they fight against sexual harassment, gender-based violence, denial of custody and inheritance, and other basic rights that they are robbed of in light of patriarchal and capitalist regimes. The denial of access to adequate healthcare is only one episode in a series of gender violations rooted in the state structure.

EXISTING CHALLENGES

Challenges to women's access to the right to health are manifold, ranging between cultural, ethical, economic, and political. Gender cultural norms play a role in creating an environment that directly impacts women's relationship with the health system and access to its services as one of their rights. A set of cultural and social factors are key to understand the decline in Arab women's relationship with their health-related rights. Beliefs rank on top of these factors. For instance, while many women believe in the importance of early detection of types of tumors such as breast cancer and cervical cancer, they also believe that cancer is a matter of fate. This is why some women do not undergo a preventive examination. Despite awareness campaigns, these beliefs are still deeply rooted in women's health behavior. The same applies to linking mental illnesses and their reactions, due to ingrained cultural beliefs, to envy, the evil eye, and the jinn. This inevitably leads to women not seeking medical help and psychological treatment, and resorting instead to methods unrelated to medicine (Assi 2020). Health systems cannot be blamed when it comes to beliefs, but it is necessary to understand the risk that may arise from health systems which overlook the impact of such beliefs and their resulting practices, especially since these systems pretend that disregarding this impact is not costly, and instead approach it as a way to reduce the costs incurred when women seek care.

A large number of women in the region suffer from health conditions that could have been prevented or treated. However, they preferred to wait long periods before undergoing or accepting treatment, which usually happens when the symptoms become concerning rather than when they appear. This situation is due to many structural, material, psychological, social, and cultural causes. Women and girls in the Arab region are brought up to neglect themselves and their problems; they are used to ignoring their pain and struggles. Women are also used to prioritizing caring for their husbands, children, and the family as a whole, which delays taking care of themselves. In a case study of Yemen, Hyzam and Shaef (2023) indicate that in light of the socioeconomic situation, extreme poverty, deteriorating living conditions and related repercussions, women in Yemeni households are forced to deal with food scarcity by reducing the size of their own meals in order to feed

family members, selling assets, or taking on jobs that could put them at risk.

Furthermore, health insurance and access to healthcare centers are done through transactions carried out by or with the permission of men, which obstructs women's access to treatment centers, if they seek treatment at all. Al-Shahrani et al. (2014) indicate that Saudi women are admitted to the hospital approximately 13 hours after suffering a heart attack, in contrast to men who are admitted within five hours. Despite the increased awareness of women in multiple Arab countries regarding the need to respond to the health risks of individuals, this gender structural cultural differentiation in the approach to women's health and well-being compared to men remains a struggle that is not limited to discussing the right to health, but also covers acquiring health knowledge.

One of the factors preventing women from undergoing treatment procedures is the issue of resorting to a female doctor instead of a male doctor. Women are often embarrassed to see a male doctor, or prohibited to see one by their spouses. Given that there are fewer female doctors compared to male doctors, especially in some Arab countries, this factor constitutes a major barrier to women's access to the necessary healthcare. In his study of the situation in Iraq, Hassan (2023) states that gender and social norms hinder the access of women and girls to adequate health services. Indeed, in the countryside of Iraq, married women or women coming from religious families only see a female gynecologist, regardless of the case, in order to avoid the embarrassment of a medical examination by a male doctor. Moreover, the norms in some hospitals in Iraq require the consent of a male member of a woman's family before any female patient can undergo any sort of surgical intervention. “For example, hospitals often deny women of surgical procedures without the consent of a male family member, fearing tribal retribution,” according to Hassan's study (2023).

POOR INFORMATION AND FINANCIAL SITUATION: REPERCUSSIONS ON HEALTH AWARENESS AND HEALTH SERVICES' DEMAND

The deteriorating economic conditions and hardships of life gravely affect women's access to health services and their understanding of health as a basic right in terms of human rights and dignity. This fact is made more evident in cases of households' low general income, when they are distant from major urban centers, and in cases of paucity of health centers and scarcity of logistical resources. According to studies by Abdulrahim and Bousmah (2019) and Hassan (2023), traditional rural gender norms also contribute to the rise of disparities in women's access to health services between urban and rural areas, as major health risks faced by women are being ignored and the importance of educating them about the necessary steps for prevention and treatment are disregarded. In fact, women struggle to access information related to family planning, health, and routine prevention through radiography and scans. Many women do not consider these tests and are not asked to perform them in many Arab cities, while they are often prescribed in other places governed by different and more prosperous knowledge and economic systems. It all goes back to health expenditure, where governments and ministries of health are responsible for allocating a significant part of their budgets and donations to push women's awareness forward and support their preventive health measures — but, is health expenditure really equitable or in women's favor (Aldosari 2017)?

