

# Cross-cutting gender issues in women's health in the Eastern Mediterranean Region



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## 1. Introduction

While advances resulting in improved health outcomes have continued to be made in science and medicine, it has become increasingly recognized that social factors have a significant impact and influence on health outcomes and behaviours. WHO and other public health actors must address the social factors that impact on the attainment and the maintenance of an optimal health status, including those social factors which translate into risk factors for ill-health within a given population.

The United Nations (UN) World Conference on Human Rights in Vienna in 1993 highlighted the importance of gender equality in all areas of social and economic development, as did the International Conference on Population and Development in Cairo in 1994, and the Fourth World Conference on Women in Beijing in 1995 which built upon the Convention on the Elimination of All Forms of Discrimination Against Women (1979). Delegates called on UN agencies and national governments to ensure that gender equality and equity were taken into consideration in establishing the goals, resource allocations, activities and outcomes of programmes. In September 2000, 189 nations signed the Millennium Declaration, following which the United Nations launched the Millennium Development Goals to reduce poverty and improve health, with a target for achievement of 2015. In 2002, the targets of Millennium Development Goal (MDG) 3 reaffirmed gender equality and the empowerment of women as primary development goals. It was also acknowledged that gender equality was a critical component for achieving the targets of the other MDGs. Three of the eight goals and nine of the 17 targets relate directly to physical health outcomes, which are influenced by social factors to which gender is inextricably linked.

Gender is a social construct which defines and describes the socially perceived roles, responsibilities, rights, opportunities and interactions for females and males for the betterment and maintenance of society, which are influenced by familial, cultural, political, economic and spiritual determinants. Gender equity refers to the fairness, justice and balance in the distribution of benefits, responsibilities and roles according to gender determinants. These differences should be identified and addressed in a manner that rectifies the imbalance between the sexes at different phases of the life cycle.

Gender inequities determine much about the health risks a woman faces in her life, her knowledge, her vulnerability, personal resilience, capacity, self-confidence and access to social support systems which help her to deal with health problems as they arise. For example, inadequate access to education for women leads to diminished social and economic opportunities, and as a result, women's access to cash income in many countries of the Region is limited, and women's economic activity rate is low, as compared to that of

men. Furthermore, limitations on the physical mobility of women and girls and restrictions on women's decision-making and autonomy provide obstacles for women and girls to effectively access and use health care services.

Gender norms shape institutions, including the health sector. In turn, these norms influence women's and men's exposure to health risks, access to health information and services, health outcomes, health care response and the social and economic consequences of disease and ill-health. To address gender inequities that form barriers to health access specific to women, it is important that health systems ensure comprehensive quality health care services are available for women, and also that women are included in health planning processes. It is also important that alternative health care-financing mechanisms (i.e. moving from out-of-pocket to risk-pooling mechanisms) for women and other vulnerable groups be explored and considered.

WHO's support to Member States in integrating gender responsiveness into health system strengthening and development is critical. Challenges are faced in addressing cross-cutting issues in health systems and increased intersectoral collaboration is needed to effectively impact on social determinants of health. Health policies can positively influence inequitable gender norms by emphasizing the importance of equity and by ensuring that the differential needs of women and men and boys and girls are addressed. Several areas have been given specific priority in WHO's policies on women's health, including the need for sex-disaggregated health data and the use of this data to inform and enhance health care delivery to meet the specific needs of males and females. In addition, the training of health staff on the management of women's health problems throughout the life cycle is critical to address the gaps being faced in women's health.

This publication will highlight the status of gender equity in literacy and education and employment for women in the Region and describe how these social opportunities impact upon health outcomes. In addition, gender issues that influence access to, and utilization of, health care will be discussed, including variables of mobility and autonomy. Women's status within marriage will also be discussed, in particular, the issue of early marriage and its impact upon health outcomes for women.

Gender influences health outcomes within a population in respect to actual health status, the perception of health status, healthcare-seeking behaviour and in the attitudes and responses of healthcare providers and of society. As women are the main carers in families throughout the Region, gender inequities can also have consequences for general child, family and community health [1]. It is important that health policies and programmes recognize the influence of gender on health and ensure that the specific and differential needs of males and females are being addressed throughout the life cycle.



