Impact of Gender Inequality on the Health Status of Women in the Middle East: A Systematic Literature Review

Lillian Russo

HPRB 5410W

Dr. Walters

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Research Question

How does gender inequality affect women's access to health care in the Middle East?

Abstract

The objective of this systematic literature review is to evaluate the influence that gender inequality has on developing barriers to quality health care for Middle Eastern women. Middle Eastern countries suffer the greatest gaps in gender equality, which has led to the development of worse health outcomes for women in those areas. Previous studies have discussed gender disparities and women's health as separate issues, but the aim of this article is to show the correlation between the two. The databases PubMed, Global Health, and Google Scholar were used to conduct an organized search of peer-reviewed articles that discussed the impact of gender discrimination on health indicators for women. The four barriers found to affect the health of Middle Eastern women included: financial dependence/lack of financial autonomy, delay in seeking medical care, implementation of governing policies, and lack of access to health resources in a community. Other factors contributing to these barriers included the implementation of traditional gender roles by the husband, acts of violence against women, and education opportunities given for women. Suggested solutions to these barriers included increased education for men about the importance of gender equality, interventions that decrease the number of responsibilities given to the wife/mother, and the development of female-only exercise facilities. Improved gender equity is the most powerful way to reduce health inequities for all individuals.

Introduction

The fight for gender equality and the empowerment of women has been a global battle that affects the health of all individuals, both men and women alike. Middle Eastern countries suffer the greatest gaps in gender equality, which has led to the development of worse health outcomes for women in those areas (Schwab, 2013). The countries represented in the geographic region of the Middle East, and that were

reported on in this study, included Algeria, Bahrain, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morrocco, Oman, Palestine, Qatar, Saudi Arabia, Syria, Tunisia, United Arab Emirates, and Yemen (Schwab, 2013). According to the 2013 Global Gender Gap Index, of the eighteen countries previously mentioned, fourteen of them were included in a worldwide analysis researching the significance and extent of the gender-based disparities seen around the globe. This report measured gender gaps present in several sectors of influence, including economic opportunities, educational attainment, health status, and political involvement. Of the Middle Eastern countries represented, all fourteen were ranked among the lowest thirty countries for having the most significant gaps in gender equality (Schwab, 2013).

There is a greater decrease in the quality of life and health status of women in nations that possess higher rates of gender inequality than in westernized countries that promote gender autonomy and independence (Enjezab, Farajzadegan, Taleghani, & Aflatoonian, 2014). One study compared countries with greater discrimination towards females to countries with fewer gender disparities and reported that the life expectancy of women in the Middle East is 59-65 years, while female life expectancy in Ireland, Norway and Sweden is 73-75 years. Many women in developing countries, such as those in the Middle East, suffer from preventable health conditions in their final years of life, such as metabolic and cardiovascular diseases, which contribute to their overall decreased life expectancy (Enjezab et al., 2014). Another health indicator that served as a representation of decreased health quality for women in the Middle East, is the disproportionate amount of disability-adjusted life years (DALYs) lost. Increased rates of depression among adolescent Arab women contributed to an increased proportion of disability-adjusted life years (DALYs) lost to mental illness for adolescent girls over their male counterparts (Obermeyer, Bott, & Sassine, 2015). Middle Eastern women also face higher rates of physical inactivity and obesity, which contributes to low health status. This is important because maintenance of healthy eating and exercise prevents many chronic diseases in adulthood (Musaiger et al., 2013). Achieving gender equality is essential in improving the health of women in underdeveloped countries, including many nations in the Middle East.

The disproportionate rates of preventable diseases amongst females in the Middle East prompted the exploration into the barriers that discouraged these women from acquiring positive health behaviors. There are multiple barriers that prevent women from obtaining the proper health care that they need, and many of these health issues stem from the degrading view of women within these societies. Previous studies have separately discussed the affects of gender inequality on a nation, as well as the trends of decreased health status for women in the Middle East, but there is little research on what specific barriers to health prevent an increased quality of life for women, as a direct result of gender inequality.

The purpose of this paper is to address the specific barriers that gender inequality introduces which negatively impact access to a healthy lifestyle for women in the Middle East. The purpose and aims of the systematic review focused on defining the barriers to health caused by gender discrimination, suggested practices for addressing those barriers, and auspicious improvements that have been previously found to bring positive outcomes.

