Regional Report

Sexual and Reproductive Health Laws and Policies in Selected Arab Countries
July 2016

منتدى السياسات الصحية في الشرق الأوسط وشمال افريقيا
MIDDLE EAST AND NORTH AFRICA HEALTH POLICY FORUM

Authors

Dr. Jocelyn DeJong
Professor and Associate Dean
Faculty of Health Sciences
American University of Beirut
Beirut, Lebanon

Dr. Hyam Bashour
Public Health Freelancer
Damascus, Syria

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Acknowledgements

In this study, the Middle East and North Africa Health Policy Forum (MENA HPF), under an implementation agreement with the UNFPA/ Arab States Regional Office (ASRO), seeks to address sexual and reproductive health in the Arab states as a priority in health development and advocacy in the post-2015 period. This exercise is intended to provide policymakers and stakeholders in the Arab states with insight about the current status of and gaps in policies for sexual and reproductive health. The report compiles data through mid 2015.
We are especially grateful to Dr. Jocelyn DeJong and Dr. Hyam Bashour for their valuable contributions to the design of the exercise, project follow up, and the compilation and analysis of the data from the 11 country reports. We are also deeply indebted to the authors of the country reports: Dr. Larbi Lamri from Algeria, Dr. Ahmed Abdel-Hamid Ragab from Egypt, Dr. Musa Taha Al-Ajlouni from Jordan, Dr. Rima Mourtada from Lebanon, Dr. Radouane Belouali from Morocco, Ms. Jennifer Elias Dabis from Palestine, Dr. Lubna A. Al-Ansary from the Kingdom of Saudi Arabia, Dr. Elsheikh Badr from Sudan, Dr. Hyam Bashour from Syria, Dr. Habiba Ben Romdhane from Tunisia, and Dr. Hamid Yahiya Hussain and Dr. Walid Faisal from the United Arab Emirates.
This work would not have been possible without the financial support of UNFPA/ASRO and the technical and administrative assistance of the MENA HPF team.

-Dr. Maha El Rabbat
Executive Director

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Acronyms and Abbreviations

CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CPS	Code of Personal Status
CRC	Convention on the Rights of the Child
CSO	Civil Society Organization
ESCWA	Economic and Social Commission for Western Asia
FGM/C	Female Genital Mutilation/Cutting
GBV	Gender-Based Violence
GDP	Gross Domestic Product
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HPF	Health Policy Forum
HPV	Human Papilloma Virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
IVF	In Vitro fertilization
KSA	Kingdom of Saudi Arabia
LAS	League of Arab States
LB	Live Birth
MAP	Medical Assisted Procreation
MDG	Millennium Development Goal
MENA	Middle East and North Africa
MMR	Maternal Mortality Ratio
NGO	Nongovernmental Organization
PHC	Primary Health Care
PoA	Programme of Action
RH	Reproductive Health
SDG	Sustainable Development Goal
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Reproductive Rights
UAE	United Arab Emirates
UHC	Universal Health Coverage
UN	United Nations
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
VAW	Violence Against Women
WHO	World Health Organization

Acknowledgements

Our thanks are due to Prof. Dr. Maha El Rabbat, executive director of Middle East and North Africa Health Policy Forum, for giving us the opportunity to work on such an interesting exercise.

This document was made possible through the efforts and commitment of national experts who worked on the national reports. Special thanks are due to: Dr. Larbi Lamri from Algeria, Dr. Ahmed Abdel-Hamid Ragab from Egypt, Dr. Musa Taha Al- Ajlouni from Jordan, Dr. Rima Mourtada from Lebanon, Dr. Radouane Belouali from Morocco, Ms. Jennifer Elias Dabis from Palestine, Dr. Lubna A. Al-Ansary from the Kingdom of Saudi Arabia, Dr. Elsheikh Badr from Sudan, Dr. Hyam Bashour from Syria, Dr. Habiba Ben Romdhane from Tunisia, and Dr. Hamid Yahiya Hussain and Dr. Walid Faisal from the United Arab Emirates.

A selection of the national reports was reviewed by other experts on the reproductive health and rights situation in the countries concerned. We are grateful to these reviewers: Algeria: Dr. Youssef Mehdi; Egypt: Dr. Ziad Bahaa ElDin, Dr. Hala Youssef, Dr. Ezz El Din Osman, Dr. Lamia Mohsen; Jordan: Higher Population Council; Lebanon: Dr. Faysal H. El Kak; Palestine: Mr. Mohanad Assaf; Sudan: Dr. Nafisa Mohamed Bedri; and Tunis: Dr. Noureddine Achour.

The team at the Middle East and North Africa Health Policy Forum provided technical and administrative support to facilitate the work with the national consultants.

The UNFPA Arab States Regional Office in Cairo Egypt provided financial support for this endeavor, which is gratefully acknowledged.

A first draft of this report was presented for discussion at a MENA Health Policy Forum meeting in Cairo, October 26–27, 2015 and a revised draft was disseminated at a meeting at the MENA Health Policy Forum May 12, 2016. The contributions, suggestions, and comments of all participants were helpful in revising this report and are gratefully acknowledged.

-the authors

Executive Summary

This regional report was commissioned by the MENA Health Policy Forum with funding from UNFPA Arab States Regional Office (ASRO). The report summarizes the findings and reports of national consultants based in 11 Arab countries: Algeria, Egypt, Jordan, Lebanon, Morocco, Palestine, the Kingdom of Saudi Arabia, Sudan, Syria, Tunisia, and the United Arab Emirates. The countries were selected by the MENA Health Policy Forum and UNFPA ASRO to represent the diversity of the Arab world. Regional consultants developed a standardized mapping tool based on a review of international literature and similar exercises in other regions of the world to guide the drafting of national reports by a team of consultants based in those countries. In addition, the regional consultants provided a guidance document to the national consultants. Using the mapping tool as a guide, experts in the countries under review drafted their national reports on the basis of literature reviews, a desk review of all relevant laws and policies, and interviews with key informants and stakeholders.

In terms of international mechanisms to ensure sexual and reproductive health and reproductive rights (SRHR), all countries except one are part of the universal declaration of human rights. All countries under review ratified the Convention on the Rights of the Child (CRC) and all countries except one ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR). All countries under review except one ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), but Tunisia is the only country to have removed all reservations to CEDAW.

Within the national legal frameworks of all reviewed countries, the right to education and the right to equality and non-discrimination are both specifically mentioned and safeguarded in national constitutions. The right to health, which is extremely relevant to reproductive health, is guaranteed by all countries except two. None of the countries except Morocco, however, are committed to the right to decide the number and spacing of children. Although there have been reforms in some countries, to date, Lebanese, Jordanian, Palestinian, Syrian, Sudanese, and Saudi Arabian women cannot pass their nationality to their children if married to non-citizens.

Polygamy is outlawed only in Tunisia, although other countries have instituted reforms to marriages involving more than one wife. The personal status laws in most countries contain provisions with respect to the prevention of child marriage, and some countries have issued laws that prohibit marriage before the age of 18. Egypt has developed a strategy for the prevention of child marriage to support the law prohibiting early marriage. Though all countries under review except two have laws that protect women against rape, the protection is insufficient. All countries except Morocco maintain statutes that allow reduced sentences for rapists if they agree to marry their victims and provide for clemency in cases of rape and honor crimes.

Abortion is illegal in all countries under review except Tunisia, the only Arab country to have legalized abortion on demand. In most countries, post-abortion care, including the provision of contraception to prevent further unwanted pregnancy, is inadequate.

In countries where harmful practices against women such as female genital mutilation/cutting (FGM/C) are prevalent (specifically, Egypt and Sudan among the review countries), there are legal measures to address the practice.

All countries except two have special family planning plans/policies in their health plans. Some countries, such as Jordan, have eliminated restrictions on access to family planning. In all countries, services for the treatment of infertility have increased rapidly, particularly within the private sector, but efforts to regulate infertility treatment have proceeded much more slowly.

It should be noted that none of the countries except Egypt have formal comprehensive policies for the notification of maternal deaths although some countries have initiatives to thoroughly investigate maternal deaths and their causes.

Men and young people, particularly unmarried young people, remain highly neglected populations in terms of access to sexual and reproductive (SRH) services and public education. More work is needed to reach these groups. Moreover, the lack of a life-cycle approach, which follows individuals from a young age to a post-reproductive stage of life, was noted in all countries.

Poverty and conflict are contextual factors in the region that warrant special attention. All countries reported that inequalities persist in provision, access, and quality of SRH care based on rural/urban residence, geographic area, and socioeconomic status. Conflict, particularly in those countries such as Syria that are currently experiencing massive forced displacement, and the subsequent influx of refugees to neighboring countries, creates new vulnerabilities, strains health systems' capacity to respond, and creates new SRH problems that call for new approaches and urgent attention.

Extensive gaps in the realization of SRHR were identified by the national reports as summarized in this regional report. A number of recommendations are therefore proposed for governments, civil society, and regional and international institutions to address these deficiencies in the post-2015 period.

I. Background

The importance of the social determinants of reproductive health (RH) has long been recognized. Indeed, sexual and reproductive health (SRH) is one area of public health in which these factors, often related to gender relations and roles within societies, are particularly salient. As Glasier and Gulmezoglu stated: "Perhaps more than any other area of health, sexual and reproductive health is affected by sociocultural factors, including gender disparities, taboos, and strongly held behavioral norms" (Glasier and Gulmezoglu 2005). Moreover, the delivery of sexual and reproductive healthcare is deeply influenced by the laws and policies in place within specific national contexts.

At the 1994 International Conference on Population and Development (ICPD), 179 governments joined together to establish that equal rights for women and girls and universal access to sexual and reproductive health and reproductive rights (SRHR) are necessary for sustainable development and a priority to improve the quality of life for all people. It was the first time in history that inter-governmental agreement on the definition of SRH was reached. A Program of Action (PoA) was agreed upon that included 16 chapters that defined objectives and actions for more than 44 dimensions of population and development. A hallmark of the 1994 ICPD was its inclusivity, enabling an unprecedented level of participation from civil society and women activists.

The ICPD's PoA states that "Reproductive health ... implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. ... Reproductive health includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases" (UN 1994).

The ICPD recognized the centrality of SRHR to health and development. The impact of SRHR spans the life-cycle of both women and men, offering individuals and couples the right to have control over and decide freely and responsibly on matters related to their SRH and to do so free from violence and coercion (UN 1994).

At the Millennium Summit in 2000, the world community committed itself to meeting eight goals (the Millennium Development Goals/ MDGs), of which five demonstrate a clear overlap with both the ICPD's PoA and the ICPD+5 document: Goal 2: achieve universal primary education; Goal 3: promote gender equality and empower women; Goal 4: reduce child mortality; Goal 5: improve maternal health; and Goal 6: combat HIV/AIDS, malaria, and other diseases. Although the population aspects of the ICPD's PoA may not directly converge with the MDGs, it cannot be denied that implementation of the ICPD goals impacted the achievement of the MDGs (UN 2000).

A strong claim has been made in the context of the post-2015 development agenda that due recognition should also be given to SRHR in the Sustainable Development Goals (SDGs), since SRHR is a critical dimension of development and a critical component of individuals' health and well-being (Temmerman et al. 2014). Health is both a precondition for and the outcome of policies to promote sustainable development. The right to the highest attainable standard of health, the significance of good health to the enjoyment of dignity and human rights, and the importance of healthy populations to sustainable development are undeniable. The Open Working Group Proposal for Sustainable Development Goals stated that one objective is to ensure by 2030 universal access to sexual and reproductive health care services, including for family planning, information, and education, and the integration of RH into national strategies and programs (UN 2015). This aim to ensure universal access to SRHR is in accordance with the ICPD's PoA and the Beijing Platform for Action.

Other elements of the SDGs address the core principles of SRHR, including under Goal 3 *(Ensure healthy lives and promote well-being for all at all ages),* as follows:

3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births

3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births

3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases

3.4 By 2030, reduce by one-third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

3.7 By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information, and education, and the integration of reproductive health into national strategies and programs

3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all

Goal 5 of the SDGs *(Achieve gender equality and empower all women and girls)* also includes relevant elements to the achievement of SRHR, including:

5.1 End all forms of discrimination against all women and girls everywhere

5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation

5.3 Eliminate all harmful practices, such as child, early, and forced marriage and female genital mutilation

5.4 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Program of Action of the ICPD and the Beijing Platform for Action and the outcome documents of their review conferences

5.5 Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels

A progress report 20 years after the ICPD stated that its achievements were remarkable (UNFPA 2014). Further, it indicated that the evidence of 2014 overwhelmingly supports the ICPD consensus that respect, protection, promotion, and fulfillment of human rights are necessary preconditions for improving the dignity and well-being of women and adolescent girls and for empowering them to exercise their reproductive rights, and that SRHR and understanding its implications for population dynamics are foundational to sustainable development. Principle 1 of the PoA affirmed that all human beings are born free and equal in dignity and rights, and are entitled to the human rights and freedoms set forth within the Universal Declaration of Human Rights without distinction of any kind (UN 1994).