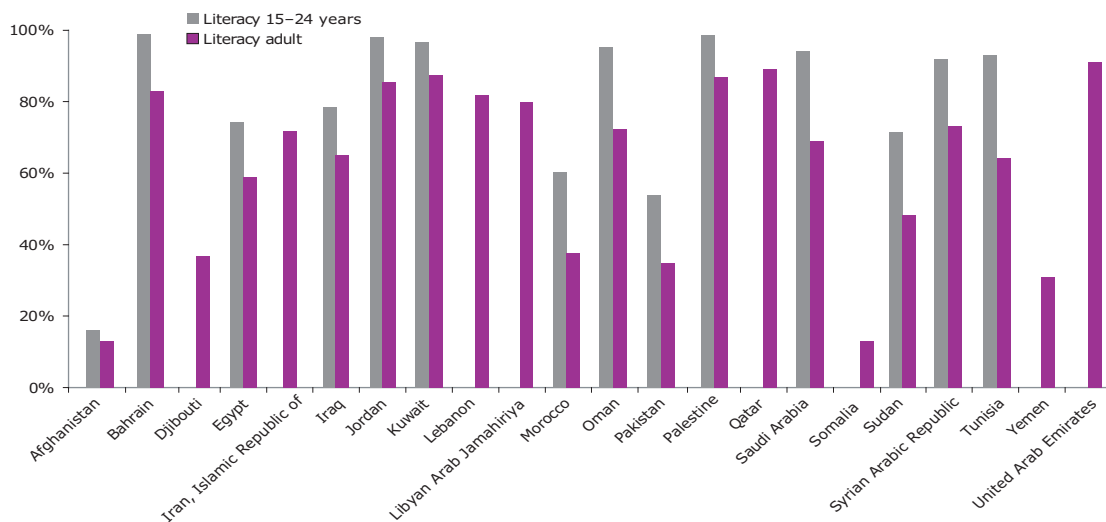


## 2. Gender issues and their influence on health

### 2.1 Literacy and education

Access to education is a key element in health and development. The UN International Conference on Population and Development (1994) identified the education of women and girls as the single most important factor in improving a nation's health [2]. Gender gaps in education have been shown to have a significant negative influence on female health outcomes, and despite substantial efforts made over the last few decades in the Region to address these disparities, significant numbers of women remain illiterate or are excluded from the educational process. Figure 1 shows the low rates of female literacy in countries of the Region, in particular, in Djibouti, Egypt, Iraq, Morocco, Pakistan, Sudan and Yemen.

The goal of providing universal primary education for girls has almost been reached in many countries of the Region and there has been increased access for girls to both secondary and tertiary education. However, countries such as Djibouti with an overall ratio of female-to-



Source: UNESCO Institute for Statistics, 2006 [3]. The data given for Djibouti, Lebanon, Libyan Arab Jamahiriya, Somalia, Yemen and the United Arab Emirates refer to women aged 15+ years [WHO Regional Office for the Eastern Mediterranean. *Demographic, social and health indicators for countries of the Eastern Mediterranean*, Cairo, 2006].

**Figure 1. Female literacy rates in the Eastern Mediterranean Region, 2000–2004**

male education of 62:100, and Yemen with a ratio of 66:100, are still falling sharply behind in the goal of providing universal education for females [4]. Despite achievements made, the number of girls who graduate, particularly from tertiary education, remains much lower than the number of boys in many countries. Many girls are unable to complete their education as a result of economic constraints. The expected economic returns of a girl's education are low as many women move away from their families following marriage. Other constraints that limit girls' access to education are national education policies, a shortage of female teachers, low expectations of employment opportunities for girls, domestic servitude and early marriage [5]. In addition, many girls do not receive the quality of education necessary to enter the modern and global labour market, and sex-disaggregated schooling, which is common in the Region, can also promote gender stereotyping [6, 7].

The level of education a woman receives is an essential determinant of her future autonomy and status as it determines the entry point to employment and the level of economic power she may expect to possess. It is also a key source of knowledge and information and has been proven to be an important predictor of female life expectancy [8].

Educated women have been shown to possess greater reproductive autonomy as was demonstrated by a study conducted in Egypt, in which a large discrepancy in the rate of contraceptive usage was identified between university-educated women (93%) and illiterate women (33%) [9]. Contraceptive usage has important implications for reproductive and maternal health, as unintended pregnancies may result in unsafe abortion, and the unavailability of contraception may lead to multiple pregnancies which can have a detrimental effect on the health of mothers. Condom usage also serves the dual purpose of preventing both pregnancy and sexually transmitted infections (STIs), including HIV. It is not a coincidence that the lowest maternal mortality rates in the Region are found in those countries where there is greater gender equity in access to education [6].

