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Achieving Sexual and Reproductive Health Equity in the Arab Region

The time is right for the Arab region to embrace a policy movement towards eliminating the systematic unfair inequalities in sexual and reproductive health (SRH) as a core development goal and a whole of government performance indicator.

This movement is anchored on the three main pillars of the current development thinking. The first is the ambitious ICPD beyond 2014 framework[1] that places people's well-being at the center and acknowledges their aspirations for dignity and human rights, adopts a rights based approach, and embraces equity and fairness. The second is the social determinants of health (SDH) resolutions of the World Health Organization[2] that call for health in all policies. The third is the widely adopted 2030 sustainable development goals (SDGs)[3] and the pledge to "LEAVING NO ONE BEHIND".

The converging development thinking makes an explicit link between the unequal distribution of health and wellbeing among social groups and the unfairness in three interlinked upstream and structural domains, namely governance, public policies, and social arrangements. It recognizes that the unfairness on these three fronts is a real threat to the cohesion and sustainability of the society. SRH holds a central place in this thinking.

Sexual and Reproductive Health Equity (SRHE) is no longer considered just a public health priority, SRHE is now a measure of fairness and social success.

The Arab countries have committed to the new international development movement. This brief builds on this commitment and investigates the degree of SRH inequalities and whether these inequalities can be traced back to the domains of governance, public policies, and social arrangements. More importantly, this brief proposes policy recommendations to address the root causes of SRH inequalities, as well as to embrace a fairness and a human right lens in the quest for "LEAVING NO ONE BEHIND".

SRH inequities in the Arab region

This policy brief is one output of a joint regional initiative that targets supporting governance and policy reforms to address "Sexual and Reproductive Health Inequities". The initiative was launched by the United Nations Population Fund for Arab States Regional Office (UNFPA/ASRO) during 2018 in partnership with the Social Research Center of the American University in Cairo (SRC/AUC).

This brief summarizes the key regional findings that are based on analytical reports of five countries: Egypt, Jordan, Morocco, Oman and Sudan. The country reports draw on existing data that span the period 2008-2015. It should be noted that some of the data sets used are not recent enough to draw national level contemporary findings. However, the systematic approach adopted and the commonality of findings, from diverse contexts and time periods, allow the proposal of general recommendations for the Arab region.

The analysis in these reports used three key classifications, namely geographic areas, wealth, and gendered cultural context. It investigated the distribution of a number of SRH indicators across these classifications and assessed their inequality using summary inequality measures (index of dissimilarity and the concentration index expressed in percent). It should be noted that these summary measures equal zero in the absence of inequality and are considered reflecting severe inequalities when they exceed 10%. The following are the key findings of the analysis.

Severe inequalities in a large number of SRH indicators

The findings demonstrate a very unequal burden of ill SRH across the three-selected social classifications. A summary measure of inequality in the burden of ill SRH exceeding 10% is not an exception in the Arab region across the three social classifications. For example, the inequality summary measures for the infant mortality by the geographic areas in Egypt, Morocco and Sudan reach as high as 11.4%, 19.6%, and 9.7%, respectively.

This picture of severe inequalities is repeated for many indicators of SRH (such as delayed primary fertility, hepatitis B virus infection, female genital

cutting, consanguinity, early age at marriage, adolescent childbearing … etc.) across the three considered social classifications.

The severity of SRH inequalities and the trend over time justify considering such inequalities as priority challenges.

Moreover, the improvement in SRH indicators overtime did not guarantee improvement in the inequality distribution and was, in some cases accompanied by a worsening of such a distribution. This implies that the improvement in SRH is not equally shared by all social groups.

Unfair inequalities in SRH-related health system performance and capacity

The findings also documented that the SRH agenda is still unfinished, particularly in terms of some stages in the life course trajectory, and a number of neglected or socially sensitive issues. These include: puberty and menopausal stages, infertility, reproductive cancers, sexually transmitted infections, gender-based violence, sexual health and reproductive rights.

The health system was assessed in terms of its performance and capacity. The performance indicators relate to SRH-related service coverage (such as coverage of antenatal care, knowledge of HIV/AIDS, coverage of breast examination…). The capacity indicators relate to availability, accessibility and affordability of services. The findings demonstrate that the health system performance and capacity indicators are highly unequal among the different social groups classified by geographic areas, wealth, and gendered cultural context.

The severity of inequality reaches as high as 36.5% and 24.5% in some of health system performance and capacity indicators, respectively.

The health system is considered unfair since its performance and capacity are worse off among social groups with higher SRH burdens.