General Assembly Resolution 65/234 on the review of the implementation of the ICPD's PoA (UNFPA 2014) and its follow-up beyond 2014 underscored the need for a systematic, integrated, and comprehensive approach to population and development, one that will respond to new challenges relevant to population issues. The findings and conclusions of the Operational Review, in the context of the resolution, suggest a new framework for population and development beyond 2014, built on five thematic pillars: dignity and human rights; health; place and mobility; governance and accountability; and sustainability (UNFPA 2014).

Numerous United Nations (UN) and bilateral development agencies defined a human rights-based approach to health as one that aims to realize the right to the highest attainable standard of health. The World Health Organization (WHO) proposed that a human rights-based approach to health is based on seven key principles: availability, accessibility, acceptability, quality of facilities and services, participation, equality, and accountability. The most authoritative definition of the right of everyone to the enjoyment of the highest attainable standard

of physical and mental health, often referred to as the right to health, is set out in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). According to General Comment 14, the right to health contains both freedoms and entitlements. (UN 1966).

According to the Centre for Reproductive Rights, states have specific legal obligations to respect, protect, and fulfill the rights protected in these human rights treaties. These obligations include both limitations on the actions that states may take (negative obligations) and proactive measures that states must take (positive obligations). States must take steps toward fulfilling their obligations by all appropriate means, including particularly the adoption of legislative measures, and should report on these measures and the basis on which they have been considered the most "appropriate" under the circumstances. Some state obligations, including civil and political rights obligations and core economic, social and cultural rights obligations, can be put to immediate effect, while others are subject to progressive realization[1].

(1)See www.reproductiverights.org

Since the ICPD, countries, including those in the Arab region, have made progress in the promulgation and enforcement of national laws responding to the ICPD priority areas related to SRHR. The progress in the Arab world is remarkable, but challenges remain, as reviewed and discussed at the Regional Conference on Population and Development in the Arab States held in Cairo in 2013 (UNFPA 2013).

Recent years, mainly since the inception of the so-called Arab uprisings, have seen not only periods of political instability and, in some cases, violent conflict in the region, but also massive societal changes. These directly and indirectly touch on the human rights and autonomy of women and girls in matters related to sexuality and reproduction as a focus of ideological and political differences. Furthermore, the conflict and violence in some Arab countries have led to the destruction of many countries' health infrastructure, rendering existing health systems, already fragile before the onset of this instability and social change, even more vulnerable. The forced displacement and migration affecting many Arab countries carry clear challenges that translate to the SRH field and need to be taken into consideration in any future plans.

II. Current Project

Since 1994 the ICPD mandate has wielded a strong influence on the field of SRH internationally, including in Arab countries. The latter have made good progress, but like other countries they are at a critical juncture to ensure universal access to sexual and reproductive health care services, an objective proposed for inclusion among the SDGs.

The UNFPA works to ensure that SRH is at the center of developmental efforts worldwide. UNFPA's work with governments, other UN organizations, NGOs, and donors has led to comprehensive efforts to ensure universal access to sexual and reproductive health care.

In this project, the MENA Health Policy Forum, under an implementation agreement with the UNFPA Arab States Regional Office, seeks to address SRH in Arab states as a priority in health development and advocacy in the post-2015 period. In its capacity as a regional think tank with policy and research expertise, the MENA HPF commissioned a discussion paper on the current situation and existing gaps with policy implications and directions. This exercise is intended to provide insights for policymakers and stakeholders in Arab states into the current framework for, status of, and gaps in rights-based policies for SRH. The objective is to identify all supporting laws, articles, and decrees in Arab states that relate to SRH services and integrated services.

This exercise covers 11 Arab countries: Algeria, Egypt, Jordan, Lebanon, Morocco, Palestine, the Kingdom of Saudi Arabia (KSA), Sudan, Syria, Tunisia, and the United Arab Emirates (UAE). Selected to represent the diversity of the Arab world, these countries include: three North African francophone countries in the Maghreb region (Algeria, Morocco, Tunisia); Egypt and Sudan on the African continent; four Middle Eastern or Mashreq countries (Jordan, Lebanon, Palestine, Syria); and two countries in the Gulf region (UAE, KSA).

Regional consultants developed a standardized mapping tool based on a review of the literature (Cottingham et al. 2010; Fernandez et al. 2011; Gruskin et al. 2007; UN 2011; WHO 2014; ICPD 2014) and similar exercises in other regions of the world to guide the drafting of national reports by a team of consultants based in those countries. In addition to the mapping tool, the regional consultants provided a guidance document to the national consultants. Using the mapping tool as a guide, experts in the review countries drafted their national reports on the basis of literature reviews, desk reviews of all relevant laws and policies, and interviews with key informants and stakeholders (see Annexes 1 and 2).

This regional report summarizes data from the national reports, collected through the compilation and analysis of national constitutions, laws, and policies with regard to SRH. A gap analysis is presented and a list of recommendations provided for specific stakeholders involved.

III. Current Situation in the Countries under Review

(2) See http://icpdbeyond2014.org/about/view/19-country-implementation-profiles

Each national report presents some background on the country under review. For the purpose of this regional report and for comparability across countries, the country profiles from the ICPD +14 were also consulted when needed.

Table 1 presents the population demographics of the 11 countries. Their populations range from less than 5 million (Palestine) to over 90 million (Egypt). The total fertility rate ranges from 1.7 in Lebanon to 4.5 in Sudan.

Table 1: Basic Demographics of the Countries Under Review

Table 1

	Total population (millions) 2015 a	Total fertility rate, per woman 2010-2015 a	Population aged 10-24, (%) 2015 a	GDP per capita (2011-2015) b
Algeria	39.4	2.9	24	5,484
Egypt	91.5	3.4	27	3,198
Jordan	7.6	3.5	30	5,422
Lebanon	5.9	1.7	28	10,057
Morocco	34.4	2.6	20	3,190
Palestine	4.7	4.3	34	N/A
KSA	31.5	2.9	24	24,161
Sudan	40.2	4.5	32	1,875
Syria	18.5	3.0	33	N/A
Tunisia	11.3	2.2	23	4,420
UAE	9.2	1.8	17	43,962

Sources: a UNFPA (2015) state of world population 2015 [3]; b World Bank.[4]

(3) Available at : http://www.unfpa.org/sites/default/files/sowp/downloads/State_of_World_Population_2015_EN.pdf
(4) http://data.worldbank.org/indicator/NY.GDP.PCAP.CD

The SRH indicators shown in **Table 2** exhibit great variation across countries. For example, the contraceptive prevalence rate (any method) ranges from as low as 16 percent (Sudan) to as high as 68 percent (Morocco).

Table 2: Selected SRH Indicators in the Countries Under Review

Table 2

	Unmet need for family planning, women aged 15-49 2015 a	Contraceptive prevalence rate, women aged 15-49, any method 2015 [a]	Contraceptive prevalence rate, women aged 15-49, modern method 2015 [a]	Adolescent birth rate per 1,000 women aged 15-19 (1999-2014) a	HIV prevalence rate (15-49 Y) b
Algeria	13	59	51	12	0.18 (2013)
Egypt	12	60	58	56	0.0 (2009)
Jordan	12	62	43	27	N/A
Lebanon	13	63	40	18	0.1 (2009)
Morocco	10	68	58	32	0.1 (2009)
Palestine	15	57	43	67	N/A
KSA	24	37	31	7	N/A
Sudan	29	16	13	102	N/A
Syria	15	58	41	75	N/A
Tunisia	11	64	53	7	0.0 (2009)
UAE	20	48	39	34	N/A

Sources: a UNFPA (2015) state of world population 2015. b http://icpdbeyond2014.org/about/view/19-country-implementation-profiles

(5) Available at http://www.unfpa.org/sites/default/files/sowp/downloads/State_of_World_Population_2015_EN.pdf

Table 3 presents a summary of maternal health indicators. As in Table 2, great variability is evident across countries. For example, the maternal mortality ratio (MMR) ranges from as low as 6/100,000 live births (LBs) in UAE to as high as 311/100,000 LBs in Sudan.

Table 3: Selected Maternal Health Indicators in the Countries Under Review

Table 3

	MMR, 2015a	Births attended by skilled health personnel (%), 2006-2014b	At least one visit to antenatal care (%)c	Abortion rate (%)d
Algeria	140	97	92.7 (2013)	N/A
Egypt	33	92	90.3 (2014)	N/A
Jordan	58	100	99.1 (2012)	N/A
Lebanon	15	98 (2004)*	95.6 (2004)	N/A
Morocco	121	74	77.1 (2011)	N/A
Palestine	45	100	99.4 (2014)	N/A
KSA	12	97	97 (2008)	N/A
Sudan	311	23	79.4 (2014)	N/A
Syria	68	96	87.9 (2009)	N/A
Tunisia	62	99	98.1 (2011)	7 (2008)
UAE	6	100	100 (2007)	N/A

Sources: [a] WHO 2015; [b] UNFPA 2015; [c] http://icpdbeyond2014.org/about/view/19-country-implementation-profiles; [d] UN:http://mdgs.un.org/unsd/mdg/SeriesDetail.aspx?srid=762

(6) Available at http://www.unfpa.org/sites/default/files/sowp/downloads/State_of_World_Population_2015_EN.pdf

IV. International Mechanisms

International treaty bodies and human rights mechanisms play an essential role in ensuring the continued consolidation and elaboration of these standards. It was clear from the mapping exercise in the countries under review that all countries have ratified international treaties and respects the mechanisms by which those treaties are monitored.

All countries except one are part of the universal system of human rights: KSA did not sign the Universal Declaration of Human Rights however on June 30, 2000, KSA, as a member of the Organization of the Islamic Conference (now the Organization of Islamic Cooperation), officially resolved to support the Cairo Declaration of Human Rights in Islam, an alternative document that states that people have "freedom and right to a dignified life in accordance with the Islamic Sharia," without any discrimination on grounds of "race, colour language, sex, religious belief, political affiliation, social status or other considerations."

All countries under review ratified the Convention on the Rights of the Child (CRC). All countries except KSA ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR). The Convention on the Protection of the Rights of all Migrant Workers and Members of their Families (CMW) was ratified by all countries under review except Jordan, Lebanon, Palestine, and KSA.

Of interest to note is that all countries are signatories of the Millennium Declaration of 2000 as well as the Declaration of the Right to Development (1986). Both declarations recognize the role of states to ensure that women have a role in development with focus on gender equality.

Table 4 shows which countries under review have ratified the specific international treaties. Their relevance to SRHR is highlighted in the table.

Table 4: International Treaties Ratified by the Countries Under Review

Table 4

year	International treaty	Relevance to SRHR	Countries ratified[1]
1948	Universal Declaration of Human Rights	Recognizes the role of states in the defense of human rights and the right to health.	All except KSA
1965	Convention on the Elimination of All Forms of Racial Discrimination	Recognizes the right to marriage and choice of spouse.	All except Sudan
1966	Covenant on Civil and Political Rights	Recognizes the political rights of women.	All except KSA
1966	International Covenant on Economic, Social and Cultural Rights	Article 12 recognizes the right to control one's own body.	All except KSA
1979	Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)	Among other issues, establishes a framework against sexual violence.	All except Sudan
1986	Declaration of the Right to Development	Recognizes the role of the states to ensure that women have a role in development.	All except Palestine
1989	Convention on the Rights of the Child (CRC)	Guarantees the rights of all children without discrimination in any form. Also recognizes the girl child.	All
1990	Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families	Recognizes human rights of migrant workers including their right to health.	All except Jordan, Lebanon, Palestine, KSA, and Sudan
1994	Commitment to the Programme of Action of ICPD	Stipulates, recognizes, and guarantees the definitions of sexual health and reproductive health and defines sexual and reproductive rights.	All except KSA and Sudan
1995	Commitment to the Platform for Action of Beijing's conference	Constitutes the political agenda in which the right to one's own body and, consequently to SRHR, is completely reflected.	All except KSA and Sudan
2000	Millennium Declaration	Recognizes gender equality, maternal health, and the fight against HIV/AIDS as axes of sustainable human development.	All
2001	Declaration of Commitment on HIV/AIDS	Describes commitments regarding the fight against HIV/AIDS and links them to inequalities and rights.	All except Palestine
2006	Convention on the Rights of Persons with Disabilities	Recognizes that women and girls with disabilities are often at greater risk, both within and outside the home, of violence, injury or abuse, neglect or negligent treatment, maltreatment, and exploitation.	All

Note: 1 Year of ratification is available in the national reports or on the relevant websites.

More specifically with regard to the main international agreements relating to the defense of human rights, gender equity, the elimination of violence against women (VAW), and advancement of SRHR, all countries except Sudan have ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). According to the government of Sudan and its judiciary, CEDAW is in conflict with Islamic law, which guides and informs Sudan's constitution and legislative framework.