Methods

Search Strategy

An organized search was conducted to find peer-reviewed articles that discussed gender inequality and women's health published within the last sixteen years. The databases used to search for the articles incorporated in this literary review included PubMed, Global Health, and Google Scholar, and used the following key terms: gender inequality, health access, medical care, Middle East, and Arab nations. The criterion for selected articles began broad and included articles from countries both in the Middle East and North Africa. This resulted in an exorbitant amount of information that varied in content and could not to be summarized in a cohesive manner. The search criteria was narrowed down to including specific countries in the Middle East that were previously established, and only incorporated research that resulted in the negative health outcomes for women alone, not men. Articles that attributed the decreased health status of women to criteria other than gender inequality were excluded. Eligible

literature could include studies that sampled women from all ages, education levels, marital states, and religious beliefs.

Results

Of the 24 articles that were evaluated, 10 were included in the literary review. Specific details about articles reviewed can be found in Table 1.

Barriers to health

Of the articles that were reviewed, four common themes emerged that illustrated the contribution of gender discrimination to negative health outcomes for women. These four barriers included: financial dependence/lack of financial autonomy, delay in seeking medical care, governing policies, and lack of access to health resources in a community.

Financial dependence

A study done in Afghanistan reported a 70% loss in productive development of the country due to the restrictions set on women's education, financial opportunities, and low health outcomes (Samar et al., 2014). Opportunities for women in the labor field are dismal in the Middle Eastern countries. Female labor participation is 26% in the Middle East, compared to the global average of 51% (Obermeyer et al., 2015). Due to the inability for women to obtain a proper, well-paying job, they are forced to be financially dependent on their husbands. Because women often do not have their own independent source of income, they rely on the finances of their husbands in order to receive any health care. If the husband is not available or if he decides that the medical treatment is not necessary, then the women must go untreated (Enjezab et al., 2014). When experienced serious medical issues, 77% of Afghani women reported not having the financial means to access adequate health care services (Samar et al., 2014). When comparing the unemployment rates of Middle Eastern immigrant women to men, they were 56.07% to 26.91% respectively (Read & Reynolds, 2012). Women who lacked financial independence chose to put off seeking care due to high costs and endangered their health by forgoing important procedures (Enjezab et al., 2014).

Delay in seeking care

Multiple reasons for why women postponed the acquisition of medical care were discovered, including the designation of traditional/conservative gender roles on women and the inability travel outside the home without a male escort. Traditional gender roles institutionalized the obedience of a wife to her husband in every aspect of life. There was a common understanding that men were the head of the household and had complete control over every decision made for the family. More than 50% of both men and women agreed that a man had the right to physically abuse his wife if she did not obey him (Amowitz, Kim, Reis, Asher, & Iacopino, 2004). The dominance of the husband's will in the family automatically placed women in a position of subordination and dependence, excluding them from all decision making and limiting their access and control over resources. Women saw personal health, healthy dieting, and regular exercise as things of little value without their husbands' approval (Enjezab et al., 2014). In a study done by *BMC Women's Health*, they reported that of women experiencing urinary incontinence, 80% refused to consult a medical physician. When women who developed urinary incontinence (UI) brought the issue to their husbands, 77.3% said their spouses did not think seeking medical care was a good idea (El-Azab & Shaaban, 2010). The husband held ultimate influence when it came to the preferences of the household, which kept many women from seeking the health procedures and consultations that they needed. Women were expected to not complain about personal hardships and were forced into silence when they had a health problem, because they did not want to burden their husband or family (Dejong, Bahubaishi, & Attal, 2012).

The only situation that created a dynamic shift in power and gave the full authority from the husband to the wife was during childbirth. According to a study with 220 Yemen women, participants reported being reluctant to seek medical assistance during pregnancy because it was a rare instance in which the male would serve the female in order to make sure his future child was safe. During childbirth, women reported had full authority over the decisions made in the house, and they wanted to stay in that environment for as long as possible, even if it put their own health at risk (Kempe, Theorell, Noor-Aldin Alwazer, Christensson, & Johansson, 2013).