The evidence also show that, even in countries where important achievements are realized on the physical SRH front (e.g: low maternal and infant mortality), the health system performance and capacity inequalities remain a concern.

Social risks are greatly undermining SRH. Their inequalities are significantly affected by the inequalities in the gendered contexts.

Social risk factors are lagging behind in all Arab countries. Child marriages still exist in some Arab countries and range from 4% to 34%. Other social challenges (such as SRH uninformed choices, risky birth

intervals, marital violence, harmful traditional practices…) continue to persist.

Social and gender policies hold lead responsibility in shaping SRH. The inequality of the gendered contexts should be explicitly addressed.

Many of these social risks are characterized by a severe degree of inequalities among social groups.
The gendered cultural context within which women are living was shown to significantly influence the inequality of these social risk factors and the SRH distribution.

Upstream determinants of SRH social patterns are not adequately integrating a fairness lens.

The framework adopted classifies upstream determinants of social patterns into three domains: governance, public policies and social arrangements.

The unfairness in upstream determinants situates the observed inequalities in an equity framing. The equity framing traces the determinants of inequalities to their root causes. This framing underlies the difference between treating social patterns of SRH as expected normal differences and recognizing that these social patterns are disturbing signals of injustices that should be pushed to the top of development priorities.

At the level of governance, the unfairness was linked to the fact that SRH inequity challenges are not at the forefront of priorities.

Economic measures continue to dominate the assessment of progress and to attract significant data collection and analytical efforts. Indeed, the mere absence of a systematic assessment and monitoring of SRHE is a clear signal of the non-centrality of this performance measure.

SRHE as a performance measure of social success and a benchmark for a just and fair society is not yet pushed to the forefront in the Arab region.

The unfairness of public policy was inferred from the absence of guarantees of such fairness. The absence of health equity impact assessment (HEIA) in formulating and evaluating public policies is but one example. In addition, there are many pieces of evidence to demonstrate the unfair distribution of resources and opportunities (sanitation, public services, education, poverty….). for health particularly by geographic region.

Also, the evidence showed that the health system and the social arrangements of the gendered cultural context are unfair. The unfairness is inferred from the inequality of these two domains among social groups and also from the observation that their policies do not specifically target or respond to SRH inequalities.

Policies and actions, driven by the equity framing, should not be only couched in a moral human right rationale and confine themselves to targeting the most disadvantaged (poverty alleviation, squatter upgrading,). These policies should adopt a transformative approach that seeks to change the unfair distribution of disadvantage in society.

The inequity framing provides an additional urgency and an ethical imperative for addressing the systematic differences in SRH. It also guides the choice of policies and the type of actions adopted.

Policy recommendations

I. Sectoral-based recommendations

The Health sector

The Health Sector is requested to pursue its efforts to address the unfinished agenda of SRH, and also to pay urgent attention to the many SRH inequity challenges.

In particular, the health sector needs to put its house in order by adopting sectoral actions explicitly targeting the high inequalities in its performance and capacities among social groups. It should respond to the different SRH needs. It should also seek partnerships with other social sectors and implement multisectoral initiatives that cater for the unequal social and epidemiological risks of poor SRH.

Another crucial role of the health sector is its stewardship role. This role is directed to all players and stakeholders whose actions influence SRH. The stewardship role aims to advocate for addressing SRH inequalities, to mainstream a fairness lens in SRH policies and actions, and to push SRHE as a whole of government performance indicator.

The stewardship role of the health sector implies the redefinition of the role of the body entrusted with health. This body is not just “producer of health and health

care" but also "purveyor of a wide set of social norms and values"[4].

The stewardship role is crucial but the realities on the ground - in terms of the unwillingness and inability of the health sector to efficiently undertake that role, and in terms of the fact that this role is mainly directed to other social sectors - suggest that this role cannot be heeded without the commitment and support at the highest political level, and without the existence of appropriate institutional structures.

Other social sectors

Other social sectors need to realize that they are key stakeholders and contributors for achieving better SRH outcomes in the society. They should be held accountable for their impact of their sectoral agendas on SRH inequities. For each SRH related policy and/or initiative adopted by the social sector, a demonstration of positive impact, or at least of a no negative impact on SRH, should be considered as a success criteria.

The Research and non-State sectors

The Research and non-State sectors need to move from advocacy to recommendations of concrete actions. These sectors should move from just understanding what causes the inequalities in SRH to how to address these inequalities. The research sector can probe the evidence base and devote the needed efforts for methodological innovations allowing the adoption of policies. The civil society can demonstrate through pilot community interventions the effectiveness of these policies and the impact of their implementations.