On the other hand, many countries have entered reservations to international treaties in aspects related to SRHR. For example, KSA has a reservation noting that in case of contradiction between any term of the convention and the norms of Islamic law, the Kingdom is not under obligation to observe the contradictory terms of the convention. All other countries have reservations on some articles (such as Articles 2, 9,

15, and 16), especially those related to family laws and nationality laws in those countries. Though civil society, as well as governmental bodies, are working hard to have those reservations lifted (e.g., in Morocco, Jordan, and other countries), only Tunisia has lifted all reservations on CEDAW (in 2011), the only country in the Arab region to do so.

Only two of the countries under review did not participate in the ICPD conference in Cairo in 1994 or adopt its PoA: Sudan and KSA. Sudan's reservation was very similar to that related to CEDAW as discussed before. Similarly, a fatwa by the Council of Senior Scholars *(majlis al 'ulema)* in KSA described the reasons for KSA's non-participation in the ICPD, raising issues such as sexual freedoms that are not acceptable to them[7]. However, it should be noted that while Sudan and KSA did not send formal delegations to the ICPD, both have taken on follow-up measures. For example, the ICPD agenda is reflected in the KSA's 9th Development Plan and National Population Strategy (in progress).

All countries under review except KSA agreed to the Cairo Declaration on Human Rights in Islam, issued in 1990 by foreign ministers of Muslim countries. And they have all acceded to the amended Arab Charter of Human Rights, prepared by the Arab Summit in Tunisia in May 2004.

In 2013, the Regional Conference on Population and Development in the Arab States (ICPD Beyond 2014) held in Cairo endorsed the findings and conclusions of the Arab regional review on the implementation of the ICPD's PoA as well as its key activities and follow-up beyond 2014. Participants reiterated the principles included in the Cairo PoA related to the sovereign right of the state in implementing the recommendations in accordance with national laws, with full respect of various religious and moral values and the cultural background of the people, and in accordance with internationally recognized human rights.

V. National Legal Frameworks

The following sections explore the legal basis of RH in the countries under review. International standards on reproductive rights are grounded in core human rights treaties and are continuously evolving. In this current mapping of the 12 human rights key to reproductive rights, **Table 5** shows the commitments of the Arab countries under review according to an analysis of their constitutions.

Table 5: Commitments Towards Key Human Rights in Countries' Constitutions

Table 5

The Right to:	Countries committed in their constitution
Life	All except, Jordan, Lebanon, Palestine, and KSA
Liberty and Security of the Person	All except Lebanon
Health	All except Lebanon and Palestine
Decide the Number and Spacing of Children	None except Morocco
Consent to Marriage and Equality in Marriage	None except Morocco, Sudan, and UAE
Privacy	All except Lebanon
Equality and Non-Discrimination	All
Be Free from Practices that Harm Women and Girls	All except Algeria, Lebanon, Palestine, Sudan, KSA, and UAE
Be Free from Torture or Other Cruel, Inhumane, or Degrading Treatment or Punishment	All except Lebanon and KSA
Be Free from Sexual and Gender-Based Violence	None except Egypt, Morocco and Syria
Education and Information	All
Enjoy the Benefits of Scientific Progress	All except Algeria, Lebanon, Palestine, Sudan, and UAE

The right to education and the right to equality and non-discrimination are both specifically mentioned and safeguarded in all countries' constitutions. The right to health, which is of extreme relevance to RH, is guaranteed by all countries except Lebanon and Palestine.

Of interest to note is that none of the countries except Morocco are committed to the right to decide the number and spacing of children. Article 19 of the Moroccan constitution says: "Men and women shall enjoy, on equal footing, the civil, political, economic, social, cultural and environmental rights and freedoms set forth in this chapter and in the provisions of the constitution, as well as in international conventions and pacts duly ratified by Morocco, and this with respect for the provisions of the constitution, immutable values [constantes], and the laws of the Kingdom. The State shall work for the realization of equality between men and women."

Only three countries' constitutions (Morocco, Sudan, and UAE) commit to the right to consent to marriage and equality in marriage. Only three countries (Egypt, Morocco, and Syria) are committed to the right to be free from sexual and gender-based violence (GBV).

The review of national laws found that certain laws are favorable to efforts to improve SRH, while others pose certain barriers to their advancement. Many of those laws are based on the French civil code and have not been updated or modified, and some are based on Islamic law (Sharia).

While many constitutions in the Arab world protect human rights and provide women with legal equality with men on issues such as their health and education, as well as the right to equality and non-discrimination, women still suffer from discriminatory statutes, such as nationality laws that prevent them from passing their nationality to their children. Even today, Lebanese, Jordanian, Palestinian, Syrian, Sudanese, and Saudi Arabian women cannot confer their nationality on their children if married to non-citizens. Those same countries have reservations on CEDAW Article 9, paragraph 2, which affirms the equal rights of the husband and wife to pass their nationality on their children. Article 9 guarantees women's: (i) equality with respect to acquisition, change, or retention of their nationality; and (ii) ability to confer nationality on their children. On the other hand, Tunisia was the first Arab country to allow women to pass on their nationality, based on a legal amendment made in 1993. More recently, Algeria, Egypt, and Morocco amended their nationality laws and gave equal rights to men and women in this respect.

Welchman's (2004) analysis of personal status legislation in the Arab world reported that a tendency toward national codification of laws began in earnest in the 1950s and continues today in Arab states as probably the major mechanism of state intervention in Muslim family matters. Of interest is that the League of Arab States (LAS) has drafted a unified Arab law of personal status. Some good progress has been made to amend family laws or personal status laws. Basic rights in family law constitute a major dimension of gender equality.

Prominent reforms in family law have occurred in North Africa. The first wave of reforms began in Tunisia as early as the 1950s. Tunisia's 1956 personal status code afforded women full and equal rights and remains one of the most progressive family laws in the Arab world today. Box 1 describes some legislative reforms of relevance to SRHR in Tunisia.

Box 1: Legislative Reforms of Relevance to SRHR in Tunisia

Box 1

• Replacement of the notion of the wife's obedience to her husband by the obligation for both spouses to have a relationship based on mutual respect (Law 79, 19 July, 1993);
• Creation of an alimony pension fund guaranteeing divorced women and their children the receipt of a pension and income after trial. In case of noncompliance with this ruling, debtors are liable to state prosecution (Law 65, 5 July 1993);
• Right of a mother to give her nationality to her children who are born of a foreign father (Law 62, 23 June 1993);
• Married couples can hold title to property as communal property (Law 94, 9 November1998);
• Right to access to modern reproductive medicine for both genders with respect of physical and psychological integrity (Law 93,7 August 2001);
• Establishment of the minimum age of marriage to 18 years for both genders (Law 32,14 May 2007);
• Introduction of social insurance even for housekeepers who are usually young and poor women living in critical conditions (Law 32, 11 February 2008);
• Right to education regardless of gender, race, or religion (Law 80, 23 July 2002);
• Provide in workplaces conditions for a mother to feed her baby (Law 58, 4 August 2008);
• Establishment of gender equality in the timing of gaining full adult rights when they reach 18 years of age (woman previously were treated by law as a minor until two years after marriage). Under Tunisian law, men and women now have exactly the same rights to vote, to enter into contracts, and to buy and sell property and goods.

A major reform of personal status legislation took place in Morocco in 2004, garnering much attention in the international literature. In February 2004, the Moroccan parliament unanimously approved legislative changes to the Family Code that eliminated the principle of obedience to the husband; established equal responsibility between husbands and wives over the household and children; gave women the right to decide legal matters without male guardianship; and required consent from both husband and wife to dissolve a marriage.

Algeria introduced several relevant amendments to its Family Code. For example, Article 7 (amended) sets the minimum marriage age for men and women at 19 years, although a judge may grant an age exemption by reason of interest or need.

At the end of 2005, UAE promulgated its first personal status code.

In Palestine, a draft Family Law awaited debate by the incoming Legislative Council after elections initially scheduled for 2005 and subsequently postponed to 2006. After Hamas won the election, the law was not approved (Welchman 2004).

In KSA, family laws relating to marriage, divorce, children, and inheritance are not codified and fall within the general jurisdiction of Sharia courts.

Reforms in family law by themselves will not suffice to achieve the legal transformation of women's status in the Arab world. To overcome human rights violations and discrimination against women, it is evident that other areas of law, particularly penal or criminal codes, require reevaluation and reform, as they continue to legitimize violations of women's human rights in both the private and public spheres (Zuhur 2005). This mapping exercise notes that the criminal code in many countries under review still stands as a barrier to actual improvements in SRHR.

V.1 Child Marriage

The personal status laws in most countries contain provisions relevant to the prevention of child marriage, and some countries have issued laws that prohibit marriage before the age of 18.

In Syria, the civil code does not bar the early marriage of adolescents. In the Personal Status (Muslims) Act, the marriageable age is specified in Article 16 as follows: "The age of eligibility for marriage is 18 years in the case of young men and 17 years in the case of young women." By contrast, Article 18 of the same act provides that: "1) If a male adolescent having attained 15 years of age claims to have reached maturity or if a female adolescent having attained 13 years of age does so and they seek to marry, the judge shall authorize the marriage if it is clear to him that their claim is genuine and that they are physically mature; and, 2) If the guardian is the father or grandfather, his consent is required." In other words, the judge has the right to authorize child marriage, provided that the guardian gives his consent. This article continues to provide an avenue for those guardians who permit girls' marriage at an early

age. The personal status laws for Catholics and other Christians in Syria specify 18 as the age of maturity and thus the legal age for marriage.

Similarly, the official minimum age of marriage in Jordan is 18 years. However, in exceptional circumstances and on an assessment based solely on judicial discretion, a judge may allow marriage at the age of 15.

In Lebanon, no national law exists setting a minimum age of marriage or age of consent. Religious, not civil, courts govern personal status/family law matters including marriage, divorce, and inheritance. The Lebanese constitution gives freedom of belief and freedom to religious communities or sects (today, 18 in number) to conduct their internal affairs as they deem appropriate. Therefore, the minimum age of engagement and marriage may differ from one religious sect to another, but they all allow children under 15 years of age, and in some cases even 9 years of age, to marry if tribunal consent is obtained.

Sudan passed a Child Protection Act in 2014 prohibiting marriage for those under 18 years, with special reference to girls.

A proposal to legalize the age of marriage in KSA was rejected by the Council of Senior Scholars due to concern that it contradicts Sharia.

In Palestine, the legal age of marriage in the West Bank is 15 years for women and 16 years for men under the Jordanian personal status law. In the Gaza Strip, the law of 1954 required that individuals reach puberty before marriage and made the legal marriage age for women 9 years and 12 years for men. The Palestinian chief justice issued an administrative decision in 1995 that raised the marriage age to 15 for women and 16 for men. The consent of the guardian is registered in nearly every marriage in the West Bank and Gaza Strip. When there is no guardian, the judge exercises guardianship in marriage.

In Algeria, Article 7 (amended) of the Personal Status Code sets the minimum marriage age for men and women to 19 years, but a judge may grant an age exemption by reason of interest or need. Article 7(a) states that future spouses must present a medical document no more than three months' old stating that they are not suffering from any disease and that they present no risk factor militating against marriage.

Morocco's Family Code sets the minimum age of marriage at 18 years for both men and women (a reform made in 2004) but also grants judges the power to reduce the age to 15 years with the consent of the guardian.

In Tunisia, Act 32, issued May 14, 2007, sets the minimum age of marriage to 18 years for both genders. The CEDAW committee especially welcomed Tunisia's equalization of the legal marriage age.

Article 28 of Egypt's personal status law previously prohibited the registration of marriage contracts for boys under 18 and girls under 16. The 2008 child law, however, prohibits the marriage of girls before the age of 18. In November 2015 a Presidential Decree was issued withdrawing Egypt's reservation on Article (21) of the Charter on the

Rights and Welfare of Child which states that: "Child marriage and the betrothel of girls and boys shall be prohibited and effective action including legislation, shall be taken to specify the minimum age of marriage to be 18 years". In addition, Article (2) of Child Law No. 12 of 1996 defines a child as any person whose age does not exceed 18. Under Article 80 of the constitution, the state is obliged to provide children with care and protection from "all forms of violence, abuse, mistreatment, and commercial and sexual exploitation." This includes protecting the child from underage marriage, which is considered a form of sexual exploitation.

V.2 Gender-Based Violence

Though all countries under review except Lebanon and KSA have laws that protect women against rape, the protection is not adequate. All countries except Morocco maintain provisions that allow a reduced sentence for rapists who marry their victims and provide for clemency for perpetrators in cases of rape and honor crimes. This is the case in Syria and Jordan, for example.