Traditional gender roles also required that women fulfill multiple responsibilities forced on them by their husbands. In Iran, tasks that were placed on the women of the house included performing all household chores, caring for family members, managing out-of-home employment, and/or working at home to help the family economy. Many Middle Eastern women were also expected to prioritize the health of their children over their own personal health at all times. These conflicting requirements gave women less time to think of their own personal health behaviors and decisions (Enjezab et al., 2014)).

Women's inaccessibility to travel outside the house alone also contributes to a delay in seeking necessary medical care. *Mehram* is a cultural practice that is custom in many Middle Eastern countries in which women are required to have a male escort with them to go outside the house or to travel to the city (Samar et al., 2014). In Afghanistan, one-third of women reported not seeking medical care due to lack of escort to take them to see a physician, while 16% of women reported inability to receive permission from husband to visit health facility (Samar et al., 2014).

Governing policies

Gender inequality has infiltrated Iran's political systems for centuries. From 1501-1722, the Safavid dynasty ruled Iran and appointed Shi'a Islam as the official religion of the country. After the 1979 revolution in Iran, the government developed into an authoritarian state that was systematically infiltrated by religion and non-elected institutions. Conservative leaders rose to power and did not view equality between man and woman as something divine. The idea of democracy and equality had vanished and the country began experiencing an era of discrimination towards minorities. Authoritative figures have done away with true Shi'a principles and turned towards a more conservative and radical view of Islam that negatively disrupts their policies on gender equality. This showed that the main barriers to equality had to do with a lack of democracy within in government, rather than a discourse between religion and social justice issues (Hoodfar & Sadr, 2010).

In many Arab states, the was an absence of laws that protected women from spousal abuse, spousal rape, and honor killings, which created obstacles to gaining autonomy and seeking medical care (Kelly & Breslin, 2010) (Obermeyer et al., 2015). Historically, authoritative figures in Middle Eastern

governmental systems have codified gender discrimination and have legalized unjust access to resources and opportunities for women (Obermeyer et al., 2015).

Lack of access to health resources in community

Inaccessibility of proper health resources for women in their communities was largely due to stigmas around women exercising, violence affecting safety, and lack of education.

In many Arab states, there was less recreational space for women to be physically active than their male counterparts, and women were sometimes prohibited from wearing sports clothing or exercising outdoors due to religious and safety reasons (Obermeyer et al., 2015). In Bahrain, 67% of women viewed the excess provision of sports facilities for men and lack of recreational areas for women as a form of sex discrimination. Many Middle Eastern communities stigmatized physical activity for women and viewed female exercise in a negative light. 24% of women reported that these negative social concepts prevented them from being physically active (Musaiger et al., 2013). Exercise and sports clothes were considered not socially appropriate items to wear in public. Women were permitted to exercise in their traditional dress, which is was made of much heavier material and physically harder to move in, and therefore discouraged girls from being physically active (Musaiger et al., 2013). In Iran, there were few places for women to exercise in private. Because of the cultural divide between men and women, women were less comfortable and more insecure exercising in front of their male counterparts. Their limitations on private space, separate from men while exercising prevented women from seeking healthy behaviors (Enjezab et al., 2014). Rates of hypertension were higher in Middle Eastern immigrant women, with 19.63% being diagnosed compared to 13.03% of men. This disparity could be the result of fewer opportunities for women to get physical exercise (Read & Reynolds, 2012).

Violence against women not only harms their health at the moment of the abuse, but also affects their long-term mental state and can deter them from veering into any sort of autonomy. Thus, preventing them from seeking medical care when necessary due to fear of abuse or assault. Iraq saw a dramatic increase in rates of gender-based community violence towards women, including honor killings, rapes, and kidnappings, which forced most women to stay in their homes (Kelly & Breslin, 2010). In southern

Iraq, there is a high prevalence of human rights abuses. Human rights abuses were defined as including torture, killings, disappearances, forced conscription, beatings, gunshot wounds, hostage taking, and forced ear amputations. In a study that measured the prevalence of human rights abuses in southern Iraq, 47% of those interviewed reported one or more human rights abuses committed on themselves or others in their household. Also, domestic violence rates were nearly seven-times the rate of the United States (Amowitz et al., 2004). In Afghanistan, 7.2% of women in reported receiving some form of physical, sexual, or mental mistreatment in their household, and 40% of women reported being hit by their husbands within the last month (Samar et al., 2014). A survey given in the town of Marivan, Iran reported that 32.9% of women experienced sexual intimate partner violence (Sohrabizadeh, 2016).

