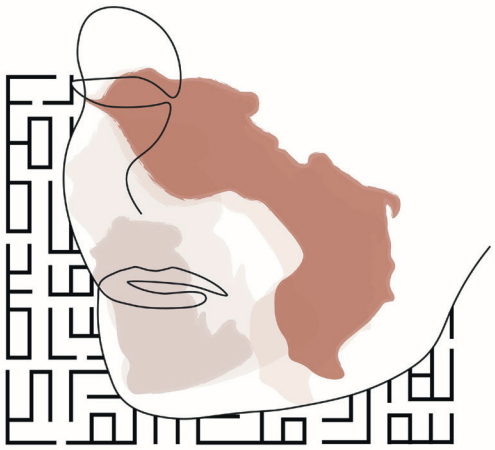
RAWSA MENA
Report

CONSIDERING TELEMEDICINE FOR SEXUAL AND REPRODUCTIVE HEALTH IN THE MENA REGION



RAWSA
MENA REGION

Groupe AWHIDA Ben Cheikh

INTERNATIONAL CAMPAIGN FOR WOMEN'S RIGHT TO SAFE ABORTION

2021 | November

Abbreviations

ANC: Antenatal consultation
FGM: Female Genital Mutilation
FP: Family planning
MENA: Middle East and Northern Africa
MICS : Multiple Indicator Cluster Survey
NGO: Non Governmental Organisation
PNC: Postnatal consultation
RAWSA: Right and Access for Women to Safe Abortion in the MENA region
SGBV: Sexual and Gender-Based Violence
SRH: Sexual and Reproductive Health
UAE: United Arab Emirates
WoW: Women on Web
WHO: World Health Organisation
YLD: Years Lived with Disability

Acknowledgement

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I would finally like to present my thanks to the focal points of RAWSA in the MENA region, Shaima Aly, Sarah Awji, Eman Emad and Hayat Ndichi, who introduced me to their context, and shared with me their perspective. I wish you all the best in your future projects in the region.

In this report, the Middle East and North African region comprises 20 countries, and three sub-regions:

- The North African with 5 countries (Morocco, Algeria, Tunisia, Libya, Egypt)
- The Arabian Peninsula with 7 countries (Saudi Arabia, Yemen, Oman, United Arab Emirates, Qatar, Koweit, Bahrein)
- The Middle East with 8 countries (Lebanon, Syria, Jordan, Iraq, Iran, Palestine territories, Israel, Turkey)

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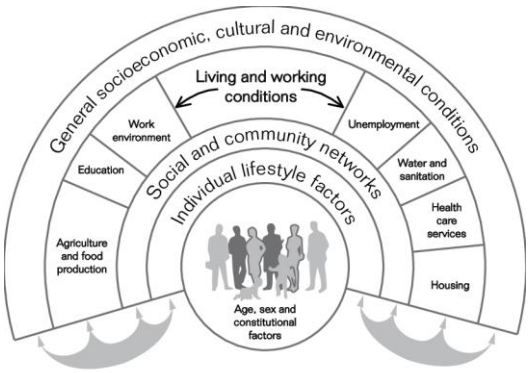
Introduction

The elements for a strong public health system are described in the editorial of the Lancet of October 2021 : "*a capable health workforce; effective, safe, and high-quality service delivery; health information systems; access to essential medicines; sufficient financing; and good governance*." But health depends on more than health systems, and this editorial urges the health sector to consider the scope of concern. Indeed, health depends on numerous conditions depicted below



"*An exclusive focus on health care is a mistake. Health is created from a broader prospectus that includes the quality of education (primary to tertiary), economic growth, gender equality, and migration policy*" (Lancet, 2021)

Therefore, SRH cannot be addressed solely without taking into account the context. From the same perspective, a journalist asked during a webinar of RAWSA MENA[1]:

"*In Lebanon […] large parts of the public opinion finds it weird that feminists are now addressing issues when basic needs such as food, fuel, medicine and medical equipment are practically absent... so you can only imagine people's reaction should we raise the issue of abortion […] especially in the midst of a pandemic on top of it all…*"

Indeed, the conditions of the pandemic of Covid-19 may result in an aggravation of all these factors, as stated by the OECD report, the pandemic is "*testing the region's fragile resilience*" (OECD, 2020).

To better understand the environment in which women in this region are living, a quick painting of the most important determinants of health will be drawn: demography, environment, education and labour and their outcomes on women's health at a macro level.

[1] Webinar report: How journalists can act on advocacy for safe abortion in the MENA region? held on the 1st of July, 2021

Demography

Children and young people (0-24 year olds) in the Middle East and North Africa currently account for nearly half of the region's population. The international projections are that the population will double in size during the first half of the 21st century. (UNICEF, 2021) .

Three over five people live in cities, with huge disparities between countries : 96% of people in Qatar live in urban areas for example, while they are 43% in Egypt (including Cairo, a city of 20 million people). Cities are usually centers of power, and show significant inequalities between people, fertile ground for revolutions, like the "Arab spring" which occurred in 2011. (Bizoirre, 2021)

Arabs are usually young, connected, and educated, with lots of differences between them, depending on the country, the gender, or the social class. (Bizoirre, 2021)

Environment

According to the WHO, 24% of all deaths (and 28% of deaths among children under five) and almost a quarter of chronic diseases worldwide can be attributed to modifiable environmental factors. Ischaemic heart disease, chronic respiratory diseases, cancers and unintentional injuries head the list.