A low level of education is also an important factor in determining whether a woman bears children at a young age, which in terms of health outcomes is unfavourable for both maternal and child health [6]. Low levels of female education are also strongly associated with depression and other mental health problems among women [10]. In addition, poorly-educated women more frequently experience domestic violence with serious physical and/or psychological health outcomes, as observed in studies conducted both in Egypt and Sudan [11,12]. In contrast, more highly-educated women have been shown to have greater power in exercising their legal rights and in making choices which affect their own health and reproductive outcomes [5].

Education also has implications in terms of health care-seeking behaviour, such as in accessing cancer screening services or antenatal or STI services. The link between female education





and child and family health has been well documented [13]. It has been demonstrated that illiteracy in mothers presents a greater risk for a higher prevalence of severe malnutrition among children. A study conducted in Pakistan showed that the proportion of low-body-weight or stunted children was highest among those whose mothers had not received a primary school education [14]. Infant and child mortality rates are lower among children whose mothers are more highly educated [1].

## 2.2 Employment

The type of work an individual performs is often closely linked to levels of education and can be an influential factor in terms of health outcomes. An adequate income is an important factor in being able to access health care services when these services are not freely provided by the State. Women's lack of education often leads them to undertake poorly paid work. Accordingly, resulting economic benefits are fewer for women and the lack of economic independence for women has implications for both their social status and their health.

The participation of women in the labour market in this Region is lower than for other regions at an average of 28%, although significant variation has been noted between countries and increasing numbers of women are now in paid employment [7]. In Jordan in 2001, women represented 15% of the labour force which represented a twofold increase from previous figures [15]. The highest numbers of women in paid employment are found in Lebanon, Morocco and Yemen. The lowest rates are found in Saudi Arabia and other member countries of the Gulf Cooperation Council (GCC), with women representing only about 7% of the labour force [1]. It is a paradox that although the number of women attending university in some countries is greater than the number of men, women in these countries are not enjoying equal employment opportunities. If women were more actively employed in paid work, average household earnings could be increased by 25% and significantly improve the socioeconomic situation of many families [16].

The reasons for low female employment rates can be explained by traditional gender paradigms which exist in the Region. These include a focus on the centrality of the family with the identification of women as mothers and wives rather than as individuals in their own right, the ongoing perception of men's responsibility as sole breadwinner and restrictions on the behaviour and the mobility of women. Employment can positively enhance a woman's physical and mental well-being and may improve her self-esteem through creating social networks and promoting greater independence. Women in employment often enjoy an improved perceived social status leading to greater respect and autonomy, factors which are favourable for positive health outcomes. In a study conducted in Egypt, it was shown that the husbands of employed women were more likely to help in domestic duties and in

taking care of children [9]. Conversely, it has been shown that women who are not in paid employment are more likely to experience increased levels of domestic violence, which may be attributable to their perceived lower social status [11].

However, not all work is beneficial to the health outcomes of either men or women. While well-paid employment in industry may actually increase life expectancy, agricultural work, which is the predominant form of work for many men and women in Egypt, Islamic Republic of Iran, Syrian Arab Republic and Yemen, can have much more of a negative effect on health [8]. Women in employment who also have to work in the home may face additional stress and may feel torn between their dual roles. This can negatively influence health outcomes, particularly if there is no societal or legal support for working women [17].

Patriarchal guardianship and dependence on men also may not necessarily end when women are employed, or when control over their own finances is improved through employment [15]. Throughout the Region, women perform unpaid work in the house or in subsistence agriculture or family businesses and are not registered in the statistics on female employment. They also do not receive health insurance or benefits. In conclusion, paid employment does not necessarily give women greater access to, or control over, their earnings but may improve the economic status of their families [18]. More highly-paid work can have positive benefits in terms of life expectancy and improved health outcomes, but often, lower levels of female education restrict women's access to these jobs.


### 3. Access to health care and services

Access to, and utilization of, health care services is determined by physical access or availability to services, economic access or affordability of services and social access or acceptability of these services. Thus, freedom of movement, financial power and social status are all important determinants in accessing health care.