In July 2011, a new Moroccan constitution was approved by referendum and promulgated. The new constitution contains some provisions that, if effectively implemented, could support a more proactive and positive approach to addressing domestic violence in the country. Article 19 provides for equal civil, political, economic, social, cultural, and environmental rights for men and women. Article 20 provides for the right to life, while Article 21 provides for the right to personal security. Of direct relevance is Article 22, which explicitly prohibits all violations of physical and moral integrity and dignity, as well as all cruel, inhumane, and degrading treatment, under any circumstances, whether committed by the state or private actors. It is notable that Morocco modified the law that allows rape charges to be dropped if the perpetrator marries the victim.

The Jordanian Penal Code (Law 16/1960) contains certain provisions that discriminate against women. For example, Article 308 allows rape charges to be dropped if the perpetrator agrees to marry the victim; he is prohibited from divorcing the woman for a period of three years. Article 98 prescribes sentences of three months to two years in prison for murders committed in a fit of rage that stems from an unlawful or dangerous act by the victim. In practice, this provision is applied to honor killings, in which a woman is murdered by a relative because of suspected extramarital or premarital sex. Sentences in these cases can also be reduced if the victim's family drops the charges, which often happens when victim and perpetrator belong to the same family. Also under Law 7/1954 on crime prevention, women whose lives are deemed to be threatened by their families for reasons related to family honor are often "protected" by being incarcerated.

In UAE, rape is a serious criminal offense punishable by death under Article 354 of the Penal Code, but many victims remain reluctant to report the crime for fear of being shamed before society. For this reason, many offenders are left unpunished.

Other critiques of those criminal laws are that they do not address marital rape or sexual coercion. Egypt in 2014 introduced an article addressing sexual harassment for the first time and Morocco did so in 2003. The Moroccan Criminal Code, as amended by Act 24.03 of November 11, 2003, explicitly created the offense of sexual harassment in Article 503-1: "Any person who abuses the authority conferred upon him by his position to harass another person, using orders, threats, coercion or any other means to obtain sexual favors, is guilty of sexual harassment and shall be punished with a term of imprisonment of one to two years and a fine of DH 5,000 to DH 50,000."

According to Egypt's 2014 sexual harassment law: "It shall be considered sexual harassment if the crime set forth in Article 306(a) of this law is committed by the perpetrator with the intention of receiving from the harassed a benefit of a sexual nature. The perpetrator shall be punished by a term of imprisonment not less than one year or a fine of not less than LE10,000 and not to exceed LE20,000, or both punishments. If the perpetrator is one of the persons referred to in the second paragraph of Article 267 of this law, or has occupational, familial, or educational authority over the victim, or exerted any kind of pressure on the victim to facilitate the context for the commission of the crime, or if the crime is committed by two perpetrators or more, or at least one of them had a weapon, the punishment shall be not less than two years and not exceed five years imprisonment and a fine of not less than LE20,000 and not exceeding LE50,000."

V.3 Human Trafficking

All countries under review except two (Sudan and KSA) have laws that protect women from human trafficking for sexual exploitation, though draft laws exist in those two countries. Actual implementation of those laws faces many challenges, however.

V.4 Family Planning

Of interest is that criminal codes can be an obstacle to the use of family planning methods. Syria's Criminal Code (Articles 523 and 524) bans the advertisement, promotion, sale, procurement, or facilitation of contraception or contraceptive use. This stands in contradiction to the wide use of family planning methods in the country, in which the Ministry of Health is the main provider of contraceptives. Other countries (such as Jordan since 2004) no longer require women to have their husbands' permission to use contraception. Family planning remains very controversial in KSA, though some contraceptives can be purchased directly from pharmacies.

V.5 Unwanted Pregnancy and Abortion

Unwanted pregnancies and unsafe abortion account for an estimated 13 percent of maternal deaths worldwide, but the actual health impact of unsafe abortion in the Arab region is not well known due to lack of data. As reflected in Table 3, many countries lack data on the abortion rate.

Abortion is illegal in all countries under review except Tunisia, the only

Arab country to have legalized abortion on demand. Legal grounds on which abortion is permitted are noted later in the report. Articles in all countries' criminal codes except Tunisia explicitly criminalize abortion. Section 2 of Algeria's Criminal Code criminalizes abortion and those who contribute to its realization. The Egyptian Penal Code of 1937 (sections 260–264) prohibits abortion in all circumstances.

Articles 539–546 of the Lebanese Penal Code, drafted in 1943 based on the French Penal Code at the time, make abortion illegal under all circumstances. A woman who induces her own abortion or allows another person to do so is subject to six months' to three years' imprisonment. In October 1969, Presidential Decree 13187 was issued allowing abortion only to preserve a woman's life, if in danger. A person who performs an abortion with the woman's consent is subject to one to three years' imprisonment, unless the woman dies, in which case the punishment is four to seven years' imprisonment.

Syria's Criminal Code (Articles from 525–530) criminalizes any act leading in a direct or indirect way to abortion, and criminalizes the person committing those acts, including and not limited to: using tools that lead to abortion; marketing, buying, or owning for commercial use those tools; assisting a woman to abort; and violent abuse that leads to abortion and other similar acts.

In Palestine, abortion is criminalized in Articles 321, 322, 324, and 325 of the Criminal Code (Law 16/1960), which is enforced in the West Bank. A woman and any person who assists her in abortion are liable for punishment. The law differentiates between abortion with or without the woman's consent.

Sudanese legislation generally criminalizes abortion apart from a few exceptions. Punishments are stipulated in the Criminal Code of 1991 for illegal abortion. If the pregnancy is of less than 90 days duration, the person who performs the abortion is subject to up to three years of imprisonment and/or the payment of a fine. If the duration of the pregnancy is of more than 90 days, the penalty for performing an abortion increases to up to five years imprisonment and payment of a fine. However, Sudan is the only country in the Arab region to allow abortion in the case of rape or incest.

In Tunisia, a law was enacted in July 1965 permitting induced abortion: (i) when it occurs within the first three months of pregnancy, in a hospital or a recognized health facility and is performed by a physician lawfully exercising his profession; and (ii) when both spouses have at least five living children. Abortion can also be performed if the health of the mother or the child is jeopardized by continuation of the pregnancy or when the unborn child might suffer from illness or a serious infirmity. In 1973, the condition on the number of children was removed. However, it is worth noting that abortion, despite its inclusion in RH services, has never been considered a method of family planning. Unwanted pregnancies are considered contraceptive failures. The use of modern and effective contraception methods must still be promoted through educational messages to further reduce the number of abortions.

V.6 Harmful Practices including Female Genital Mutilation

In countries where harmful practices against women such as female genital mutilation/cutting (FGM/C) are prevalent (namely, Egypt and Sudan among the review countries), legal measures address the practice. In Egypt, Article 242 of the Penal Code was amended in 2008 to criminalize FGM, but this provision can be circumvented by making reference to Article 61, which allows for harmful actions in case of necessity to protect oneself or others.

Sudan has a National Strategy for the Abandonment of All Types of FGM/C (2008–2018). The strategy was drafted by the National Council for Child Welfare (NCCW) after the review of the 2001 FGM Plan of Action. The national strategy aims to eliminate all types of FGM/C through a more comprehensive approach, with the inclusion of different groups including academic institutions, line ministries, and legal experts. The strategy endorsed in 2008 envisions Sudan free of all forms of FGM/C within a generation by 2018 and addresses the religious, social, health, and cultural dimensions of FGM/C.

In 2009, the Sudanese High Council for Child Welfare submitted a draft to adopt a provision prohibiting FGM in the child protection act to render FGM illegal on health, social, and other grounds. The federal government, however, failed to adopt the provision. In decentralized political systems such as that of Sudan, states have parliaments with the mandate to pass laws, and four Sudanese states did pass legislation prohibiting FGM.

V.7 Infertility

In general, the countries under review have not sufficiently addressed issues related to infertility treatment in their legislation despite increasing recourse to such treatment. Laws related to infertility treatment have been issued in KSA. Some regulatory items exist in other countries such as Syria and Jordan (see below for a further discussion on service aspects of infertility).

V.8 Birth Registration

Civil registration systems in all countries mandate birth registration with no discrimination based on gender, but few countries mandate notification of maternal death. One unexplored issue on which it will be important to collect data in the region is whether women have the right to register births without the presence of their husband; this is particularly important in the context of high rates of male migration (voluntary or forced).

In summary, while progress has been made in some areas related to legal reform, all countries' civil and penal codes contain certain provisions that discriminate against women and are detrimental to their health and well-being.

VI. ICPD-Related Strategies, Policies, and Programs on SRHR in the Countries Under Review

This section summarizes strategies and programs on SRHR in the countries under review in the following order: marriage-related issues, fertility-related issues, maternal mortality and morbidity, HIV-related issues, and finally service-related issues.

VI.1 Marriage-Related Issues

VI.1.1 Child marriage

UNFPA's position on child marriage is: "Child marriage is an appalling violation of human rights and robs girls of their education, health and long-term prospects. A girl who is married as a child is one whose potential will not be fulfilled. Since many parents and communities also want the very best for their daughters, we must work together and end child marriage" (as stated by Babatunde Osotimehi, Executive Director, UNFPA).

UNICEF defines child marriage as a formal marriage or informal union before age 18. The CRC and CEDAW recommend 18 as the minimum age of marriage. All countries under review have ratified CRC and all except Sudan have ratified CEDAW.

Adolescent birth rates vary across the countries under review, and many have cultures that encourage early marriage. The adolescent birth rate per 1,000 women aged 15–19 ranges from 7 in Tunisia to 102 in Sudan. Although early marriage is on the decline in the Arab world, the number of young girls who are married before the age of 18 is still significant, particularly in Egypt and Palestine. This leads to early childbearing and poses serious risks to the health and welfare of mothers and children.

Table 6: Legal Minimum Female Age of Marriage in the Countries Under Review as of 2014

Table 6 shows the legal minimum female age of marriage in the countries under review.

Table 6

Country	Legal Age of Marriage
Algeria	19
Egypt	18
Jordan	18
Lebanon	15
Morocco	18
Palestine	Data not available
KSA	No legislation
Sudan	10 with parental consent
Syria	17
Tunisia	18
UAE	No legislation

Source: ICPD country profiles 2014

Some countries, such as Syria, are still working to rectify the disparity in the minimum age of marriage for boys and girls by raising the legal age of marriage of girls from 17 to 18. Judicial consent continues to be a threat to those laws, as in Jordan, Morocco, and Syria, where the actual age of marriage can be as low as 13. In countries with significant non-Muslim populations, such as Lebanon and Syria, the personal status laws of different religious sects regulate the legal age of marriage.

Among Christian sects, for example, it is 18. Of relevance here is that all countries under review ratified the CRC, which prohibits child marriage. KSA proposed to modify the legal age of marriage in 2013, but the proposal was rejected by the Council of Senior Scholars (majlis al 'ulema) as it was seen as contradictory to Sharia law. Closing such loopholes allowed in the implementation of the law is of utmost priority. Of relevance here is that all countries under review ratified the CRC, which prohibits child marriage.

The Egyptian constitution of 2014 and the Egyptian child law both define a child as "anyone under the age of 18." Consequently, marriage under 18 is unlawful. Egypt developed a national strategy to prevent child marriage between November 2013 and June 2014. The National Population and Development Strategy linked to the implementation of the ICPD's PoA in Egypt recognizes the need to prioritize child marriage as a health and population issue. The strategy aims to reduce early marriage by 50 percent by the end of five-year plan, focusing on areas with the highest rates or increasing trends of early marriage. The strategy adopted a right-based approach that works toward ensuring that children's rights are upheld by religions, not just the constitution, and used a partnership approach that brought together government, civil society, and the private sector. The strategy has five operational directions:

1. Empowerment of girls (including economic empowerment).
2. Support to girls who were married early to minimize the negative impacts on them, their children, and their families.
3. Complete and updated legislation to ensure existing protection laws work in favor of girls and women.
4. Empowerment, education, and preparation of young girls so that they can tackle family and societal pressures.
5. Work with families and communities to ensure they understand the harmful consequences of child marriage.

In Jordan, the Council for Family Affairs issued a legal guide for marriage based on the personal status law, which bars marriage under age 18 without the consent of a judge; in all cases the girl must be older than 15. It also prohibits marriage if there is a difference of over 20 years between a man and a woman under 18.

Sudan developed a draft national strategy for reducing child marriage in 2015.

Given the intensity of conflict in the Arab region, it is relevant to note that the impacts of child marriage (such as interrupted education, early pregnancy, higher rates of maternal and child mortality, and an increased risk of domestic violence) are exacerbated in humanitarian settings. Child marriage is arguably often used as an economic survival strategy in the face of war and insecurity when parents and caregivers, especially those poor and displaced, find themselves in an increased state of financial and physical vulnerability. A recent qualitative study by DeJong and Mourtada (2015) reported on child marriage among Syrian refugees and found that women who married earlier faced particular impediments to the legal registration of marriage and in turn to birth registration, with subsequent effects for the next generation (personal communication).