POLICY AND PRACTICE LEVELS IN THE ARAB REGION

Data, especially after the pandemic, indicate that the biggest expenditure on women's health in the Arab region occurs in the Gulf Cooperation Council states. However, the cultural

factors related to passing, from one generation to another, men's guardianship over women, their decisions, and their access to services are still linked to their right to healthcare access. These social aspects interplay with financial factors that largely impact the context of accessing health services and information (Aldosari 2017). As for the other countries in the region with weaker incomes and implemented austerity policies, they are unable to meet women's health needs. Rather, they deduct from what is originally allocated to women and at their expense in favor of other groups. Perhaps this is what women in Lebanon majorly suffer from today due to the severe economic crisis, as women's health coverage was affected by the decline in incomes and the amounts allocated for health expenditure (Moussawi 2022). Within this context, period poverty arises as women and girls in Lebanon have become largely unable to secure the resources that allow their access to sanitary pads and most personal hygiene items. They are forced to use unhealthy alternatives that may harm their bodies and human dignity, especially since the subsidy policy associated with austerity completely disregarded including women's health requirements in the subsidy basket (Saqa 2023). The same applies in other Arab countries such as Morocco, where 30% of women suffer from period poverty, and thus from the health consequences of the use of alternatives to sanitary pads.[5]

Within the health austerity context and its impact on women and their health, especially their reproductive health, it seems that reducing government subsidies for health services provided to women comes at the expense of women's general health and reproductive health, where health services remain exclusively limited to reproductive health related to pregnancy and childbirth. Resources thus go to women who seek reproductive healthcare within the pregnancy and childbirth framework. The actual subsidy is linked to child's birth[6] and safety, not to the mother as a woman who has the right to take care of her body, regardless of the importance of pregnancy and childbirth (Moussawi 2022). This is the case in several Arab countries. Sexual, reproductive, and maternal health are at the core of Arab government policies that are either aiming to adopt and highlight them or to show that they are partially or completely inexistent. Today, this situation is due to compelling circumstances, such as asylum-seeking, economic collapse, wars, climate change, and the resulting violence and displacement (Igaziz et al. 2021; Sanubar & Duman 2016). In this reality, women pay the price as they give up their right to take care of themselves in order to prioritize and take care of

[5] Medfeminiswiya website, "Poverty in Morocco" article, available at this link.
[6] From the mapping published by Heinrich Böll Foundation, written by Fatima Moussawi, in which Tamar Kabakian spoke about the crisis' impact on reproductive health.

the health of their families, children, and husbands (Awad & Shuja Al-Deen 2019). Subsidies for access to contraceptives is at the core of political practices or "non-practices" that were excluded from the political decision-making agenda in Lebanon with the onset of the economic crisis, significantly hindering women's access to these means.

The decrease in maternal mortality[7] cases is an indicator of the development of health systems and policies. Arab countries have achieved remarkable progress within this context over the past decades. However, maternal mortality has been exacerbated today by COVID-19 and the resulting difficulty to visit care centers or follow up with specialists during pregnancy as a result of lockdowns and security measures. This has led to an alarming increase in maternal mortality rates among Lebanese women, refugees and residents in Lebanon, in light of the country's collapse, according to a study by Kabakian et.al (2022). In parallel, Al-Shaar (2023) reports that the maternal mortality rates in Palestine have been sharply increasing during and after the COVID-19 pandemic, due to the lack of basic services related to maternal safety.