Usually, there are increased rates of domestic and sexual violence during and after a country has experienced a period of tragedy or misfortune. War was rampant in many countries in the Middle East, which also explained why rates of violence against women (VAW) are so high in this region. These situations threatened the security and well-being of women in these communities and put them at higher risk of assault (Sohrabizadeh, 2016). A sense of insecurity was reported by one-third of women as being their primary reason for not seeking healthy behavior choices or seeking necessary care from a physician (Samar et al., 2014). Also, high rates of physical, psychological, and sexual abuse of Lebanese women led to negative impacts on their mental, reproductive, and overall health (Usta, Farver, & Hamieh, 2016).

The lack of education and schooling opportunities for women in the Middle East affected their knowledge about healthy foods and diagnosis of medical problems. Women's lack of understanding of nutritious meals impacted the types of food they cooked for their families. This resulted in meals consisting of increased carbohydrates and fats, leading to an increase in prevalence of non-communicable diseases ((Farahmand, Tehrani, Amiri, & Azizi, 2012). Education level also affected women's knowledge of specific medical problems and misunderstanding of appropriate measures to take health emergencies. In a study done on Afghani women, 10% reported they were unaware of where to go when they or their family was sick (Samar et al., 2014). In another study evaluating the barriers to seeking consultation for a urinary inconsistence (UI), 46.7% of women viewed their UI as a normal part of life and did not realize

the medical implications, and 15.8% believed the issue would resolve itself (El-Azab & Shaaban, 2010). A need was seen among Middle Eastern women for increased education on specific medical issues, such as knowing preventative measures to take for sicknesses, how to spot problematic symptoms, and understanding appropriate treatment for basic illnesses.

Suggested practices for addressing barriers

Along with reporting the barriers that were previously established, many articles also included suggested practices for addressing the issues around women's health that stemmed from gender inequality in the Middle East. According to an article done by the *Journal of Biosocial Science*, interventions in the Middle East should focus on not only improvements in the education of women, but should primarily look at educating the public, and especially men. They suggested the integration of a program that is focused on eliminating discriminatory views of women that were held by Middle Eastern men. This practice would quell patriarchal tendencies and accelerate achievements in the fields of women's health and gender equality (Enjezab et al., 2014). Another solution that was suggested centered on the reduction of responsibilities given to the mother/wife and the transformation of the societal meaning of "traditional gender roles" within a family. The prevention program focused the idea that less children would equate to less responsibilities for the mother. The article said an intervention could be established that focused on reducing unplanned pregnancies and increasing contraceptive use (Enjezab et al., 2014).

One suggestion discussed benefits of developing exercise facilities that would be for women-only and closed off to the public. This would give the women the privacy they desired, and would also increase physical activity among Middle Eastern women and decrease rates of obesity and chronic, non-communicable diseases (Musaiger et al., 2013).

Promising Improvements

Although many countries in the Middle East still need to make substantial improvements in order to close their gender gaps, some states have made progress in improving the health and opportunities available for women. For instance, Iraq's government has established a new quota system that requires a minimum of 25% of seats in parliament be held by women (Kelly & Breslin, 2010). In Afghanistan, after

the fall of the Taliban in 2001, the government established the Ministry of Women's Affairs (MoWA), which held a significant position in decreasing the gaps in opportunities for women and helped normalize gender equality in Afghanistan (Samar et al., 2014). Also, in recent decades, the Arab Middle East has increased educational opportunities for girls and increased the rate of female school enrolment three-fold since 1990 (Obermeyer et al., 2015). These advancements are positive indicators that improvements in gender equality are occurring and a hopeful desire to see an increase in the health status of Middle Eastern women who have been discriminated against for too long.

Discussion

Purpose/Aims

This systematic literature review evaluated the influence that gender inequality and lack of female empowerment has on the production of barriers for women to receiving quality health care in the Middle East. My goal was to link together the cause and the effect, tracking the increased rate of gender discrimination to the decreased health indicators for Middle Eastern women. The collection and analysis of 10 peer-review articles that met the selection criteria helped me to establish the missing part of the equation: the barriers. Through the research, I saw a natural progression of institutionalized gender inequality leading to barriers for women that resulted in lower health outcomes. The barriers that were discussed as a result of gender disparities included the financial dependence of women on their spouses, the delay in seeking medical care, the assimilation of traditional gender roles, the enactment of undemocratic governing policies, and the lack of access to public health resources for Middle Eastern women.