#### 3.1 Physical access/availability

The lack of availability of health care services is a problem in many countries of the Region, particularly those facing war and experiencing ongoing conflict, such as Afghanistan, Iraq, Palestine and Sudan. Although in countries such as Qatar, the United Arab Emirates or Jordan, the ratio of physicians per population is over 200:100 000, this number is drastically lower, for example, in Yemen (22:100 000), Afghanistan (19:100 000), Sudan (16:100 000), Djibouti (13:100 000) and Somalia (4:100 000) [19]. In Afghanistan, health infrastructure is virtually non-existent and the lack of roads and transportation further limits access to medical care for the predominantly rural population [20]. Other conflict-torn areas are experiencing similar problems. Where there are a lack of medical services, long-distance





travel to medical centres is a barrier to accessing health care services, particularly for women who may have restrictions placed on their mobility or who may not be able to afford the transportation costs or the time needed for travel [21]. This is particularly true when accessing antenatal care services, when emergencies and the need to access services quickly may be necessary but the availability of services locally is not guaranteed. In Afghanistan, the number of women presenting late with complications of pregnancy, such as haemorrhage or obstructed labour, has resulted in interventions targeted primarily at saving the mother because in 50% of these cases the fetus has already died before the woman reaches the health care facility [20].

The lack of births attended by trained birth attendants represents a major problem in the Region and results in negative health outcomes for both women and newborn infants. In Bahrain, Jordan, Kuwait and Qatar, the majority of births are attended by trained birth attendants but numbers sharply decrease for the following countries: Morocco (40%), Somalia (34%) Pakistan (23%), Yemen (22%) and Afghanistan (14%) [19]. It is an undisputed fact that perinatal mortality is dramatically reduced by the presence of trained birth attendants during delivery, and yet, currently, more than 50 000 women die each year in the Region as a result of pregnancy-related complications [22].

### **3.2 Economic access**

As already stated, socioeconomic factors play a crucial role in access to health care services. Women who are financially dependent on their husbands are often unable to access services without their spouse's consent, and this may be particularly problematic if there is stigma associated with the use of those services, as in, for instance, attending a clinic for the treatment of sexually transmitted infections. The choice of which health care provider an individual chooses is also strongly influenced by financial considerations. In Morocco, it has been observed that women generally prefer to use traditional medicines or to attend public health facilities that are less costly, while men often choose more expensive private clinics [23].

### **3.3 Sociocultural access**

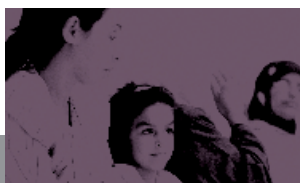
As a result of sociocultural norms, women in the Region are more likely to ignore symptoms of serious illness over longer periods of time without seeking medical advice. Women's health is often neglected or subordinated to the family's health and this may result in the worsening of medical conditions as a result of significant delays in seeking treatment [24]. Women's lack of information and knowledge of health issues and the inability to recognize symptoms of disease also exacerbate the problem.


Poor access to, and utilization of, health care services has implications for female health in terms of under-recognition of disease, treatment delay and non-adherence to treatment. In a study conducted in Egypt, male cases of tuberculosis were shown to outnumber female cases by more than double indicating that women's poor access to health care services had led to under-recognition of the condition in women. As women tend to present at health care centres at late stages of illness, they often have more advanced symptoms of disease or poorer survival chances; this is particularly true for conditions such as cancer for which early treatment is optimal [25]. Studies conducted on trachoma have shown that there are greater complications in the disease among women as they often delay seeking treatment for the problem [26].

Restrictions placed on female mobility and a lack of female health care workers also result in negative health outcomes for women. Conversely, negative health outcomes can also result for men due to the fact that health centres may predominantly focus on antenatal care or maternal and child health care and this can represent a barrier to men accessing these services. It does, however, need to be noted that accompanied mobility, which is socially more acceptable for many women, does not necessarily interfere with health care-seeking behaviour. Male supervision can actually lead to improved health outcomes for women, as shown in a study conducted on the success rates for tuberculosis treatment in Yemen [27]. Men felt responsible for ensuring women's adherence to treatment and accompanied them on visits to health centres for treatment under the directly observed treatment, short course (DOTS) strategy. Men, however, were shown to less likely succeed in their own treatment and were also less likely to visit health centres on their own behalf.