VI.1.2 Premarital testing

Many of the countries under review encourage their citizens to conduct premarital screening for genetic and infectious diseases (Jordan, KSA, and UAE) and some have made doing so a legal requirement for marriage (Egypt and Syria). Premarital testing was introduced in many countries of the region partly out of a concern for genetic diseases, given high rates of consanguinity in the region. More recently, concern over limiting the spread of HIV has led to the inclusion of HIV testing. However, the cost-effectiveness and public health impact of such a strategy needs to be studied carefully. It needs to be accompanied by genetic counseling and information and education about HIV transmission.

VI.1.3 Polygamy

Polygamy is important in the context of Arab countries as it is commonly practiced in the Islamic world. Tunisia was the first and only country in the region to outlaw polygamy on the grounds that it is not possible for a husband to treat multiple wives equally. Its personal status law, promulgated on August 13, 1956, also abolished unilateral divorce, provided legal regulation of divorce, allowed either a husband or wife to initiate divorce proceedings, and abolished *jabr* (the right of fathers to force their daughters to marry against their will), thus allowing young women to choose their own spouses. Polygamy remains a significant practice in other countries of the region, but the SRH implications of the practice are not well documented.

VI.2 Fertility-Related Issues

VI.2.1 Abortion and post-abortion care

As described earlier, national laws in all the countries under review criminalize abortion except in Tunisia, which allows abortion on demand. Some changes have been made in the legal grounds for abortion in some countries, including to save the mother's life (Syria), preserve the mother's mental health (UAE), and avoid fetal impairment (Jordan). In the spring of 2015, Morocco held a major public debate about the health burden of unwanted pregnancy and unsafe abortion. The result was an initiative by officials of the Ministries of Health, Religious Affairs, and Justice to propose a reform of the Penal Code; the initiative was ratified by the king of Morocco (see **Box 2**).

In most of the countries that criminalize abortion, abortion is permitted on certain grounds, as listed in **Table 7**.

Table 7: Legal Grounds on Which Abortion Can Be Permitted in the Countries Under Review

Table 7

Country	Legal Grounds to Permit Abortion
Algeria	To preserve mental health To preserve physical health To save a woman's life
Egypt	To save a woman's life
Jordan	Fetal impairment To preserve mental health To preserve physical health To save a woman's life
Lebanon	To save a woman's life
Morocco	To preserve mental health To preserve physical health To save a woman's life
Palestine	To save a woman's life
KSA	To preserve mental health To preserve physical health To save a woman's life
Sudan	Rape or incest To save a woman's life
Syria	To save a woman's life
Tunisia	On request
UAE	To save woman's life

Source: ICPD country profiles 2014

Box 2: Revision of Abortion Legislation in Morocco, 2015

Box 2

Until recently, the law in relation to abortion in Morocco allowed abortion only for the mother's health (Criminal Code, Article 453) but the law was not clear. Several studies show that abortion is common in Morocco and that maternal mortality is still high (112 deaths per 100,000 live births). The debate about legislative reform initially began on the basis of advocacy by NGOs and a national report. The topic was taken up by four partners: the Ministry of Health, the Ministry of Religious Affairs, the Ministry of Justice, and the Ministry of Health as part of the reform of the Penal Code, and the National Human Rights Council. Their recommendations were submitted to the King of Morocco, who ratified them. This allowed for the broadening of the conditions under which abortion is permitted to include the health conditions of women (including mental health) and cases of rape, incest, and congenital malformations. The recommendations also include education on reproductive health, which should be accompanied by making contraceptives more accessible to unmarried women.

In all countries, post-abortion care is inadequate due to the illegal nature of abortion. Some countries report abortions being carried out illegally by private doctors under safe conditions. At issue in such cases, however, is the situation of inequity as typically only those able to pay can access safe abortion.

VI.2.2 Family planning

A central feature of the ICPD's PoA is the recommendation to provide comprehensive RH care, which includes: family planning; safe pregnancy and delivery services; abortion where legal; prevention and treatment of sexually transmitted infections (including HIV/AIDS); information and counseling on sexuality; and the elimination of harmful practices against women (such as FGM/C and forced marriage).

The ICPD established voluntary family planning as a fundamental human right. This underlying premise enables women and couples to determine the timing and spacing of their pregnancies. During the past two decades, evidence has grown demonstrating the contributions family planning can make to global health and development, including the achievement of the MDGs.

All countries except UAE and KSA have special plans/policies or strategies on family planning in their health plans. Some countries are highly committed to ensuring a wide range of access to family planning methods (Egypt, Jordan, Morocco, Tunisia, and Syria). As an example, Tunisia's Office National de Planification Familial (ONFP), created in 1973, contributed to the success of the National Policy of Family Planning and Population with two fundamental objectives: reducing population growth and protecting the health of women and their families. It later supported the Reproductive Health Program. Early in the 1960s, Tunisia adopted an ambitious Family Planning Program (FPP). The FPP initially focused mainly on demographic objectives, as Tunisia's fertility rate was very high (almost 7). However, over the years, the way in which family planning has been implemented in Tunisia has become a central element of a comprehensive SRHR strategy that has women's rights at its center.

Syria is an interesting example in that its tenth five-year plan (2006–2010), its National Population Strategy (2010), and its National Strategy for Reproductive Health (2009) are all fully committed to family planning. Syria has one of the highest population growth rates in the Arab region. However, the country's Criminal Code still has articles that criminalize the use of any family planning methods, as mentioned above. Activists in the country are working to change those provisions.

Jordan is another interesting example as women are no longer required by law to inform their husband or obtain his approval concerning their choice of contraception under legislation covering family planning matters (Law 5/2004). The Ministry of Health has a specific Strategy for Family Planning (2013–2017).

Although UAE and KSA do not have special plans or policies to encourage family planning, family planning methods are available in these countries and can be purchased directly from pharmacies.

Countries in this review showed variance in the degree of access to family planning methods by young people. Married youth are typically non-users of family planning in most countries, and utilization rates are low in other segments of communities where stigma and/or religious reasons prevail. Proper screening of the implementation of family programs in all countries shows some deviation from the recommendations of the ICPD's PoA with regard to the full access of persons with disabilities or minorities. Another major deviation from the ICPD's PoA is unmarried people's lack of access to contraceptive methods.

VI.2.3 Infertility

Infertility carries a special stigma in the Arab world, particularly for women, due to the high value placed on reproduction. Women are discriminated against due to infertility of the couple even before it is medically proven that they are the cause of the infertility.

According to Inhorn and Gurtin (2012), the globalization of assisted reproductive technologies has meant that overcoming infertility through medical intervention is increasingly a possibility around the world. They argue that the growth of the in vitro fertilization (IVF) industry is particularly noticeable in Middle Eastern countries due to pro-natalist social norms. For example, according to these authors, Egypt hosts over 50 IVF clinics and Turkey has over 100, while the tiny country of Lebanon has one of the highest per capita concentrations of clinics in the world.

However, this "industry" is not well regulated and has many implications for the inequitable use of health services. Issues in need of national public deliberation and policies/legislation include: the types of infertility treatments allowed in a given country; the number of embryos that can legally be implanted; and the outlawing of infertility treatment for reasons of sex selection as well as other issues. While in many cases religious leaders have made pronouncements on such issues, public debate on the social and ethical implications of such practices, as well as their legal basis, is often lacking (Inhorn and Tremayne 2012).

It has been reported that in Morocco, the Medical Assisted Procreation (MAP) is mainly practiced in the private sector. In 2014, a major debate on this issue took place and the Scientific Society of Reproductive Health submitted to the Ministry of Health a draft document outlining potential areas for regulation of MAP. The draft is currently being revised and will be submitted to the Government Council and Parliament for approval. The Ministry of Health has set up a pilot center of MAP.

VI.3 Maternal Mortality

Since the ICPD, maternal health has been a core component of a range of global policy frameworks, most notably the MDGs established in 2000. MDG 5 (improve maternal health) targeted a 75-percent reduction of MMR by 2015. In 2007, a target on RH was added after some controversy. MDG 5b called for universal access to RH care; it explicitly merged the ICPD's PoA with the MDGs.

The MMR reported in 2015 in the countries under review ranges from 6/100,000 LBs in UAE to 311/100,000 LBs in Sudan. The MMR is reported to have decreased in all countries and good monitoring is noted by all, especially given their commitment to the MDGs. Reported causes of death include hemorrhage, sepsis, and other indirect causes. Early marriage still contributes to maternal mortality in the Arab countries. The proportion of women aged 20–24 who were married by the age of 18 exceeds 17 percent in Egypt and Palestine. A study conducted in UAE indicated that one-third of maternal deaths are preventable (Ghazal-Aswad et al. 2011) and another study in Syria indicated that over 90 percent of deaths were due to avoidable factors (Bashour et al. 2009).

Few countries have policies for the notification of maternal deaths, although initiatives were made in some countries to investigate maternal deaths through confidential enquiries (Lebanon, UAE, and

Morocco). For example, in Morocco, all deaths must be declared by law (Law 37-99 on civil status, October 2002, Chapter VI, Article 24). In this context, all maternal deaths are audited regardless of the place of death (Ministry of Health, Sectoral Strategy, 2012–2016). The same applies in Egypt.

In Lebanon, as part of efforts to reduce maternal mortality, the Ministry of Public Health issued in 2004 a decree for the formation of the National Committee on Safe Motherhood. This committee works in collaboration with the Lebanese Society of Obstetricians and Gynecologists (LSOG) and is supported by UNFPA to receive notification of maternal deaths and document the cases (via hospital-based chart review and verbal autopsy).

In Egypt, efforts at reducing maternal mortality are considered top priority. Documentation and investigations of cases of maternal deaths are done through a national maternal mortality surveillance system and safe motherhood committees existing in all governorates.

The area of maternal death surveillance needs urgent attention and improvement and much can be learned from international experience. While progress has been made in maternal mortality surveillance in the region, the system should be extended to include morbidity (Dr. H. Madi, WHO-EMRO, personal communication).

VI.3.1 Reproductive cancers

Reproductive cancers are gaining in importance. They are included in the RH package of services in some countries (Palestine, Syria, and Morocco). In other countries, such as Lebanon, screening for reproductive cancers is still of low priority and practiced at a limited scale in the public sector, although there have been efforts to introduce public education campaigns to encourage mammography, for example. The private sector provides services for women who are able to pay in countries such as Syria and Lebanon. KSA has a screening program for breast cancer but not for cervical cancer. Insufficient attention has been given to making the human papilloma virus (HPV) vaccine widely available. Although HPV vaccination is now recommended in the United Kingdom, the United States, and Canada, as well as other countries, Arab countries typically do not subsidize this vaccine or undertake public health campaigns to encourage its uptake.

VI.3.2 Gender-based violence, sexual harassment, and honor killing

The ICPD's PoA adopted gender equality and women's empowerment as one of its main guiding principles and therefore affirmed the relationship between advancement and fulfillment of rights and gender equality and equity, including women's RH and rights. The issue of GBV received much attention.

Most of the countries under review have initiatives, strategies, policies, or even laws to reduce GBV. All countries except KSA report having a national strategy for women as well as a special body/institution to deal with women's issues.

Palestine has a National Strategy for Combating Violence Against Women 2011–2019, under the responsibility of the Ministry of Women's Affairs. It established strategic goals to strengthen mechanisms of protection and empowerment for Palestinian women from the violence of the Israeli occupation; strengthen the legal framework and institutional mechanisms for the protection of women from violence; improve social protection and social support provided to battered women; and improve health services in dealing with cases of VAW. A unit to combat VAW was established several years ago at the national level with a director and a small staff, which helped to bring gender issues to the forefront of national debates and plans. Several state-level VAW units and gender focal points were established and the government introduced the position of advisor for women's affairs in state level governments. These efforts helped to galvanize the momentum on women's rights and empowerment in the country, especially at the level of states and local communities.

In Tunisia, a National Strategy on Violence Against Women was developed in 2008 and the first national survey on VAW was conducted in 2009–2010. Particular advances are also noted in extending the human right to dignity and non-discrimination and rights protections to people with disabilities.

Morocco's law on VAW has not yet been issued despite a willingness displayed by the government; numerous attempts over several years to pass such a law have not been successful. Currently, no specific legislation addressing VAW exists in Morocco. Instead, VAW is covered under the outdated, generally applicable provisions of the 1962 Penal Code (most recently amended in 2003 and in 2014). Some recent developments in Morocco's overall legal framework relate to the government's fulfillment of its obligations under CEDAW to prevent domestic violence, protect victims, and hold perpetrators accountable (Penal Code reform, 2015).

Syria initiated national studies on VAW in 2008–2010 and drafted a strategy against violence. A certain focus on VAW was allowed for in the National Strategy for Advancement of Women.

Honor killing is of special relevance in the Arab world, and changing legislation to address the issue is a prominent area of advocacy by civil society institutions. In 2009, Syria, issued a decree on honor killing to modify the Criminal Code and ensure that the so-called "justification" clause is removed.