From a report, done by UNEP Faith for Earth Initiative in 2019, about environmental challenges in the MENA region, many environmental deteriorations are described: **Water scarcity**[2], **desertification**[3] **air pollution**[4], estimated to be responsible for 176,000 premature deaths in 2013 in the region. **Waste management** is a rising environmental concern in the MENA region as stated by the GEO-6 on West Asia (2016)[5]; and finally **coastal and marine ecosystems are threatened**.[6] These elements have a direct impact on the health of the population : **in MENA, the environment is killing 850 000 persons every year.**

Education and Labour: The MENA paradox

"***The youth in MENA have achieved much higher education levels than their parents, more than any region in the world***." according to Ferid Belhaj, Vice President of the World Bank in MENA region. Despite the fact that the region invested heavily in education, and worked on a series of reforms, MENA has "*remained stuck in a low-learning, low-skills level*." (World Bank,

[2] with an average renewable fresh water resource per capita of 444 cubic meters (FAO, 2018) when the UN water scarcity limit is of 1000 cubic meters (UN-Water, FAO, 2007)

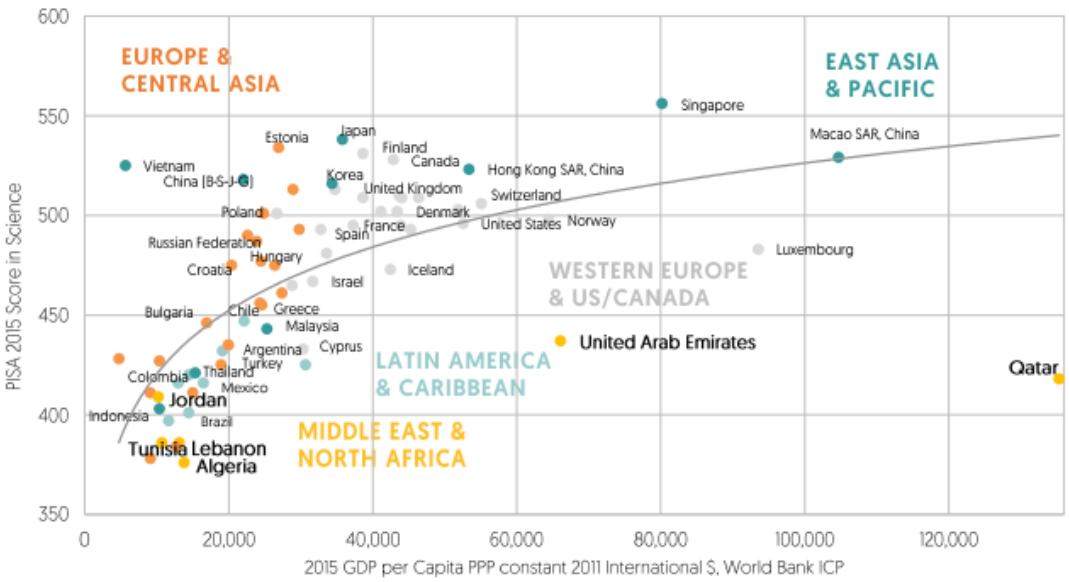
[3] Through soil erosion, salinization and increased dust storms. Also, long-lasting wars are also damaging the environment, with the burning of 15 million barrels of oil and overgrazing in Iraq, to heavy deforestation rates and forest fires in Syria for example. The desertification imperils food security thus setting off socio-political conflicts in this region.

[4] with a concentration of particulate matter (PM10) very high from WHO guideline or legal standards of 20 µg/m3 annual mean. Saudi Arabia reported in 2016 an annual mean PM10 of 251 µg/m3, while Greater Cairo (Egypt) reached 284 µg/m3 in 2015 (World Health Organisation, 2018)

[5] The waste management crisis in Lebanon in 2015, illustrates this issue.

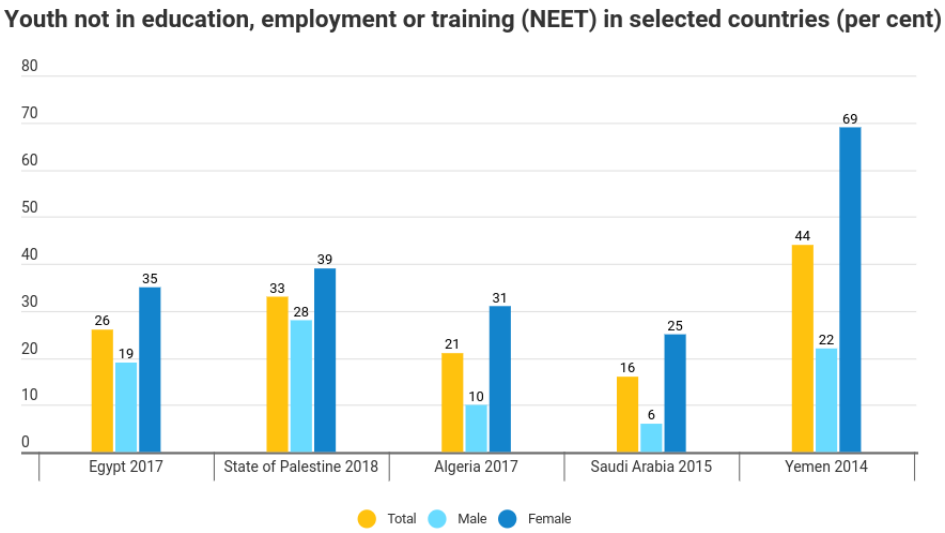
[6] by unregulated coastal development, desalination plant discharge, waste, agricultural drainage run-offs (40 % of sewage effluents in the Gaza Strip are discharged to the sea without treatment), and oil spills (5 000 estimated tons in the Red Sea) all contribute to introducing nutrients, hydrocarbons and heavy metals into marine environments.