### **3.4 The impact of public services on health outcomes**

Limited access to safe drinking-water, sanitation and drainage is a source of risk to both male and female health in respect of waterborne diseases, such as schistosomiasis [28] and diarrhoeal diseases. While 84% of the population in member countries of the GCC have access to safe water, this is true for only 69% of the population in both Yemen and Sudan, 29% of the population in Somalia and 13% of the population in Afghanistan. There is even greater variation in regard to adequate sanitation between countries. In Lebanon, Libyan Arab Jamahiriya, Qatar and United Arab Emirates, people have access to almost 100% adequate sanitation, whereas one third of countries in the Region are unable to provide adequate sanitation to even 50% of the population. Only 35% of the population have access to adequate sanitation in Somalia, 34% in Sudan, 30% in Yemen and 8% in Afghanistan [19]. Access to safe water and adequate drainage and sanitation are relevant issues in gender. Water management and related activities such as the collection, storage and disposal of water, or duties involving washing, cooking, laundry or the bathing of children, are typically female responsibilities in the Region, and the maintenance of good health relies on safe





water supplies [28]. The safe disposal of wastewater represents a serious problem with potential negative health implications for both sexes.

## 4. Marriage

### 4.1 Early marriage

Marital age as a sociodemographic factor has a significant impact on female and child health outcomes in the Region. Early marriage may be favoured as a result of cultural values or traditions and is undertaken for reasons such as the desire to protect the virtue of young women, social pressures, a belief that fertility will be ensured when marrying during puberty or for economic reasons. A study in the Islamic Republic of Iran revealed that young women face strong pressure to marry and to have children [29]. In a survey conducted in Saudi Arabia, 27% of girls were married before the age of 16, and the youngest age recorded for marriage was 10 years old. In Yemen, 17% of girls were reported married between the ages of 15 and 19 years [30]. An early marital age is heavily associated with low education levels, as girls who are denied educational opportunities are more likely to marry young. Girls married in their teens often lack the motivation to pursue an education following marriage or may find it difficult to take advantage of educational opportunities as a result of familial and maternal responsibilities. Teenage marriage, which is also often associated with a large age gap, may also contribute to higher rates of domestic and sexual violence, in addition to higher divorce rates [30]. A study conducted in the Syrian Arab Republic found early marriage to be an important indirect correlate of mental distress and morbidity [10].

Early marriage is also likely to result in teenage pregnancy with higher rates of unfavourable pregnancy outcomes and higher rates of abortion, in not only the first pregnancy, but in subsequent pregnancies as well. Research has indicated approximately double the risk of spontaneous abortion and approximately four times the risk of losing a fetus or an infant with early teenage marriage. [30]. As teenage women are biologically and psychologically immature, teenage pregnant women fall into a high-risk category. Childbirth at a young age is an important determinant of frequent pregnancies and health problems throughout a woman's childbearing years, and also represents an excessive responsibility for a young woman. Teenage pregnancy can have serious health implications for infants in terms of low birth weight and higher rates of stillbirth [31].

### 4.2 Women's decision-making power within the family

Freedom in decision-making is a significant aspect of an individual's autonomy, empowerment and personal freedom. It comprises the ability to take decisions and to act accordingly in order to achieve personal wishes, desires or goals. In the Region, women's

decision-making power may be limited and male family members often have the primary say in matters related to finances, freedom of movement, children's education, health care-seeking behaviour and the use of family planning methods [32]. In many countries, decisions concerning women are often taken by the husband or by the entire family [33], although it has been shown that women's decision-making power within the family is often enhanced through employment [15] and is linked to education. These two determinants of decision-making power can also act as indicators for other aspects of independence, for example, the freedom to choose a spouse [24].

In Oman, it has been shown that women more highly empowered in decision-making were, for example, more likely to have their first child at an older age and to have longer intervals between births [2]. The ability to discuss and achieve consensus on family planning between a husband and wife is an important outcome of female decision-making power within marriage. The interaction of decision-making and autonomy in the family, and in the community, and the availability of quality health services interact to impact on maternal morbidity (and mortality), the physical and mental exhaustion of multiparas, birth-related complications, unsafe abortions, low-birth-weight infants and malnutrition. Women's participation in family decision-making processes has also been shown to have a significant impact on child health in terms of lower mortality rates among children under 5 years of age and higher immunization rates [32].

#### **4.3 Freedom of movement and societal interaction**

Free and unrestricted mobility, in addition to decision-making power, are important elements of a person's autonomy. Traditions and sociocultural norms can encourage women's seclusion or result in restricted mobility. Reasons for restrictions on women's mobility lie in the tradition of male guardianship or in the male perception of the necessity of protecting women. A survey conducted in Punjab, Pakistan, revealed that only 35% of women were allowed to go unescorted to a market in their village, 28% were allowed to attend health centres unescorted and only 12% were allowed to visit neighbouring villages unescorted. On a mobility index with a maximum value of 5, the women of Punjab were assigned a value of 1.4 [33].