Since 2007, the Lebanese parliament's Woman and Child Committee has worked closely with civil society organizations (CSOs) on a review of laws that discriminate against women with the aim of amending some laws and achieving gender equality, with CEDAW providing the legal framework. As a result, 26 proposals to amend laws discriminating against women were submitted in the period 2007–2012, of which six had been adopted at the time of this report's preparation. One of these proposals was the repeal of Article 562 of the Penal Code. Twelve years after replacing the concept of "justifiable excuse" with "mitigating circumstances," the Lebanese legislature annulled, under Law 162/2011 (August 17, 2011), Article 562 of the Penal Code, which facilitated the

killing of women by allowing for reduced sentences in honor crimes (UN 2014). On April 1, 2014, Lebanon's parliament passed the law on the protection of women and family members from domestic violence. While establishing important protection measures and related police and court reforms, the law still leaves women at risk of marital rape and other abuse. The law defines domestic violence narrowly, thus failing to provide adequate protection from all forms of abuse and falling short of UN guidelines on protection from domestic violence.

In Sudan, a number of legal documents include stipulations related to the protection of women from GBV. Rape and sexual harassment are considered VAW and are punishable under the Criminal Code of 1991 (Article 149, section 3). The punishment is stated as 100 lashes and imprisonment up to 10 years, while same-sex rape is punishable by death.

Box 3

In Egypt, domestic violence against women (VAW) is largely tolerated, and the government has not made efforts to combat it. On the contrary, several articles of the Penal Code can be used to downplay the gravity or even justify this kind of violence. For instance, Article 17 can be used to lower the sentence as an act of mercy, often used in cases of rape and honor crimes. Article 60 allows the perpetrator to be pardoned if he acted in "good faith." This article is mostly used to justify domestic violence as "the husband's right to discipline his wife" and to justify so-called "honor crimes." Moreover, marital rape is not recognized as such in the Penal Code.

The problem of sexual harassment has grown in Egypt in the past 10 years. However, the recent amendment of Article 306 of the Penal Code is very encouraging as it defines "sexual harassment" for the first time in Egypt's history. This law represents a major step towards achieving safety of Egyptian women and girls in public spaces. This law is a concrete result of combined efforts by the Egyptian government together with civil society and UN agencies. Previously, no specific law proscribed sexual harassment in Egypt. However, three articles in the Penal Code were sometimes applied in cases of sexual harassment.

The new law states that a sexual harasser is one who "accosts others in a public or private place through following or stalking them, using gestures or words or through modern means of communication or in any other means through actions that carry sexual or pornographic hints."

Under the new law, harassers face from six months to five years in prison. The longer sentences are reserved for offenders who hold a position of power over their victims, such as being a woman's superior at work or being armed with a weapon. As well as jail terms, offenders face fines of up to 5,000 Egyptian pounds (US$714). Repeat offenders would see their sentences doubled.

VI.5 People Living with HIV/AIDS

The prevalence of HIV/AIDS is generally low in the countries under review, but measurement of its prevalence is challenged by the lack of information and proper surveillance and reluctance to share information. The stigma that the disease carries in the region is of special concern. Moreover, despite efforts to widen access to treatment, the region compares negatively to other regions in terms of the proportion of HIV-positive individuals needing treatment who are on antiretroviral treatment.

Countries under review varied from those that have a special national program for AIDS (Egypt, Jordan, Lebanon, Syria, and Tunisia) to those that have a program integrated with the RH strategy (Morocco) to those

that have no program at all (KSA).

Egypt, Jordan, Syria, and Tunisia have drafted AIDS strategies. Most strategies are multi-sectoral in principle, with the strong involvement of civil society (e.g., as in Lebanon). Many legal barriers remain to optimizing HIV prevention and treatment in the countries under review. Although not addressed in the mapping tool, restrictive policies relating to HIV in relation to both residence and mobility are common in the Arab region. Indeed, Chang et al. (2013) showed that the Eastern Mediterranean region generally has the highest proportion of countries with HIV-related travel restrictions mandated by law. Some countries, such as Jordan, mandate HIV testing for employment in the public sector. Given the widespread availability of antiretroviral therapy for HIV, such policies are not warranted and analysis toward potential revision of such legislation is called for.

Special attention is needed in the region to encourage HIV testing for women who are at risk of contracting HIV (DeJong and Battistin 2015). In a comprehensive review of existing epidemiological evidence on HIV in the region, Abu-Raddad et al. (2010) showed that marriage is the main risk factor for women contracting HIV in the Arab region. Yet women experience many barriers to access both to testing and treatment if infected.

VI.6 Service-Related Issues

VI.6.1 Young people's access to services

All countries under review have strategies on youth and all have special bodies to tackle youth issues.

Tunisia addressed the needs of adolescent and youth populations through its National Program on Adolescent Health in School, implemented since the 1990s. It developed a strategy to promote counseling and youth-friendly services in 2007. To empower young people to make responsible and autonomous decisions about their sexuality and SRH, the National Board of Population and Family Planning established specific youth units in RH facilities.

Syria's Commission for Family Affairs undertook many studies to prepare for its National Youth Strategy and the Ministry of Health initiated pilot youth clinics in primary health care (PHC) centers. Evidence showed that stigmatization of this segment of the population often prevents them from accessing available services.

Palestine has a pilot youth clinic in south Hebron to increase adolescents' access to comprehensive SRH services.

Sudan developed a National Youth Strategy that focuses on addressing issues and challenges related to youth, including RH aspects such as early marriage, adolescent health, and combating harmful practices. UNFPA facilitated the establishment of youth parliaments at the level of states to enhance advocacy and promote networking on actions related to youth and adolescents in Sudan (UNFPA 2013). The national government has a special ministry dedicated to Youth and Sport and it includes a General Directorate on Youth Affairs. The Ministry of Youth and Sport works with civil society and the National Youth Association to empower young people and promote their full participation.

Morocco's Advisory Council for Youth and Community Action is "a consultative body involved in the protection of youth and the promotion of community life, is responsible for studying and keeping up with issues related to these areas, as well as making recommendations on any economic, social or cultural subject bearing direct relevance to youth and community action. It shall also encourage the creative energies of youth and help young people become involved in public life, as responsible citizens." In 2014, the Council of Ministers adopted a new national Integrated Youth Strategy (IYS) that seeks to expand the country's network of youth services.

VI.6.2 Quality of care of SRH services

The availability and use of integrated SRH services (including family planning, maternal health, and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access have always been areas of concern in many of the countries under review. A research network from Egypt, Palestine, Lebanon, and Syria produced research in international, peer-reviewed journals that shows that the quality of care of maternal health is problematic in those countries as it is not always evidence-based and does not typically give women scope for involvement in key decisions around their pregnancy and childbirth (Choices and Challenges in Changing Childbirth Research Network 2005). National reports prepared for this review emphasized the need to institutionalize quality improvement mechanisms, as well as those of evaluation and accountability. Lebanon also mentioned lack of quality assurance mechanisms in the private sector as an issue.

A number of the barriers to the achievement of SRHR mentioned by the national reports relate to the overall functioning of the health system. Issues relating to human resources, supplies, public-private divisions, and the verticalization of health programs and lack of universal health coverage (UHC) were underlined. For example, a lack of integration typically exists between services provided under safe motherhood initiatives and those for reproductive cancers or between those for sexually transmitted diseases, including HIV. The need for better integration of SRHR services within existing services was also stressed in the national reports. For example, the region particularly needs to link women's SRHR services with services in mental health and non-communicable diseases, taking advantage of women's contacts with the health system to maximize prevention and treatment opportunities. The low coverage of the HPV vaccine in the region is a case in point, where better linkage between SRHR and non-communicable diseases is needed. Taking a life-cycle approach to health more intentionally within the health system would also ensure continuity of care and the inclusion of previously neglected population groups such as young, unmarried women or post-menopausal women.

One of the main challenges is the need to improve health information systems in the countries under review. Such systems should allow access to quality information on all aspects of RH services. Without comprehensive systems, it is difficult to obtain the most complete and reliable picture of health needs to inform evidence-based interventions.

VI.6.3 Population policies

All countries under review have policies/strategies on population. Most have a component of family planning or RH but some, such as KSA, make no mention of RH or family planning. Egypt has a population strategy and a reproductive health strategy both having family planning as a strong component complementing one another. In some countries where the population growth rate is very high (such as Syria), policies discriminate against large families so that maternity leave or family incentives for children of government workers are not granted after the third child. Also, when Jordan's social security system was amended in 2014, mention of the fourth child was removed.

VII. Determinants of SRHR Beyond the Health Sector

VII.1 Women and Work

In the MENA region, although women's labor force participation rates have risen, they remain among the lowest in the world. Thus examining legislation pertaining to women's work—and the protection of their health while at work—is particularly important.

VII.2 Maternity Leave

Some countries (such as Lebanon, which until recently had the shortest maternity leave in the region) have made legislative changes to maternity leave to encourage women to re-enter the workforce after childbirth. Jordan is a particular success story in this regard, as its labor law provides for a legal obligation to provide nurseries for the children of women workers and the right of mothers to raise their children for a period of one year without pay, and prohibits the dismissal of a female worker from service because of pregnancy or during maternity leave or on the basis of her marital status. The law punishes sexual harassment and grants workers the right to leave work and be granted rights when faced with any form of sexual abuse.

VII.3 Sexual Health Issues

VII.3.1 Discrimination against sexual minorities or due to sexual orientation

Very little data exist on the issue of sexual identity or orientation and barriers to access to SRH services in the countries under review.

VII.3.2 Sexuality education

The ICPD's PoA recommended that countries provide scientifically accurate and comprehensive sexuality education programs within and outside of schools that include information on contraceptive use and acquisition.

Implementation of this recommendation is not up to the standard in most countries. As an example, CEDAW committee recommendations to UAE state that the specific content of sexuality education programs should be addressed and that they include information on reproductive

rights, responsible sexual behavior, SRH, prevention of sexually transmitted infections including HIV/AIDS, prevention of teenage pregnancy, and family planning.

Lebanon's Ministry of Education and Higher Education and Ministry of Public Health approved Decree 6610/11 (June 4, 2010) to introduce a school-based reproductive health education and gender curriculum. It has yet to be widely implemented in the country's schools. The same holds true in Egypt where role of education is emphasized in both population and RH strategies but full implementation is yet to occur.

In Palestine, the Ministry of Health conducts comprehensive sexuality education programs within and outside of schools that include information on contraceptive use and acquisition. To eliminate the financial barriers to contraceptive use by marginalized populations, including adolescents and the poor, and to make contraceptives affordable to all, the Ministry of Health co-pays the costs.

VIII. Neglected SRH Issues

Although the countries under review have made many achievements under the ICPD's PoA, many relatively neglected issues still deserve attention. An example of such a critical gap is access to post-abortion care and post-abortion contraception, which would prevent unsafe abortions in the future. Infertility and abortion remain outside of Ministry of Health policies in several countries.

Safe motherhood programs have advanced a great deal in the Arab world. However, the post-natal period is neglected and rates of post-natal care utilization remain low. Part of the challenge is the lack of integration between maternal and child health in health programs. Full integration of maternal and neonatal health remains an enormous challenge.

Women's SRH during menopause and beyond the reproductive health age is also important but is minimally addressed in services, programs, and public education.

Furthermore, the role of men is not well studied in most of the work on SRHR, and the region has made insufficient efforts to include men in available services and to engage them in public education about SRHR.

IX. Vulnerable and Neglected Groups/ Inequities

The ICPD called for special efforts to be made to provide comprehensive contraceptive information and services to displaced populations. Displaced populations are increasing in some of the countries under review due to widespread and devastating conflicts affecting the region.

Syria is the most noticeable example: over 4 million people have fled the country to neighboring countries and another 7 million have moved to safer areas within the country. In both cases, the majority of those forcibly displaced are women and children, and thus their health care needs are by definition high. UN agencies as well as the Syrian government through a Rescue and Emergency Committee are handling the issue of service provision to women and children. As an

example (according to a UNFPA report for December 2014 to January 2015), UNFPA-assisted partners reached around 40,000 women of reproductive age in ten governorates with RH and GBV services. Also, on the International Day of HIV/AIDS, UNFPA organized a one-day policy dialogue for 80 participants representing different related ministries and partners to advocate for the importance of prevention and treatment of HIV/AIDS during the crisis. UNFPA conducted a field mission to Lattakia and Tartous, which together host 744,000 internally displaced persons, including 186,000 women of reproductive age. The mission included discussions with partners on monitoring the humanitarian response.

In Lebanon, UNFPA's humanitarian response to displaced Syrian populations involves supplying health centers with emergency RH kits, supplies, contraceptives, RH drugs, and food supplements.