2019) The PISA (Program for International Student Assessment) shows the education system in the region as one of the lowest in the world, as shown in the graphic below:



These defaults in education are equivalent to approximately three lost years of education, according to the World Bank report. This report develops these aspects : "*Overemphasis on discipline leads to memorization and passive learning, leaving little space to develop critical thinking skills*". (World Bank, 2019)

However, the report highlights : "***Girls are, by far, outperforming boys in learning outcomes—with the highest gender gap among all countries. Yet the region has the lowest female labor force participation rates in the world***." (World Bank, 2019). This phenomenon is known as "the **MENA paradox**" (Assaad & al., 2020). Around 4 out of 5 women are not in the labour force in the region, the lowest proportion in the world. The very low participation rate of women and the high volume of high youth unemployment are the two major characteristics of the national labor markets in the region. (Guerraoui & Tamer, 2019). The graphic below represents the differentiation between genders on the Labour Market :



Source: UNICEF analysis based on Key Indicators of the Labour Market (KILM), ILOSTAT, 2018

It is projected that at the current rate it will take **142.4 years to close the gender gap in the MENA region** (World Economic Forum, 2021, p.7). As stated by UNICEF in 2021: "*This region needs investments and opportunities in learning, engagement and work, especially for women, refugees, and youth with disabilities*".

Women's Health in MENA

By studying outcome indicators (mortality, Years Lived with Disability) independently of the procedures that affect them, we observe the burden on women's health in different countries of the region.

Through the graphics of the Institute for Health Metrics and Evaluations (IHME), we note that **mental disorders**, NCDs, musculoskeletal disorders and neurological disorders are the main causes of burden for women in reproductive years in the MENA region.

The mental disorders are in almost all the countries of this region a constant burden, and can be the result of experiences of war or ongoing conflicts, unemployment, violence and displacements.[7]

However, ischemic heart disease, neoplasms, transport injuries and diabetes are the leading cause of deaths for women in MENA region. **Maternal and neonatal deaths are the sixth cause only of women's death in MENA.**

This quick analysis of women's health at macro level permits to situate sexual and reproductive health in a larger landscape, and consider some of the determinants which have an impact on their health.

[7] The WHO's 2020 Mental Health Atlas show that the median number of mental health workers per 100 000 population is 8.8 in 2020, while the global median is 13/100 000, but still increasing from the last survey in 2017 where there were 7.7 mental health workers per 100 000. (WHO, 2021) [The lack of mental health professionals in the MENA region to take care of women can be readjusted by a telemedicine service]

Affected by the Covid-19 pandemic, health systems as well as individuals had to adapt to a new organisation of their care and services. Telemedicine was the most used way to deal with the pandemic and is becoming in many countries a mean to provide safe and quality medical care and services.

What is Telemedicine

Telemedicine is defined as the use of electronic communications and information technologies to provide clinical services when participants are at different locations.

Concretely, the woman contacts a platform, the doctor or midwife sends a link, inviting her to connect to a secure site or application, via her phone or computer.

The consultation is of the **same standards as a face-to-face consultation,** meaning that enough information and time will be given to allow the opportunity for questions and to give informed consent.

The telemedicine aims to decrease the contact with healthcare facilities, during a pandemic like the covid-19, to **ensure a safe and confidential access to a health provider in contexts where women face obstacles to care** (lack of infrastructures, difficulties to find a transport, a qualified personnel, or because of financial barriers…)

A possible example : safe abortion care by telemedicine

For a safe access to abortion, in countries where the legislation restricts it - for example all the MENA countries except Tunisia and Turkey - various studies find that telemedicine abortion is as **safe** and **effective** as a face-to-face care done by a professional (Endler & al., 2019). The World Health Organization recommends this alternative to manage safe abortions and incomplete abortions, to limit visits in health structures, and contacts between providers and clients, at the condition that an access to a trained provider is possible if a complication arose (WHO, 2020)

Safe abortion via telemedicine is described as **non invasive**, which means that it doesn't harm the body, unlike the surgical abortion, called "curetage" in some MENA countries.

It is **the cheapest and the most effective technique to manage an abortion**, and it is acceptable for women's health. (WHO, 2019) This practice also promotes a **greater autonomy**, as the person can take the tablets at home, in the privacy of their own house, with or without a person, whenever they are willing to do it. This allows a greater control over the process, they may feel **more comfort and support** during the process (Makenzius et al., 2013) This leads some authors to say that putting abortion pills in women's hands is the realization of their full potential (Jelinska & Yanow, 2018), that we could translate into greater autonomy.

Moreover a recent study shows that abortion via telemedicine **without an ultrasound** is safe and acceptable for women. (Reynolds-Wright & al., 2021). Abortions take place earlier in the pregnancy, increasing safety and reducing the risk of complications, and the vast majority of women report feeling safer and more comfortable undergoing the procedure in the comfort of their own home.

The FIGO[8] (International Federation of Gynecology and Obstetrics) issued an endorsement for permanent adoption of telemedicine abortion services. And WHO published in 2020 recommendations on self-care interventions, among others self management of medical abortion[9]

In response to all these aspects, a question therefore arises **: "To which extent telemedicine can be considered to answer SRH needs for women in the MENA region and in what is it well perceived by providers and women seeking an abortion ?"**

I will answer this question by making **an assessment** through three elements: the **cultural context**, the **communication landscape** and the **operational feasibility** of telemedicine in the MENA region.
A second part will **describe SRH challenges in the region,** through a focus on four countries (Algeria, Oman, Palestine, Iraq) to give more insights in order to define the SRH needs that telemedicine could meet.

This report's aim is to evaluate the pertinence of telemedicine for SRH in the Middle East and North African context.

Assessment of telemedicine in MENA context

Cultural Context

In order to think of introducing telemedicine in MENA context, the cultural context, rich and varied, had to be researched.