Broad overview of findings

The lack of financial autonomy for women was evident in the report that stated the disparity of women's labor participation in the Middle East when compared to the global average. The percent of women working in the Arab states is half that of the global average of female labor participation

(Obermeyer et al., 2015). The lack of job opportunities for women results in higher rates of poverty, which is another contributing factor to poor health (Enjezab et al., 2014). The effects of financial reliance by the wife on her husband continue the cycle of dependence and relinquishing of autonomy by the woman.

The postponing or foregoing of important medical procedures is the result of other contributing factors, such as the implication of traditional gender roles in the house, increased responsibilities given to the wife, and the need for women to receive permission to travel outside of the home. Putting women in a traditionalized, conservative role such as a caregiver, chore completer, or at-home employer, restricts their movements to the home, thus placing them a subordinate position at all times (Enjezab et al., 2014). In addition, according to the practice of Mehram, many Muslim women cannot leave the house with out a male escort (Samar et al., 2014). This perpetuates women's internalization that they are unable to complete tasks on their own, outside of their wifely duties, which keeps them from seeking proper health procedures and consultations that they need (Enjezab et al., 2014).

The historical implementation of authoritative, non-democratic policies by fundamentalist governmental figures in the past (Hoodfar & Sadr, 2010), has allowed for many Middle Eastern countries to be entrenched with policies allowing gender discrimination (Obermeyer et al., 2015)). Few Middle Eastern countries have policies that protect women from domestic violence or community violence. This lack of legal and physical protection for Middle Eastern women constructs a fear of insecurity and safety in them that can be debilitating.

The disparities between access to health services and recreational areas for men versus those available for women in the Middle East can suppress women from wanting to access those resources at all. Many women in the Middle East do not feel comfortable being physically active in public, especially in front of men, and due to lack of spaces for women to exercise in private, they may decide to not exercise at all (Musaiger et al., 2013). There are increased rates of obesity among young women than men in the Middle East, which is due to a lack of physical activity for girls (Obermeyer et al., 2015). This contributes to the emergence of non-communicable diseases (NCDs) in Iran. Examples of NCDs include

coronary heart disease, various cancers, diabetes, and diseases associated with bone and joint pain (Farahmand et al., 2012). Lack of access to recreational areas puts women at higher risk for obtaining some of these diseases.

The impact of these barriers was shown through the decreased life expectancy and proportion of DALYs lost for women living in nations with large gender gaps.

Implications for future research

Acquiring and collecting the data needed for the articles included in this review seemed to be difficult because of the geographic location of the samples. The violence that is currently happening in the Middle East and North Africa could potentially disrupt future research or result in inaccurate conclusions. Another implication for future research is for the researchers to focus on the customs and culture of the participants they are sampling. One article measured the prevalence rate of violence against women (VAM) in Iran after the Shi'a uprising and the study was done through a qualitative research using interviews to acquire data. The issue that I noticed was that the key population in this study was compromised of both men and women. A possible issue could stem from the fact that interviews of women could have been done in front of their spouse, or another male figure in the house, and therefore, affected the validity of their responses (Amowitz et al., 2004).

Limitations

Limitations of this literary review include having a narrow focus on specific health outcomes for women. There also may be other additional contributing factors or barriers to health that were not mentioned in the articles that I examined. This study also does not include in-depth research about historical events before the year 2000. Meaning, the health outcomes for women could have been way worse than they are today, and Middle Eastern countries could have made bigger strides in gender disparities than recognized in this paper.

Conclusion

Now that I have a better understanding of the development of negative health outcomes for women in the Middle East, I can appropriately apply prevention strategies and interventions to positively influence the quality of life for women. Women make up a substantial portion of the population and their health affects the health and success not only themselves, but of the public around them.

Achieving gender equality is essential in improving the health of women in underdeveloped, Middle Eastern countries. There are multiple barriers that prevent women from obtaining the proper health care that they need, but many of these health issues stem from the degrading view of women within societies. If we focus on solving the cause that brings about the effect, then we can demolish negative health outcomes for women at its root. Improved gender equity is the most powerful way to reduce health inequities for all individuals.

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