Poverty is one of the most important challenges to achieving equitable access to SRH services. UHC is a critical and often cost-effective element in any strategy to address poverty and social exclusion, key pillars of the post-2015 sustainable development agenda. Reports from countries indicate that poverty is one the major challenges to achieving the ICPD's PoA. Examples include the lack of equitable access to emergency obstetric care for women (EmOC) in Tunisia, the inequitable geographic distribution of emergency services in Sudan, and the gap in available services in rural areas in Syria. Unemployment and poverty are cited as some of the main challenges to achieving SRHR in Jordan. Jordan, for example, developed the National Strategy for Poverty Alleviation in collaboration with UNDP (United Nations Development Program) and provided direct cash compensation to citizens suffering from the liberalization of prices of some goods, especially fuel.

In Syria, the focus on studying poverty issues by the Syrian Planning Commission (SPC) made it possible to further understand the socioeconomic determinants of health, including SRH. Many initiatives started in the country for poverty reduction.

Because of Morocco's high MMR, its Ministry of Health's strategic plan provides for free deliveries and caesarean sections in all public hospitals for all pregnant women. This decision helped to improve access and increase the percentage of institutional deliveries and caesarean sections, contributing to the reduction in the MMR from 226 to 121 per 100,000 LBs.

X. Different Actors and Their Roles

The states/governments are the key player in securing SRHR, but other key actors play a role as well. The role of civil society is critical in the defense of SRHR. Fostering dialogue among the myriad players involved in implementing SRHR is vital so that they can learn from each other, identify barriers, and develop coordinated strategies.

National reports varied with regard to the role of civil society in SRHR. Tunisia, Lebanon, Egypt, and Jordan indicated that civil society has a major role working both with government and independently in eliminating discrimination against women and in implementing a wide range of services. In many cases, civil society institutions have initiated programs or services that are later taken up by government. This was

the case, for example, in activities on FGM in Egypt. Many CSOs have been working on youth empowerment initiatives in Lebanon since 2000. UN involvement there started with UNESCO's research in 2003, which aimed to understand Lebanese youth's challenges and needs, and its organization of a national conference of around 200 youth organizations in 2005.

Other countries, such as Syria, reported the role of civil society to be weak.

Streamlining and coordinating national and international players was reported as a challenging area in the context of SRHR in Sudan. Cases exist where potential resources of donors and NGOs could not be utilized due to communication and coordination problems; in other cases, SRH packages of services are not consistent across governments and donors. Some national and international civil society factions and NGOs function in disarray in areas of conflict and emergency, such as Darfur. The Sudanese civil society machinery, including youth groups, lacks essential capacity and opportunities for involvement to play a needed role in SRHR and associated services.

Outside of the health sector, ministries of education, the private sector, the media, and local community organizations have carried out certain activities in the promotion of SRH and well-being through the provision of relevant education and public information. Pharmacists, not often emphasized in the SRHR field, can play a critical service provision role in the Arab region and need to be better engaged within the field.

It is also of importance to mention the key role of partners who worked on the regional Population and Development Conference for the Arab States hosted by the LAS in Cairo in 2013. These partners compiled and discussed the findings of background papers, a global survey, assessment studies, and an expert opinion survey. These documents portrayed the regional consensus about the future beyond 2014. The United Nations Economic and Social Commission for Western Asia (ESCWA) and the LAS promote closer relations between member states and better collaboration between them to safeguard their independence and sovereignty and to consider in a general way the interests of Arab countries. UNFPA also facilitates regional coalitions of women's NGOs and youth CSOs to help them consolidate and voice their priorities vis-à-vis the ICPD's PoA.

XI. Gaps in Policy and Law and Gaps in Implementation

The gap analysis in this report is organized along three themes: gaps in the legal environment, gaps in reproductive health rights, and gaps in implementation.

XI.1 Gaps in the Legal Environment

- Violations are best demonstrated by specific laws such as nationality laws or personal status legislation (for example, related to early marriage or honor crimes).
- No mechanisms exist to enforce existing laws in many settings.
- The cross-sectoral nature of SRHR strategies makes addressing issues such as GBV challenging given the lack of engagement by all partners (such as the Ministry of Interior

for the notification of cases).

- The lack of awareness of legal professionals on SRHR issues and the lack of interaction between legal and health professionals in general limit the understanding of the implications of legislation for women's health.

XI.2 Gaps in Sexual and Reproductive Health and Reproductive Rights

- All countries under review report the existence of national strategies on population, youth, women, and RH, but the human rights-based approach is not well represented in those strategies.
- Lack of awareness among women about their own rights is a major constraint to the realization of their rights.
- Inherited social and cultural traditions, particularly in rural areas, deprive women of their human rights.
- All countries noted the critical gap pertaining to the SRH needs of adolescents, who constitute a major proportion of the populations in the Arab region.
- Cultural taboos are a major obstacle to informed discussions about SRH issues, particularly for young people.

XI.3 Gaps in Implementation

- Despite progress in closing many health and development gaps in the Arab countries reviewed, urban/rural as well as regional disparities remain a great challenge.
- SRH services for young people are generally not well integrated into existing PHC services in all countries.
- The lack of a solid statistical basis and the lack of a clear policy on systematic monitoring of GBV in all countries make it difficult to assess the appropriateness and scale of the response (although some are more advanced than others). The service component so far is patchy and largely provided on a small scale by NGOs. Furthermore, the underreporting of cases due to stigma or women's economic dependence on men jeopardizes the care and support of victims of GBV.
- Maternal death surveillance is in urgent need of improvement, and countries with deficient reporting and documentation should mandate reporting of maternal deaths and establish mechanisms to review causes of death.
- In most countries, vulnerable populations (including women without health insurance, women with disabilities, nomads, and women under armed conflict) lack full access to SRH services. Moreover, the needs of these vulnerable groups are not fully understood.
- None of the countries under review have national policies to increase men's access to SRH, although some micro-level initiatives are in place to further engage men.
- Many countries continue to have stigmatizing views in their policies with respect to people living with HIV/AIDS. Legislation in the region allowing dismissal from employment and deportation of HIV-positive workers contravenes universal standards on the protection of the rights of people living with HIV.
- The private sector of the countries under review (especially

Lebanon, Jordan, and to a lesser extent Syria) provides a large proportion of SRH services, but they are not well integrated with public health services, nor are they adequately regulated. This is particularly the case in fields such as infertility treatment.

- Though the provision of contraceptive information and services was found to be acceptable in most countries, it was clear that it does not satisfy the requirements of proper provision as per the ICPD.
- None of the countries reported full integration of SRH and HIV services.
- None of the countries reported implementing comprehensive sexuality education; even where curricula exist, teachers are not sufficiently trained and implementation is weak.
- Both poverty and illiteracy were cited as the main barriers to proper access to SRH services, especially in Tunisia, and Syria. Large out-of-pocket expenditures on SRH care are a critical constraint to access.

XII. A Way Forward – Recommendations for Action

Based on preliminary findings from this mapping exercise of SRHR policies in the Arab world, for the full attainment of SRHR and as is consistent with the ICPD's PoA, the following recommendations for action are made for specific parties.

Countries/governments:

- Arab countries should bring laws and regulations that affect SRH into alignment with human rights laws and standards. Special focus should be devoted to gender equity, personal and family status, adolescents, child marriage, and GBV, according to each country's laws, regulations, and culture.
- Arab countries should remove all legal and regulatory barriers to services. Special focus should be devoted to GBV, HIV, and the prevention of unwanted pregnancy according to each country's laws, regulations, and culture.
- An in-depth review of the criminal law/penal code in all countries is needed to ensure that the law is properly used and in alignment with improved SRHR. This review should consider available data on the prevalence and burden of SRH problems within each country. Specific attention should be paid to the need for the decriminalization of access to and the provision of acceptable family planning methods or access to information and services as needed. The appropriateness of criminal law provisions on rape and honor killings should be considered after a review of the relevant legislation.
- RH services, although noticeably better in all Arab countries, still need improvement to guarantee privacy, confidentiality, and informed decision-making, and, importantly, to guarantee the quality of services.
- Sexual health services are still stigmatized in many settings of the Arab world. All efforts should thus be made to advance the agenda of sexual health as per the ICPD definition and in accordance with cultural norms and national legislations.
- Access to information and education relating to sexuality and sexual health including comprehensive sexuality education is

essential to enable people to protect their health and make informed decisions about their sexual and reproductive lives.

- Arab countries should continue to consider lifting any remaining reservations to CEDAW, according to each country's laws, regulations, and culture.
- All countries should review their national strategies on population, youth, women, and SRH to ensure that they respect the human rights principles to which these countries have committed.

Regional and international partners:

- Regional and international partners should work closely with countries to assist in creating or fostering alignment with international treaties according to each country's laws, regulations, and culture.
- All opportunities should be pursued to ensure mechanisms through which regional and international charters are respected and implemented within the cultural contexts of each country.
- Cooperative policies between countries, local partners, and international partners should be developed.

Civil society:

- The strong work of civil society in many Arab countries must continue and should be encouraged.
- Partnerships with CSOs that are able to supplement decision makers with programs and measures that advance women's status should be developed to fully implement international commitments.
- Regional networking of CSOs working on SRHR should be strengthened given cultural and linguistic commonalities across the region.
- CSOs should continue to launch advocacy campaigns using evidence from public health research to advocate for the change national laws that impede the advancement of SRH, considering each country's laws and policies.
- CSOs should expand their legal and health aid services for women.
- CSOs should assist in educating women about their rights.
- CSOs should partner with the broader community, specifically religious leaders.

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Annex 1: Guidance on the Mapping Exercise

Mapping the Sexual and Reproductive Health and Rights Policies in the Arab World

Guidance on the mapping exercise

Background

Sexual and Reproductive Health and Rights (SRHR) encompasses the right of all individuals to make decisions concerning their sexual activity and reproduction free from discrimination, coercion, and violence.

Laws and policies within the health sector as well as other related sectors can provide the supporting environment for achieving the preferred outcomes related to sexual and reproductive health and rights. On the other hand, laws and policies that are not evidence-based can also be obstacles to the achievement of sexual reproductive health and rights.

MENA-HPF is undertaking this exercise of mapping laws and policies with regards to the sexual and reproductive health and rights in the Arab World. This exercise is supported by MENA-HPF and UNFPA and it is planned to be carried out in ten Arab countries.

Aim and Objective

This exercise will equip policy makers and national partners with evidence and tools for formulation of rights based policies for integrated sexual and reproductive health services.

The objective of this exercise is to identify all policies, supporting laws and articles in constitutions in relation to integrated sexual and reproductive health in your country.

The expected output

A national report is the main outcome excepted from national consultants in the different countries. The report should summarize the output from the mapping tool as well as a list of recommendations.

At a regional level, a report will then compile the outputs from all national reports and it will be extensively discussed and disseminated in a regional meeting planned by MENA-HPF.

Mapping Approach

The exercise should be mainly based on a search, retrieval and review of available documents, published or unpublished. Any

written and electronic sources as well as websites can help in this exercise. It is also useful to benefit from Key informant at the national levels however no formal interviews with key informants is needed , otherwise the data collection tool should be reviewed by institutional review boards and this is not our aim.

The tool

To structure the data collection process, we attach the following tool for this exercise. The structured the tool has space for individual consultants to add to it based on their setting and expertise.

Who can help?

The following resource persons can be of help: lawyers, academicians, Ministry of health personnel, personnel as national and international organizations of relevance.

The timeline

National reports should be ready by end of July 2015, while the regional report should be ready by end of September 2015.

The main definitions

For the purposes of this exercise, we are adopting the following terms:

Sexual and Reproductive Health

A per the ICPD Programme of Action, reproductive and sexual health care in the context of primary health care include:

Family planning;

Antenatal, safe delivery and post-natal care;

Prevention and appropriate treatment of infertility;

Prevention of abortion and management of the consequences of abortion;

Treatment of reproductive tract infections;

Prevention, care and treatment of STIs and HIV/AIDS;

Information, education and counselling, as appropriate, on human sexuality and reproductive health;

Prevention and surveillance of violence against women, care for survivors of violence and other actions to eliminate traditional harmful practices, such as FGM/C;

Appropriate referrals for further diagnosis and management of the above.

Reproductive rights

As suggested by the Reproductive Rights monitoring tool published by UNFPA, reproductive rights issues include the following:

freedom from discrimination

contraceptive information and services

safe pregnancy and childbirth (mm and em)

abortion and post-abortion care

comprehensive sexuality education

freedom from violence against women

HIV/AIDS

Health policy

As per the WHO, health policy refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society. An explicit health policy can achieve several things: it defines a vision for the future, which in turn helps to establish targets and points of reference for the short and medium term. It outlines priorities and the expected roles of different groups; and it builds consensus and informs people.

Health law

Health law focuses on the legislative, executive, and judicial rules and regulations that govern the health.

Useful resources

The following resources were consulted for this exercise, and serve as useful resources for national consultants:

Center for Reproductive Rights. Reproductive Rights: A Tool for Monitoring State Obligations.

Cottingham J et al. Using human rights for sexual and reproductive health: improving legal and regulatory frameworks. Bull World Health Organ 2010;88:551–555

EngenderHealth, GNP+, ICW, IPPF, UNAIDS, Young Positives. Advancing the Sexual and Reproductive Health and Human Rights of People Living With HIV: A Guidance Package. Amsterdam, GNP+.2009

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UN. Reproductive rights are human rights: A handbook for national human rights institutions. 2011.