This part has been worked through interviews with RAWSA members, and through a survey, shared through RAWSA MENA network where the anonymized responses left space for the participants to describe it.

[8] https://www.figo.org/FIGO-endorses-telemedicine-abortion-services
[9] https://apps.who.int/iris/bitstream/handle/10665/332334/WHO-SRH-20.11-eng.pdf?ua=1

Authority figures

The "religious leaders" were the most frequently named as the authority figures at national level. In the survey we conducted, a participant wrote : "*The sheikh / pastor is a religious authority approved and trusted by the community in the event that any religious fatwa is requested, he is the one who presents it and accordingly families make many decisions related to their lives.*" Zouhour*[10] an activist who has worked intensively in the region, adds: "*Even the religious leaders are on social media and can be a figure of authority".*
The politicians are mentioned, but not representing a moral figure to follow. An Iraqi woman, biologist and engaged in women's rights and health, that we will call Maysaa* said : "*The politicians influence a group of people, but too many politicians are seen in Iraq. So there is not one that I can actually mention.*"

On the household level, the authority figures are mostly "*the man*", "*father*" and "*husband*" which mainly comes up in speeches. The "*mother-in-law*" is also a figure of authority who seems to have more impact inside households. As summarized by Maysaa: "*husband, and if he is not present, mother-in-law. But you know she can have authority even if he is present* [laughs]".
Inside households, "*mothers*" for girls and "*mother-in-law*" for married women are figures which can have an impact on their husbands or sons. But it is mainly a patriarchal architecture that leaves little space for women's autonomy on their health and their choices.

Women's position in the society

A young activist dropped into the discussion : "*Women [...] are a thing, not a human being. They are just here to give birth and to take care of the children. They do not work, they are at home*." As described in the introduction, although women are educated, they are in the vast majority, not able to work or allowed to make a decision for themselves. At best, this decision is shared with their husbands.
As pointed out by Zouhour, "*all the payments are through the man.*" As we will see in the last part of this report, the financial constraints are one of the leading cause for women to ask for an abortion through a telemedicine service, such as Women on Web.

➔ **In order to address women's health issues, focus groups discussions with religious leaders, and civil right activists might help to improve the situation. Journalists, artists and now influencers on social media can also open the discussion, to promote a debate on women's health and rights in the region.**

Communication landscape

In order to propose telemedicine services, it is important to understand the communication landscape in which women are evolving, to answer to their SRH needs in the most pertinent way.

[10] All the names have been modified to preserve anonymity of the participants

To get information

Depending on the MICS (Multiple Indicator Cluster Surveys) in the four countries analysed (Algeria, Oman, State of Palestine and Iraq) women are mostly watching TV, at least once a week to get information. Less women use the radio and even less - usually the most educated - read newspapers or magazines. Therefore **they are mostly getting information without reading a text.**

Nevertheless, social media or applications such as Whatsapp, Viber or Facebook are changing the way women are getting and receiving information. "*Voice messages*" are vastly used, and in all social classes.

Also, they may use social media and applications to get specific information. Zouhour explains it like this: *"they use Facebook groups for specific questions like "who is the best gynecologist" or "where is the best hospital", and then they go to Whatsapp groups."*This process has been described in abortion services in UAE, where women search on Facebook for a doctor's number and then ask him or her via Whatsapp for the abortion pills.

➔ **Social media and applications are a way for women to get information, aside from traditional media such as TV or radio. Information and misinformation can therefore spread quickly. A quality telemedicine service should therefore consider these aspects and have a proper communication strategy.**

To make a complaint, ask questions

Women are helping each other in the majority of cases. They are fairly connected between each other, and usually get information by word of mouth. "*Close neighbors*" have been cited, as well as sisters and friends. Social media are not considered as a reliable source of information by women interviewed.

➔ **Telemedicine services or a hotline would help engage a more reliable information on different subjects such as sexuality, STIs, abortion, pregnancy, or mental health without judgement or fear of spreading personal or confidential information.**

Connectivity

The connectivity in the MENA region varies widely. The data from the International Telecommunication Union[11] shows that urban households are 74% to have an internet access, while they are only 38% in rural areas in Arab states. The gap between genders is also marked: 47.3% of women in the region use the Internet while 61.3% of men use it. To note however that internet use by women is much higher in a number of Arab countries than the global average. (For more details, to see the ITU report, 2021)

During the interviews some women were not having access to a stable connection, and the video was not supported by the connection. For an interview with a Lebanese woman, the

[11] itu.int

connection was so bad that we postponed the meeting several times, and the interviewee had to go to a café to have electricity and a stable connection. We ended up corresponding by email.

➔ **Connectivity issues will have to be taken into consideration while putting in place a telemedicine service. A backup service by a hotline for example could be considered to allow a safe procedure in case of complications or questions.**

Digital literacy

Digital literacy is also a factor that should be taken into consideration. Depending on all the factors mentioned above, some women are using "*colors and voice calls*", to share their thoughts with their community as mentioned by a participant. For example the Multiple Indicator Cluster Survey (MICS), analysed in four countries (Algeria, Oman, Iraq and Palestine) shows low computer skills (Algeria MICS, 2018- 2019, Oman MICS, 2014, Iraq MICS, 2018, State of Palestine MICS 2019-2020) . Less than 15% of women in the four countries studied know how to attach a picture or a video in an email, to connect or install a new device (printer, modem..), or to transfer a file from a computer to another device. They are for example 4.6% in Iraq to use a copy and paste tool to duplicate or move information in a document. (Iraq MICS, 2018). The most educated , and youngest women are also the most prone to have more complete computer skills.