Physical restriction on women's freedom of movement has consequences for psychosocial development, particularly in respect to interpersonal relations and communication. The results of a survey conducted in Jordan revealed that girls from a young age learn to fear being alone in certain places, they are taught to feel vulnerable and to rely on male protection and communication with wider society is discouraged. In some cases, women's disobedience against a spouse's or family's wishes can result in the loss of family support, divorce or the loss of custody of children [16].



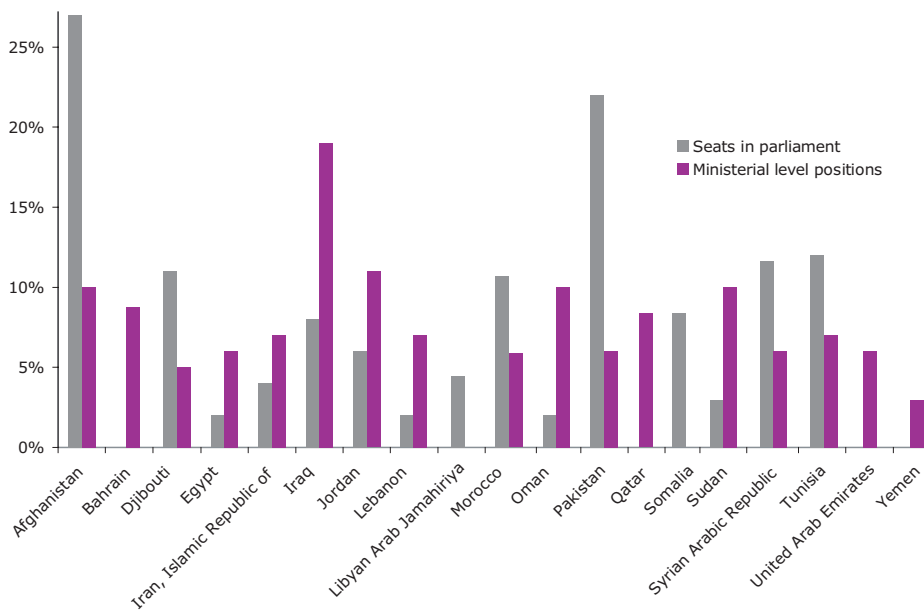


## 5. Women in public life

The political representation of women in the Region is very low; in fact the percentage of women holding parliamentary seats and in ministerial level positions is the lowest in the world (see Figure 2). In Saudi Arabia, women are completely excluded from the political process, and despite the fielding of 27 female candidates in the election held in Kuwait in 2006, no parliamentary seats were won by women. Women's participation in the political process is higher in Afghanistan and Iraq where newly-elected governments have introduced gender quotas [34].

Education is an important prerequisite for greater political involvement and acts as a vehicle through which social and political consciousness can be raised. It also increases women's knowledge of legal processes and their rights and is important for increasing advocacy efforts [5, 6].

Women's lack of representation in public life and their limited decision-making power at the societal level has a significant impact on how public discussions in regard to gender issues are led and for the resulting legal and political implications. Greater participation by women in the political process could contribute to the development and improvement of



Source: World Bank Genderstats [35].

**Figure 2. Percentage of women holding parliamentary seats and in ministerial level positions in the Region, 2004**

structures that advance health, either through direct health-related decisions, or indirectly, through legislative and political decisions which may have a secondary impact on health in terms of policies on employment legislation, education or the protection of human rights.

## 6. Implications for research and policy planning

Despite the inclusion of a gender-focused perspective in social science and health research, the interrelation and dynamics of demographic, economic, social or cultural aspects of gender and health remain under-investigated. Although limited data on gender-differentiated health indicators exist, quantitative epidemiological statistics do not demonstrate adequate insight into the relative and complex health status of men and women in the Region. Thus, more qualitative research is needed to analyse health outcomes and the factors which influence health outcomes. Gender and its implications for health is a neglected area which does not find adequate expression in most health surveys. Research on gender issues in health needs to be undertaken to a greater interdisciplinary degree as integrated frameworks are necessary to ensure that specific political, social, cultural and legal contexts relating to gender are synthesized and integrated into health.