Universal Access Project. Briefing Cards: Sexual and Reproductive Health and Rights (SRHR) and the Post-2015 Development Agenda

Annex 2: The Mapping Tool

Mapping the Sexual and Reproductive Health and Rights policies in the Arab World

Mapping Tool

Section 1: Identification

1.1. Name of the Country	
1.2. Name of the Consultant	
1.3. Date completed:	

Section 2: National Legal Framework

2.A. Constitution and Human Rights of relevance to reproductive rights
Please fill in the following table based on proper screening of the Country's constitution.

2.A.1. Date of Constitution	
2.A.2. Does the Constitution have a special chapter on human rights?	1) Yes 2) No 3) Not sure
2.A.3. Does the Constitution have a special reference to the Right to Life?	1) Yes 2) No 3) Not sure
2.A.4. Does the Constitution have a special reference to the Right to Liberty and Security of the person?	1) Yes 2) No 3) Not sure
2.A.5. Does the Constitution have a special reference to the Right to Health?	1) Yes 2) No 3) Not sure
2.A.6. Does the Constitution have a special reference to the Right to decide the number and spacing of children?	1) Yes 2) No 3) Not sure
2.A.7. Does the Constitution have a special reference to the Right to consent to marriage and Equality of marriage?	1) Yes 2) No 3) Not sure
2.A.8. Does the Constitution have a special reference to the Right to privacy?	1) Yes 2) No 3) Not sure
2.A.9. Does the Constitution have a special reference to the Right to equality and non-discrimination?	1) Yes 2) No 3) Not sure
2.A.10. Does the Constitution have a special reference to the Right to be free from practices that harm women and girls?	1) Yes 2) No 3) Not sure
2.A.11. Does the Constitution have a special reference to the Right to free from torture or other cruel, inhuman, or degrading treatment of punishment?	1) Yes 2) No 3) Not sure
2.A.12. Does the Constitution have a special reference to the Right to be free from sexual and gender-based violence?	1) Yes 2) No 3) Not sure
2.A.13. Does the Constitution have a special reference to the Right to Education and information?	1) Yes 2) No 3) Not sure
2.A.14. Does the Constitution have a special reference to the Right to enjoy the benefits of scientific progress?	1) Yes 2) No 3) Not sure

2.B. National legislation
Please fill in the following table based on a proper review of all national laws of relevance to sexual and reproductive health and rights (SRHR)

2.B.1.Name those legal documents you reviewed as being the main source of National legislation of relevance to SRHR	…… …… …… ……	
Item:	1) Yes 2) No 3)Not sure	Short description (date, number, summary)
2.B.1. Does the national law recognize equity of rights and protects from discrimination based on gender?		
2.B.2. Does the national law ensure equal treatment and freedom from discrimination in the context of SRHR?		
2.B.3. Does the national law protect women against gender based violence?		
2.B.4. Does the national law protect women against rape?		
2.B.5. Does the national law protect women against female genital mutilation?		
2.B.6. Does the national law prohibit early marriage (Marriage of under 18 years)?		
2.B.7. Does the national law protect women against human trafficking for sexual exploitation?		
2.B.8. Does the national law prohibit discrimination on sexual identity?		
2.B.9. Does the national law criminalize abortion?		
2.B.10. Does the national law recognize the right to choose the number and spacing of children?		
2.B.11. Does the national law enforce the notification of maternal death?		

2.C. National strategies and institutions of relevance to SRHR
Please fill in the following table based on a proper review of all national strategies and institutions of relevance to sexual and reproductive health and rights (SRHR)

	1) Yes 2) No 3) Not sure	Short description (date, body responsible, items of relevance)
2.C.1. Does the country have a national strategy for Sexual and Reproductive Health and Rights?		
2.C.2. Does the country have a national strategy for women?		
2.C.3. Does the country have a national strategy for adolescents/youth?		
2.C.4. Does the country have a national strategy for population?		
2.C.5. Does the country have a special body/institution to deal with women needs/issues?		
2.C.6. Does the country have a special body/institution to deal with youth needs/issues?		
2.C.7. Does the country have a special body/institution to deal with population needs/issues?		
2.C.8. Does the country have a special body/institution to deal with development needs/issues?		

Section 3: International conventions/mechanisms
Please fill in the following table based on a proper review of all international mechanism in the country

	1) Yes 2) No 3) Not sure	(date of ratification /signature)	Responsible body	Implementation summary
3.1. Has the country signed the Universal Declaration of Human Rights?				
3.2. Has the country signed the Millennium declaration?				
3.3. Has the country signed Declaration of the right to development?				
3.4. Has the country signed Declaration of commitment on HIV/AIDS?				
3.5. Has the country ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) ?				
3.6. Has the country ratified the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment?				
3.7. Has the country ratified the Convention on the Elimination of All Forms of Racial Discrimination)?				
3.8. Has the country ratified the Convention on the Rights of the Child (CRC) ?				
3.9. Has the country ratified the Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families?				
3.10. Has the country ratified the Convention on the Rights of Persons with Disabilities?				
3.11. Has the country ratified the Covenant on Civil and Political Rights?				
3.12. Has the country ratified the Covenant on Economic, Social and Cultural Rights?				
3.13. Has the country committed to the plan of action of the International Conference on Population and Development (ICPD) of 1994?				
3.14. Has the country committed to the plan of action of Beijing's conference (1995)?				

Section 4: National health policies/plans addressing ICPD issues
Please fill in the following table based on a proper review and analysis on the health plans in the country

	1) Yes 2) No 3) Not sure	List those policies	Short description
4.1. Does the country have special plans/policies on the family planning?			
4.2. Does the country have special plans/policies on antenatal, safe delivery and post-natal care?			
4.3. Does the country has special plans/policies on the prevention and appropriate treatment of infertility?			
4.4. Does the country have special plans/policies on the prevention of abortion and management of the consequences of abortion?			
4.5. Does the country have special plans/policies on the treatment of reproductive tract infections?			
4.6. Does the country have special plans/policies on the Prevention, care and treatment of sexually transmitted infections (STIs) and HIV/AIDS?			
4.7. Does the country have special plans/policies on the information, education and counselling, as appropriate, on human sexuality and reproductive health?			
4.8. Does the country have special plans/policies on the prevention and surveillance of violence against women, care for survivors of violence and other actions to eliminate traditional harmful practices, such as FGM?			
4.9. Does the country have special plans/policies on the appropriate referrals for further diagnosis and management of the above?			

Section 5: Detailed list of issues regarding SRHR

5.A. Detailed list of ICPD related policies regarding SRHR

Please fill in the following table based on a proper screening of all the health plans and polices in the country

Item:	1) Yes 2) No 3) Not sure	Name the policy/ plan	Implementation body/bodies	Implementation body and Summary
5.A.1. Increasing women's accessibility to information and counselling on sexual and reproductive health				
5.A.2.. Increasing women's access to comprehensive sexual and reproductive health services, regardless of marital status and age				
5.A.3. Increasing indigenous people's and cultural minorities' access to comprehensive sexual and reproductive health services, regardless of marital status and age, including access to contraception				
5.A.4. Increasing access of persons with disability to comprehensive sexual and reproductive health services, regardless of marital status and age, including access to contraception				
5.A.5. Increasing men's access to sexual and reproductive health information, counselling, and services				
5.A.6. Provision of adequate food and nutrition to pregnant women (including nutrition supplementation)				
5.A.7. Referrals to essential and comprehensive emergency obstetric care (EmOC)				
5.A.8. Access to antenatal care				
5.A.9. Increasing access to comprehensive sexual and reproductive health services for adolescents				
5.A.10. Providing social protection and medical support for adolescent pregnant women				
5.A.11. Increasing access to STI/HIV prevention, treatment and care services for vulnerable population groups and populations at risk				
5.A.12. Increasing access to voluntary and confidential HIV testing				
5.A.13. Eliminating mother-to-child transmission of HIV and treatment for improving the life expectancy of HIV-positive mothers				
5.A.14. Integration of SRH and HIV services				
5.A.15. Breast cancer screening and treatment				
5.A.16. Prevention and management of the consequences of unsafe abortion				
5.A.17. Cervical cancer screening and treatment				
5.A.18. Access to safe abortion services to the extent of the law				
5.A.19. Others, specify				

5.B. Detailed Issues in the provision of contraceptive information and services

Please fill in the following table based on a proper screening of the health plans and polices regarding contraceptive information and services in the country

Item:	1) Yes 2) No 3) Not sure	Name the policy/ plan	Short description
5.B.1. Is access to comprehensive contraceptive information and services provided equally to everyone voluntarily, free of discrimination, coercion or violence (based on individual choice)?			
5.B.2. Are comprehensive contraceptive information and services provided to all segments of the population?			
5.B.3. Are contraceptive commodities, supplies and equipment, covering a rangeof methods, including emergency contraception, integrated within the essential medicine supply chain to increase availability. Invest in strengthening the supply chain where necessary in order to help ensure availability?			
5.B.4. Does the country provide scientifically accurate and comprehensive sexuality education programmes within and outside of schools that include information on contraceptive use and acquisition?			
5.B.5. Are there any efforts to eliminating financial barriers to contraceptive use by marginalized populations including adolescents and the poor, and make contraceptives affordable to all?			
5.B.6. Are there any interventions to improve access to comprehensive contraceptive information and services for users and potential users with difficulties in accessing services?			
5.B.7. Are there any special efforts be made to provide comprehensive contraceptive information and services to displaced populations?			
5.B.8. Are the contraceptive information and services, provided as a part of sexual and reproductive health services, be offered within HIV testing, treatment and care provided in the health-care setting?			
5.B.8. Are the comprehensive contraceptive information and services provided during antenatal and postpartum care?			
5.B.9. Are the comprehensive contraceptive information and services routinely integrated with abortion and post-abortion care?			
5.B.10. Are mobile outreach services used to improve access to contraceptive information and services for populations who face geographical barriers to access?			
5.B.11. Is there a need for spousal authorization for individuals/women accessing contraceptive and related information and services?			
5.B.12. Are sexual and reproductive health services, including contraceptive information and services provided to adolescents without mandatory parental and guardian authorization?			

5.B.13. Does the country provide gender-sensitive counselling and educational interventions on family planning and contraceptives that are based on accurate information?			
5.B.14. Are follow-up services for management of contraceptive side-effects prioritized as an essential component of all contraceptive service delivery?			
5.B.15. Are quality assurance processes, including medical standards of care and client feedback, incorporated routinely into contraceptive programmes?			
5.B.16. Are there ongoing competency-based training and supervision of health-care personnel on the delivery of contraceptive education, information and services?			
5.B.17. Are evidence-based, comprehensive contraceptive information, education and counselling to ensure informed choice provided?			
5.B.18. Are individuals ensured an opportunity to make an informed choice for their own use of modern contraception without discrimination?			
5.B.19. Are privacy of individuals respected throughout the provision of contraceptive information and services, including confidentiality of medical and other personal information?			
5.B.20. Are communities, particularly people directly affected, have the opportunity to be meaningfully engaged in all aspects of contraceptive programme and policy design, implementation and monitoring?			
5.B.21. Are effective accountability mechanisms in place and are accessible in the delivery of contraceptive information and services, including monitoring and evaluation, and remedies and redress, at the individual and systems levels?			
5.B.22. Are evaluation and monitoring of all programmes to ensure the highest quality of services and respect for human rights occur?			
I5.B.23. Is there a system of checks and balances in place that assure accountability			

Section 6: Policy issues of potential impact on SRHR
Please fill in the following table based on a proper analysis of the existence and relevance of the listed policy issues

	1) Yes 2) No 3) Not sure	Short description	Relevance to SRHR
6.1. Integration of health services			
6.2. Decentralization of services			
6.3. Policy reform process within the health sector			
6.4. Public-private mix in terms of the provision of services			
6.5. Financial reform of the health sector among others			
6.6. Capacity building policies of the health personnel			
6.7. Medical insurance			
6.8. Quality assurance of health services			
6.9. Others; please name			

Section 7: Overall evaluation of the policies
Please fill in the following table based on a proper analysis of the existence and relevance of the listed policy issues
On a scale of 1 (very bad) to 10 (very good), please score the main policies addressing SRHR that you screened based on your own reflections and judgment

Name of Policy	Accessibility score	Policy background score	Goals Score	Resources Score	Monitoring and evaluation Score	Public opportunities Score	Obligations Score
7.1.							
7.2.							
7.3.							
7.4.							
Etc.							

Section 8: Main gaps identified
Please address here the main gaps and barriers you noted in the review process of all policies you reviewed

Name of Policy	Main gaps	Main barriers
8.1.		
8.2.		
8.3.		
8.4.		
Etc.		

Section 9: Comments section
Please address any other issues you feel relevant to this mapping exercise based on your setting and expertise.