➔ **Therefore a very easy tool, without downloading documents, or following complex procedures to retrieve information, has to be promoted, to avoid inequity and misinformation in the treatment and support given to women.**

Access to a phone

Women are mostly using a phone (more than 95% in the four MICS), and less a computer; but women may not equally and continuously access a phone or a computer.

In fact, men are holding the mobile phone (husband or eldest son) in a lot of contexts. Therefore, women have to wait for men to come back from work in the evening to have access to the mobile phone (Talhouk & al., 2016). Maysaa* describes this situation: "*A daughter of 18-20 doesn't get a mobile phone till she gets married for example. When she gets married, her husband gets her a mobile phone."*

The patriarchal structure of Arab society thus continues in new technologies, and this element should be taken into consideration when proposing a safe telemedicine service.

➔ **A proposition could be to have a safe "exit button" to erase the history on the computer or phone; and avoid any security gap during the consultations. Also, no call should be made by the telemedicine service providers, and if possible not by men, as it can create more trouble for the woman or the girl. An assessment of the context can be proposed at the beginning of the teleconsultation; for example "can you talk safely?" and explain the measures she can take if someone interrupts the call or the video call. Also, a detailed procedure should be made available for the service providers.**

Languages

The languages are varied in the region, and differ between the Arabic which is spoken and the Arabic which is written.
Lebanese or Kurdish for example use frequently the latin alphabet and numbers (ex: dawa2) while Iraqi or Egyptians for example use the Arabic alphabet (ex: دواء). In North Africa, a local language with an Arabic base called derja or Darija, or a mix of French and Arabic are used, frequently with the latin alphabet. As Zouhour mentioned: "*The language spoken in the streets is Arabic. On Whatsapp the language of young men and women educated is English, but from Aswan to Sudan, it is Arabic.*"

Also, the Women on Web data (annex B) show that on 1991 requests of abortion across the region, 1164 were made in English (58%), then in Arabic (22%), then French (12.7%), but number of other languages were also used : Farsi, Turkish, Thai, Spanish, German, Russian… these data show that a large panel of women can be in need of telemedicine services for their sexual and reproductive health.

➔ **Service providers would have to speak Arabic and English to be able to reach a large number of women. Other languages (of documented and undocumented migrants) should also be taken into consideration while planning for a telemedicine service. (French, Farsi, Kurdish, Thai, Russian…)**

Operational feasibility

After the cultural context and communication landscape, this report proposes to analyse the operational feasibility of a telemedical service in the MENA region, to suggest some keys of analysis

Existing hotline or telemedicine services

Of the 20 persons answering the survey, none knew of active telemedicine services provided in their country, but they were 10 to say that their workplace provides a hotline. One participant to the survey mentioned a telemedicine platform "Es2el tbibek", which was still not operating.

A Moroccan feminist, Aya* said about telemedicine that "*the word itself is not known*[12]". A gynecologist had warned her about these "*pills over the Internet*[13]" with no explanation, and no lab analysis. For Aya* the process consists of "*clicking on the tabs and get them*"[14]

➔ **A small video about telemedicine is actually in progress to explain what telemedicine is and how it can be a solution for women in MENA. (the text can be read in Annex F) . This report can also help to understand the challenges that telemedicine makes possible to address.**

[12] [le mot même n'est pas connu]
[13] [les pilules par internet]
[14] [Tu cliques sur les comprimés et tu as les pilules]

During interviews, some examples were given such as the government of Oman which set up a telemedical service for lactating and pregnant women during the pandemic, but has stopped after the decrease of covid-19 in the population. Another example was given for gender-based violence care in Saudi Arabia, or experimentations in Tunis and Jordan for disabled and refugees through non-governmental organisations. They were described as "*counselling platforms*" or a "*hotline of education*".

An article retrieved an "e-health initiative" in Jordan in 2000 which was stopped shortly after. (Neamah & al., 2018) The Saudi government proposes e-health services[15] as well as some countries from the Arabian Peninsula, "Al Shifa" system in Oman for example. I didn't find assessment, definition, implementation or evaluation documents about these initiatives.

On 21 september 2020, a discussion between WHO and ITU regional directors was held to collaborate on the development of mobile technology in health strategies. [16] with the first point being "mapping innovations on improved health care delivery, and key health technologies in the context of COVID-19". The continuity of this meeting has not been found

- ➔ **A mapping of the existing telemedicine services could be asked directly to WHO or ITU regional directors, to facilitate the integration of an SRH telemedicine service in the region**
- ➔ **Even scattered it could be interesting to find what were the challenges these services faced**

The cost of SRH telemedicine

Most of the participants of the survey wrote that the SRH services should be "*free*", and that "*the government should pay for the costs*", considering these services as "*essential care*[17]"

As women can have very different socio-economic backgrounds in the region, the cost could be adaptive. **The goal is to keep the service of good quality, and sustainable.**

In Canada for example, women are asked to give as much as they want after their abortions in order to be able to provide the same quality service to other women (Mathieu, 2016). The NGO Women on Web propose to women to make a donation at the end of the abortion process for the same reasons.

Moreover, Women on Web data for the region showed that 38% (758 women over 1983) said that they want to abort because they don't have the money to raise a child, and 27% (650/2416) to say that they didn't do an ultrasound because they cannot afford one. The economic constraint shouldn't be a barrier to access quality care.

- ➔ **A proposition could be to find external fundings, and ask women to donate if they can, and if they want, to permit a sustainable offer.**

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[15] moh.gov.sa

[16] http://www.emro.who.int/ehealth/ehealth-news/who-and-itu-regional-directors-discuss-collaboration-on-digital-health-and-innovation.html

[17] [*de première nécessité*]

Legal aspects

No participant to the survey or interviewees knew about a specific legislation regarding telemedicine.