## 7. Conclusions

Strong government commitment is needed to address gender-based health inequities in deeply traditional and patriarchal societies. Investment in female education as a core determinant of female health outcomes needs to be given higher priority and policies need to reflect the particular situations of countries. Increased female representation and participation in public life represents a key element in changing existing paradigms and for improving health outcomes for women in the Region. Possible ways of encouraging greater female political participation could include the use of gender quotas, a decentralization of authority and the provision of training or awareness-raising through the media, particularly television. The use of the media as an independent means to educate the public and to provide information needs to be further exploited.

There is a need for greater female autonomy to be encouraged and integrated into social systems. More comprehensive, context-specific strategies need to be found, which involve increasing gender consciousness in women and in society as a whole. It is essential that women are enabled to access community resources and services and there is a need for increased support in challenging traditional norms of gender inequity. It is also essential that women are empowered and are facilitated to acquire life skills, and that women's access and control over resources is increased and support is given to establish the realization of women's rights [32].





The community-based initiatives (CBI) programme implemented by the WHO Regional Office for the Eastern Mediterranean represents an example of good practice for increasing the involvement of women in society. The initiatives not only positively influence the health of women but also of their families, and by extension, the larger community. Community-based initiatives follow an integrated approach to socioeconomic development and aim to achieve health for all by improving people's quality of life and by reducing poverty through the active involvement of all members of a community, including women and other marginalized groups, in making local decisions and setting health priorities.

The Millennium Development Goals provide useful policy guidelines for the implementation of national development plans and for monitoring progress. The target of MDG 3 identifies indicators related to gender equity and female empowerment, which include the ratio of girls to boys at all educational levels, the ratio of adolescent literate females to literate males, the percentage of women in paid employment in non-agricultural sectors and the proportion of national parliamentary seats held by women. Reaching the targets of this MDG will significantly contribute to improving health outcomes for all individuals, but particularly for women.

To ensure that women and men have equal access to the opportunities necessary to achieve their full health potential and to achieve health equity, the health sector must recognize that women and men differ in terms of both sex and gender. Because of social (gender) and biological (sex) differences, women and men experience different health risks, undertake different health care-seeking behaviour and experience different health outcomes and responses from health systems. Health policies and programmes must integrate and address the specific social contexts of women and men and boys and girls in order to achieve the attainment of optimal health for all.

## 8. References

1. Ouakrim M, Badr A. Overall view of the health status of women and its determinants in the Eastern Mediterranean Region. *Eastern Mediterranean Health Journal*, 1998, 2(3):545–557.
2. Al Riyami A, Afifi M, Mabry RM. Women´s autonomy, education and employment in Oman and their influence on contraceptive use. *Reproductive Health Matters*, 2004, 12(23):144–154.3.
3. UNESCO Institute for Statistics, Literacy rates and illiterate population by country and by gender ([http://www.uis.unesco.org/TEMPLATE/html/Exceltables/education/Literacy\\_National\\_CurrentRel.xls](http://www.uis.unesco.org/TEMPLATE/html/Exceltables/education/Literacy_National_CurrentRel.xls), accessed 15 February, 2007).
4. UNFPA Millennium Development Goals Indicators (<http://millenniumindicators.un.org/unsd/mdg/SeriesDetail.aspx?srid=589&crd=>, accessed 15 February, 2007).
5. Moghadam V. *Educating women for a globalizing economy*. In: *Women, work and economic reform in the Middle East and North Africa*. Boulder, CO, USA, Lynne Rienner Publishers, 1998:27–47.
6. Roudi-Fahimi F, Moghadam V. *Empowering women, developing society: Female education in the Middle East and North Africa*. MENA Policy Brief, Population Reference Bureau, Washington, USA, 2003.
7. World Bank. *The economic advancement of women in Jordan: A country gender assessment*. Social and Economic Development Group, Middle East and North Africa Region (MENA), 2005.
8. Williamson J, Boehmer U. Female life expectancy, gender stratification, health status, and level of economic development: A cross-national study of less developed countries. *Social Science and Medicine*, 1997, 45(2):305–317.
9. Abdel Rahman D, Maximos M, Ragheb S. Employment and education of women and their family planning practices. *Bulletin of the High Institute of Public Health*, 1997, 27(1):83–92.
10. Maziak W, et al. Socio-demographic correlates of psychiatric morbidity among low-income women in Aleppo, Syria. *Social Science and Medicine*, 2002, 54:1419–1427.