II. Governance and whole-of-government-based recommendations

The ICPD beyond 2014 framework and the SDGs do recognize fairness as a pillar of good governance. The Arab region, particularly following the many popular expressions of dissatisfactions, is much more sensitive to the importance of fairness and to the role of social justice in addressing the many signals of unrests and polarizations in society.

Embracing fairness requires integrating an equity lens in all policies and social arrangements. It requires ensuring fair distributions of power, money, resources and transformative opportunities. More importantly embracing fairness requires pushing SRHE to the forefront.

The achievement of SRHE requires implementing a policy reform movement that includes:

- Articulating SRHE as a whole of government responsibility, and developing SRHE strategies and plans.
- Enforcing SRHE impact assessment in all policy approaches.
- Establishing institutional structures (high-level multisectoral health equity councils) and availing financial resources to manage and oversee the implementation of the whole of government responsibility and the accountability process.
- Adopting policies and devoting resources to support intermediary actors and intervening forces to foster equality among social groups and to be responsive to differentiated needs and higher risks of disadvantaged social groups.
- Developing surveillance systems for routine monitoring and accountability of SRHE, and measuring impact of interventions.
- Ensuring a wide participatory engagement in the development, implementation, monitoring and evaluation of the health equity strategies.

Enablers for policies and actions

The enablers require strengthening the health information system to be able to systematically and periodically measure and monitor inequality. It also requires building an information system for health that includes additional pieces of information needed to trace and relate inequality to their structural root causes and to the fairness of these causes.

Supporting and nurturing research and analytical capacities are also needed to ensure the existence of well qualified institutions and individuals who command the skills to analyze data and information and can draw evidence-based policy recommendations.

Other enablers include engaging and developing capacities of policy, decision makers, and health practitioners, as well as establishing policy dialogue forums and widening opportunities for participation. Policy dialogues provide the space for completing the policy cycle and linking the different stakeholders. They provide the needed bridge between policies and plans, and actual achievements on the ground in terms of health and well-being. They allow sharing of evidence to modify actions and support achieving the desired impact. They secure a socially inclusive framework for policymaking and enable non-state actors to participate and contribute to the achievement of SRH equity.

Another important enabler is in supporting informed public demand for

fair social policies and health equity. The current public outcry for SRH is focused on blaming the health system and on requesting quality health care and sophisticated medical technologies.

The fair allocation of resources and social arrangements are not recognized as main determinants of preventing ill SRH and promoting well-being. Clearly, public demands need to be built on information and knowledge.

A final note

The evidence, based on the analysis in the five Arab countries, demonstrated that the core challenges are generally similar which allowed for broad policy recommendations. However, the analysis also pointed to specificities of each country. For example, the data accessible for investigating SRH inequalities were very different in periodicity, coverage and details. Also, the priority stratifiers were not similar (eg: the geographic area in Egypt reflected quite severe inequalities in SRH, while in Jordan the wealth was a much more classifier of inequalities than geographic areas). Similarly, the priority inequality challenges and their configurations differed in each country. Needless to say that Arab countries in conflict situations and political upheavals have their own nontraditional categories of disadvantaged groups (refugees and displaced, women and children in conflict situations…) and different SRH set of needs and priorities.

Clearly, each country needs to conduct its own detailed in-depth and up to date investigation and to contextualize its findings. The articulation of evidence based country level specific policy and actions still demand improved data, methodological innovations, and further efforts. This report is but one-step in the right direction.

References:

1. United Nations. Framework of Actions for the Follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014. Report of the Secretary-General; 2014. https://www.unfpa.org/sites/default/files/pub-pdf/ICPD_beyond2014_EN.pdf. Accessed 16 October 2018.

2. World Health Organization. Sixty-Second World Health Assembly Resolutions and Decisions Annexes; 2009 May 18–22: Geneva. WHA62/2009/REC/1. http://apps.who.int/gb/ebwha/pdf_files/WHA62-REC1/WHA62_REC1-en.pdf

3. United Nations. Transforming our world: The 2030 agenda for sustainable development; 2015. A/RES/70/1. https://sustainabledevelopment.un.org/post2015/transformingourworld/publication. Accessed 23 October 2018.

4. Gilson L. Trust and development of health care as a social institution. Social Science & Medicine 2003; 56(7):1453-68

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http://schools.aucegypt.edu/research/src/Pages/SRH-Inequities.aspx