These developments reflect the regimes' political view regarding women's right to health and their status in political priorities. Women's right to health in the Arab region is very much dependent on women's positioning within the human rights framework as a whole. This right also depends on Arab countries' vulnerability to wars, turbulences, and worsening economic decline. In Yemen, a country that is about to emerge from a devastating war that has destroyed its health infrastructure, there is a critical gap in the provision of therapeutic, nutritional, and preventive materials for pregnant and lactating women, which has led to an additional 1.3 million women facing malnutrition in 2022. Maternal mortality cases in Yemen have reached 385 deaths out of 100,000 live births due to the failure to treat the symptoms associated with pregnancy and childbirth. In parallel many obstacles face rural women in Yemen, preventing them from accessing health services, especially with the decline in resources and the paucity of female doctors, as women's check-up visits during pregnancy are decreasing (Hyzam & Shaef 2023). Tunisia has established a national plan to reduce maternal mortality rates and supported it by ensuring health monitoring of women during pregnancy. However, inequalities persist in the access to these services between urban and rural areas, where services are free in the public sector and paid for in the private sector. Notably, Tunisia

[7] 2023 update issued by the World Health Organization, click on the following link.

recognized the right to abortion years ago, despite recent restrictions (Ayadi & Caid Essebsi 2023).

In Mauritania, the 2019 National Health Information System data revealed that only 13.3% of married women used contraception and that only 25% of health authorities provided family planning services (Al Mahboubi & Al Atigh 2023). The study by Al Mahboubi and Al Atigh (2023) lays out the steps taken by the Ministry of Health in adopting several programs to deal with reproductive health, combatting cervical diseases and birth complications, in addition to establishing specialized health programs, providing health insurance for women, and other programs that have not yet contributed to bridging the gender gap at the health level. This is because structural problems exist and are deeply rooted, including the strong influence of customs and traditions, health violence, violence against women, and early marriage. In Tunisia, for example, there have been successive laws and government procedures that are often incomplete, either in terms of incomplete texts or lack of implementation. The Tunisian labor law includes a clause that guarantees the right of women working in the public sector to obtain paid leave after maternity, and rest for breastfeeding for a period of six months, and after that, an hour of breastfeeding every day during working hours for all women in the workplace. However, this does not apply to women working in the agricultural sector, in fragile sectors and for daily wages in the context of a safe birth system (safe in 95% of the birth cases), whether in urban or rural areas, according to the study conducted by Ayadi and Caid Essebsi (2023).

THE VISION FORWARD

Efforts are poured to improve the health status of Arab women, but they often do not consider women's complex conditions and often ignore their strengths on the personal or collective level. Within the framework of some international programs, a woman is considered a person who needs protection, as there is no deep delving into the social and political structures that create their health reality (Assi 2020). In light of this, we present some recommendations that can serve as the foundations of

a comprehensive health vision that guarantees rights in legal texts and their implementation:

- The political, health, and social institutions in Arab countries should grant importance to women and girls' health education and raise awareness among them from an early age about their needed healthcare services, starting from schools, universities, and decentralized facilities such as municipalities. This may be important in terms of guaranteeing that the information has a wide and systematic reach. Women need better education about their health needs, to be able to claim them, have their needs met and preserved.
- Essentially, this education requires the creation and expansion of individuals' health data. These data should link health facts and phenomena with gender factors to facilitate a sound assessment and identify differences and problems in both diagnosis and treatment.
- Such data would be the main pillar for guiding policies and working on their development and implementation later, especially in the absence of an agenda aiming at pursuing women's right to health or in the existence of a political agenda that is opposing or austere to this proposition.
- Work to encourage speaking about health issues and women's health rights in a way that helps overcome fears and to break patterns as much as possible, especially outside urban areas, in order to establish practical responses and change women's attitude toward accepting and asking for treatment.
- Dive into further analysis and research on economic, environmental, and cultural factors, as well as the barriers that prevent women and girls in rural areas or areas that are less covered in terms of services and support, from accessing health services.
- Civil society organizations should unite and work to participate in raising awareness and continue advocating for improving the health conditions of women and providing them with currently prohibited rights, working to pass laws related to gender-based violence, sexual harassment, and the right to work and employment procedures that consider maternal health and reproductive conditions, and to promote them.
- A large and thorough networking between local civil society

actors and international health and women's organizations is important to raise the implemented health standards and to monitor both the preventive and treatment systems within the larger framework of women's right to health.

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