11. Yount K. Resources, family organization, and domestic violence against married women in Minya, Egypt. *Journal of Marriage and Family*, 2005, 67:579–596.
12. Ahmed AM, Elmardi AE. A study of domestic violence among women attending a medical centre in Sudan. *Eastern Mediterranean Health Journal*, 2005, 11(1/2):164–174.
13. Egmont van K, et al. Reproductive Health in Afghanistan: Results of a knowledge, attitudes and practice survey among Afghan women in Kabul. *Disasters*, 2004, 28(3):269–282.
14. Ali S, Karim N, Billoo A, Haider S. Association of literacy of mothers with mothers among children under three years of age in rural area of district Malir, Karachi. *Journal of the Pakistan Medical Association*, 2005, 55(12):550–553.
15. World Bank. *Gender and development in the Middle East and North Africa: Women and the public sphere*. MENA Development Report, Washington DC, 2004.
16. Kwar M. Jordanian women's voices on impact of work. *Al-Raida*, 2004, 22–23(106–107):50–55.
17. Ahmad-Nia S. Women's work and health in Iran: a comparison of working and non-working mothers. *Social Science and Medicine*, 2002, 54:753–765.
18. Kishor S. *Autonomy and Egyptian women: Findings from the 1988 Egypt Demographic and Health Survey*. Calverton, MD, USA: Macro International, Demographic and Health Surveys (Occasional Papers 2), 1995.
19. UNDP, Human Development Report 2006 (<http://hdr.undp.org/hdr2006/statistics/indicators/58.html>, accessed 15 February 2007).
20. Reilley B, Puertas G, Coutin A. The battle for access—Health care in Afghanistan. *New England Journal of Medicine*, 2004, 350(19):2231–2233.
21. Shaikh B, Hatcher J. Health seeking behaviour and health service utilization in Pakistan: challenging the policy makers. *Journal of Public Health*, 2004, 27(1):49–54.
22. Mahaini R, Mahmoud H. Reducing maternal mortality in the Eastern Mediterranean Region. *Eastern Mediterranean Health Journal*, 2005, 11(4):539–544.

23. Manhart L, et al. Sexually transmitted diseases in Morocco: gender influences on prevention and health care seeking behaviour. *Social Science and Medicine*, 2000, 50:1369–1383.
24. Abou Shabana K, et al. Women's perceptions and practices regarding their rights to reproductive health. *Eastern Mediterranean Health Journal*, 2003, 9(3):296–308.
25. Aziz Z, Sana S, Akram M, Saeed A. Socioeconomic status and breast cancer survival in Pakistani women. *Journal Pakistan Medical Association*, 2004, 54:448–452.
26. Courtright P, West S. Contribution of sex-linked biology and gender roles to disparities with trachoma. *Emerging Infectious Diseases*, 2004, 10(11):2012–2016.
27. Date J, Okita K. Gender and literacy: factors related to diagnostic delay and unsuccessful treatment of tuberculosis in the mountainous area of Yemen. *International Journal of Tuberculosis and Lung Disease*, 2005, 9(6):680–685.
28. Watts S. Women, water management and health. *Emerging Infectious Diseases*, 2004, 10(11):2025–2026.
29. DeJong J, et al. The sexual and reproductive health of young people in the Arab countries and Iran. *Reproductive Health Matters*, 2005, 13(25):49–59.
30. Rashad H, Osman M, Roudi-Fahimi F. *Marriage in the Arab world*. Washington, DC: Population Reference Bureau, 2005.
31. Shawky S, Milaat W. Early teenage marriage and subsequent pregnancy outcome. *Eastern Mediterranean Health Journal*, 2000, 6(1):46–54.
32. Kishor S. *Empowerment of women in Egypt and links to the survival and health of their infants*. In: Presser H, Sen G. (eds.): *Women's empowerment and demographic processes. Moving beyond Cairo*. New York, Oxford University Press, 2000:119–156.
33. Jejeebhoy S, Sathar Z. Women's autonomy in India and Pakistan: The influence of religion and region. *Population and Development Review*, 2001, 27(4):687–712.
34. Dahlerup D, Nordlund A. Gender quotas: a key to equality? A case study of Iraq and Afghanistan. *European Political Science*, 2004, 3(3):91–98.
35. Worldbank GenderStats database of Gender Statistics, Political Participation (<http://genderstats.worldbank.org/genderRpt.asp?rpt=participation&cty>, accessed 15, February 2007).