➔ **This aspect should be discussed country by country with a jurist specialized in international law.**

Prescriptions

The prescription of abortive medications, such as the Misoprostol, depends on the pharmacist, and the "*good collaboration you can have with him or her*" as Zouhour* mentioned. In different locations, doctors were referring the patient to a pharmacist who was calling the doctor to have his or her acceptance on the delivery of the medication. A simple piece of paper can permit access to antibiotics for example in Syria, or Iraq. Maysaa declares "*Only psychiatrics need to prescribe, otherwise, you can go and ask direclty to the pharmacist.*" The medication monitoring is variable between countries

➔ Nevertheless, to ensure a good quality, and security of the service, **a proper medication circuit should be in place. A mapping of partners in the region seems important.**

Restrictions of the law concerning women's health

The different restrictions in the law for women's access to health is mentioned in nearly all the surveys. In all languages, participants were asking to change the law :

"*A campaign to change the laws*"[18], "*Legalize safe abortion in the country and increase awareness on dangers of unsafe abortion and where to access safe services when wanted and/ or needed*.", "*Advocate to change the laws*[19]"

The Global Abortion Policies Database (GAPD)[20] can be used to see the different legislations between countries on abortion for example. Beside Turkey and Tunisia, abortion is restricted in all the other MENA countries.

Some exceptions can be made depending on women's health, but the legal process to access to an abortion (face a jury of doctors, explaining the causes…) can stop many women and girls to resort to it.

Egypt, Lebanon, Algeria, Morocco or Libya are for example pursuing abortion in the penal code, and sanctioning the woman, the provider and the person who assists.
Yemen sanctions the woman and the provider but not the person who assists; while Iran and the UAE sanction the providers and the persons who assist but not the woman. However, Saudi Arabia sanctions only the providers. As stated by a gynecologist, we will call Wael*: " *Iran and Saudi Arabia have better laws than in Lebanon*", asking again for a change of the law : "*The abortion law must be revised, it is coming from the First Constitution of the French Mandate.*"

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[18] "حملة دعوى لتغيير القوانين السارية"

[19] Plaider pour changer les lois

[20] https://abortion-policies.srhr.org

➔ **The restrictions of the law make it difficult to advertise abortion services for example. However, the word of mouth and the link with NGOs, health professionals, can help the telemedicine to deploy.**

The same discussion can be made on SGBV : laws vary widely between countries, and are not in line with the international conventions signed. A participant of the survey mentioned for example: "*Legally speaking, minors are still allowed to marry and there is no minimum age for marriage. Domestic violence rates skyrocketed during lockdown and Lebanon is tragically known for feminicide…*" Another participant writes: "*There are all kinds and forms of violence without imposing or enacting a law and punishment that prevents and criminalizes it*"[21]

➔ **Telemedicine services, including abortion care, SGBV care, mental health, contraception, STI care can help to advocate for a better answer to women's needs. The numbers would prove scientifically the huge challenge of sexual and reproductive health in the MENA. It would be a base to challenge the authorities on their policies.**

➔ **Also, more research on SRH in MENA is mandatory to have a better picture of the challenges women face, and how they adapt to them.**

Unsafe abortion testimonials

From Maysaa, Iraq: "*For example I recall a woman, she was married, and had an unwanted pregnancy. They tried many doctors. [...] Nobody wanted to help her. She had three children, and she was poor, this is why she had difficulty finding a doctor; until she found someone, she was not a gyne or a nurse. She asked her for a huge amount of money. And she did her abortion at home. She had a major infection. It is like this. The husband doesn't care, he says that he will not pay for her abortion. That it is your problem, you have to take a pill or something. She almost separated from her husband after that. Almost her life has been changed because there was no abortion services.*"

From Wael, Lebanon: "*if someone 17-18-19 is pregnant. What are her options: she cannot travel, she cannot terminate her pregnancy. It cannot happen easily with professional expertise. They shop this under the counter. You take this, you bleed, you go to the hospital […]The abortion law should change. [...] The doctors who are doing this are helping a lot.*"

From Aya, Morocco :

"*A text from the Ministry asks not to mention cases of hemorrhage [...] They do not report them; In rural areas, women have access to plants, 'chouub' […] it is difficult [...] in the city, there is everything, married women, single [...] most of them. In this case, they come alone, in offices especially, because it is private […]. They are all imprisoned! Doctors, midwives, women.*"[22]

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[21] يوجد جميع أنواع العنف وأشكاله دون فرض أو سن قانون وعقوبة تمنع ذلك وتجرمه

[22] "*Un texte du Ministère demande de ne pas mentionner les cas d'hémorragie [...] Ils ne les déclarent pas"; "Dans les milieux ruraux, les femmes ont accès aux plantes, "chouub" […] c'est difficile [...] en ville, il y a de tout, des femmes mariées,*

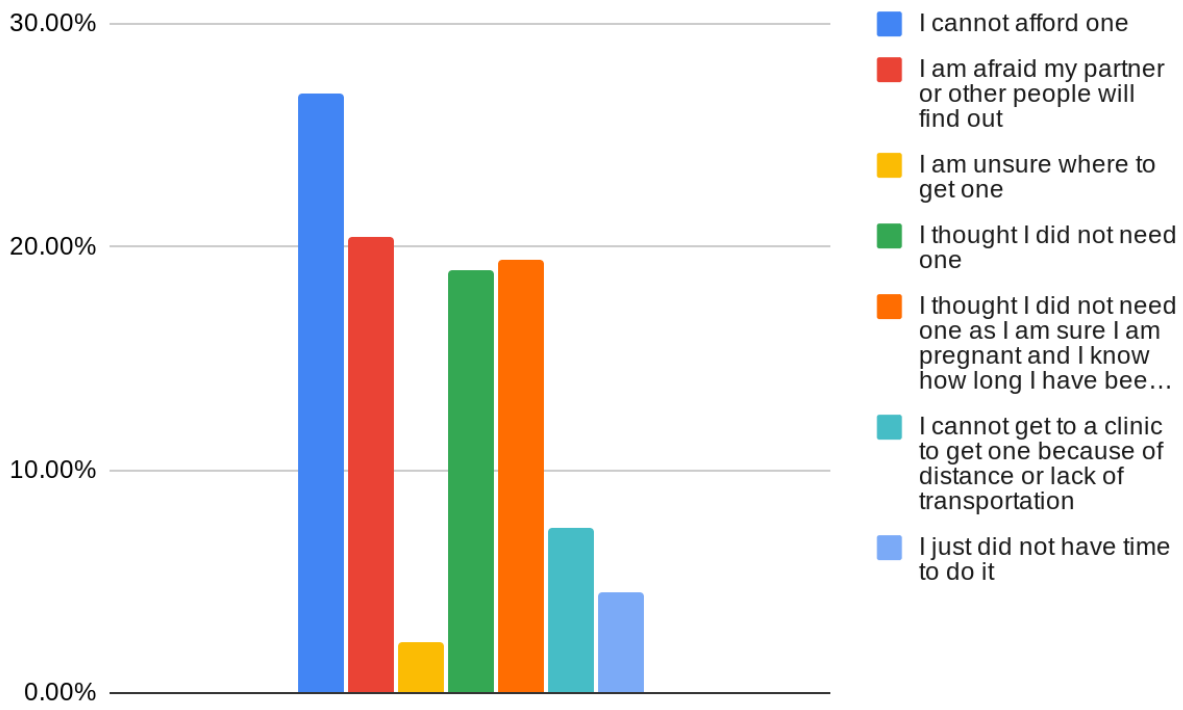
Abortion via telemedicine: An example via Women on Web (requests of 2019)

All the requests made in 2019 in all the MENA countries through Women on Web platform have been analysed for this report.

WoW received 1991 requests in 2019 across the MENA, of which 1983 for an abortion (others include contraception requests). The languages used were mainly in English (58.46%), Arabic (22.35%) and French (12.75%). Other languages used were Turkish, Farsi, Spanish, Korean, Russian, Dutch, Thai.. Women living in the MENA comprise also of documented and undocumented migrants, who are facing the same dilemmas. A women in UAE wrote for example in 2020:

"This service was literally a life saver. I was scheduled to have major surgery which was blocked after we discovered I was pregnant. Our only other option was for me to travel to my home country where abortion was legal. Given the COVID-19 related border closures, this would have meant losing my job, our only source of income, and displacing my family. Womenonweb.org provided a necessary service that saved me and helped my family avoid an uncertain fate."

The vast majority of women (76%) didn't do an ultrasound. The reasons for not doing an ultrasound can be seen in the chart below :



célibataires [...] la plupart des cas, elles viennent seules, dans des cabinets surtout, parce que c'est privé […]. Ils sont tous emprisonnés! Médecins, sages-femmes, femmes."

They mostly stated that they didn't do an ultrasound because **they cannot afford to pay for an ultrasound** (26.9%) and because **they were afraid their partner or other people will find out** (20.49%).
The logistical barriers (transportation, time, or to know a place where to get one) didn't seem to be a major issue. As seen in the analysis of the four MICS analysed (Annex A), women have access to a healthcare provider during their pregnancy and know where to seek care. But in the case of an unwanted pregnancy, **the confidentiality of their pregnancy and their choice, often criminalized, challenge their access.**

Moreover, on 1983 requests for an abortion, they were all sure they wanted an abortion, and only 43 felt troubled (2.1%). They are sure and serene in the majority of cases about their decisions.
Also, **95% were stating they would have somebody with them during their abortions.** This fact challenges the idea of being alone during a telemedicine service, as women project to be accompanied by relatives or friends during the process, and the platform seems to be supportive to women, although it is via emails. A woman in Saudi Arabia mentioned for example in her evaluation in 2020 : " *Thanks for help me to go through everything and not leaves me alone and always supportive and answered all my queries..*"

Medical history

0.2% had an IUD, 5.4% a medical history (mainly asthma, hypothyroidism and anemia), 7% had at least one previous c-section, one woman having a previous 4 c-sections. All had a good outcome.

Age

2 girls of 15 year old, one in Algeria, one in UAE, both were raped, and are the youngest to request an abortion. The oldest was 52 years old and was from Libya.

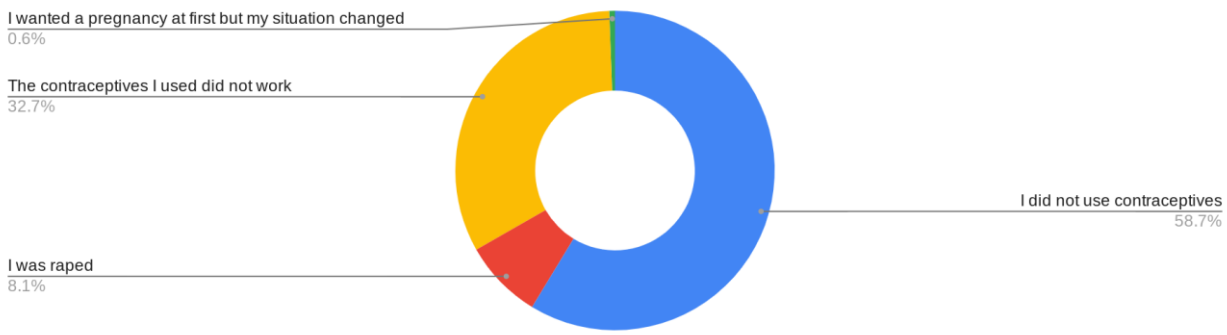
Cause

The causes of the abortion requests are summarized below. Not using a contraception is the cause for more than half of the requests, and can be a parameter to take into consideration.

- ➔ **The lack of access to contraception should be addressed, for married and unmarried women.**

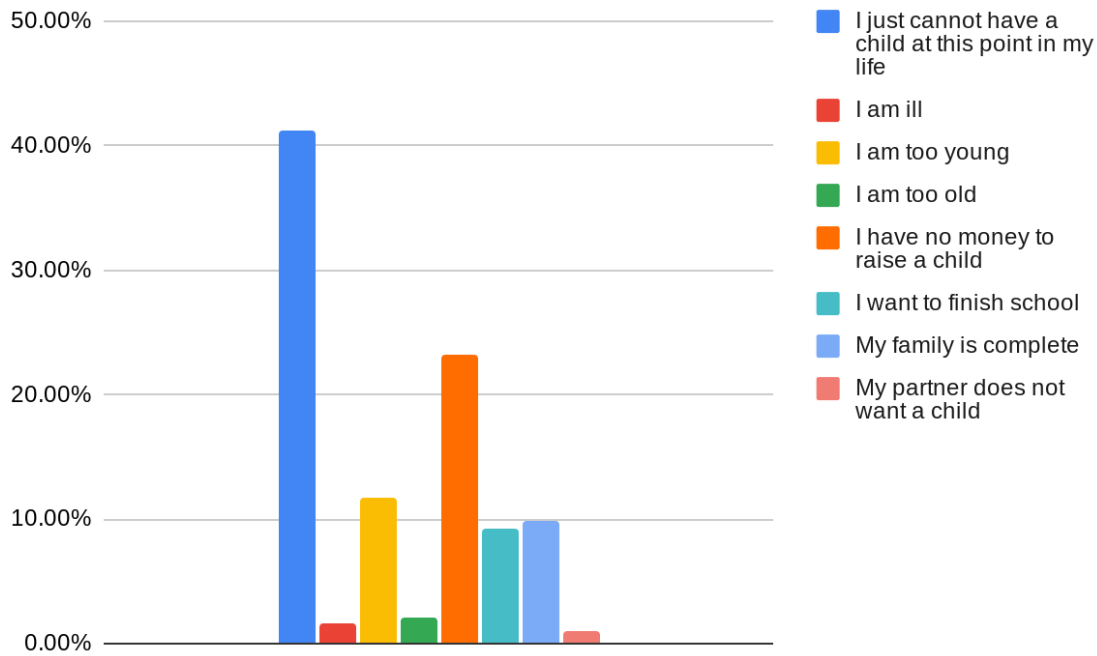
Also, the mention of **6 minors (less than 18 years old) and 147 adults "I was raped", equivalent to 8.1%** of women is a quantification of a **major problem of public health.** Other studies and quantifications should be done in the region, in order to verify these figures.
Some testimonies during this work were tending in the same direction: "*They are two things highly stigmatized [...], abortion and rape. You will be stigmatized forever.*"

- ➔ **Telemedicine services can help reduce the stigma around abortion and sexual violence, by giving a secure and confidential access to women to a trained health provider**



Reasons

The reasons women want an abortion in the MENA are mainly because they cannot have a child at this point of their lives (41%), followed by the **financial constraints** (23%) which was also the main cause for not doing an ultrasound. The other reasons can be seen in the diagram



below:

1380 had no abortion before, 270 had one abortion, and 60 had more than 2 abortions before. 330 had already one or multiple abortions, which mean that 19% stated they had previously an abortion in countries were the legislation is restricted.

The reality of abortion, as the reality of sexual violence can be better apprehended by these figures.

➔ **A telemedicine service would help to advocate for women's health and rights by analysing anonymized data on the region, as the ones Women on Web is producing.**

Finally, the access via Women on Web platform was for 1181 women (20.15%) because it was hard for them to access **because of legal restrictions**, then **because abortion pills are not**

available in their countries (11.41%), because they would prefer to keep their **abortion private** (9.43%), because they need to keep their **abortion a secret** from their partner or family (8.48%), because of the **cost** (7.15%) or to be **more comfortable at home** (6.96%). All the other reasons such as an abusive partner (2.2%), stigma or school commitments can be found in the WoW data in Annex B.

- ➔ **These figures show the same results as in the survey or in the interviews. The criminalization of the abortion, and the social stigma made it hard for women to ask for safe abortion care. An access through WoW, or another safe, and good quality telemedical service can therefore be a good solution for women in need. (annex G for evaluations and comments of MENA women about the WoW services)**
- ➔ **A telemedical service would benefit women as well as help to advocate for women's health and rights.**

SRH needs in MENA region based on the MICS data

Sexual and Reproductive health include: antenatal consultations, postnatal consultations, delivery, family planning, safe abortion care, sexually transmitted infection and sexual and gender based violence care.

In order to assess the SRH in the MENA region, a focus on four countries have been made from the Multiple Indicator Surveys (MICS), where key indicators on the well-being of children and women can be found. These indicators can therefore guide public health strategies.

The four countries analysed were Algeria (MICS, 2018-2019), Oman (MICS, 2014), Iraq (MICS, 2018) and State of Palestine (MICS, 2019-2020). I chose these countries as they were the most recent to have their MICS results being published.[23]

Socio-demographic indicators

The samples studied were women from 15-49 years old, and **more than half of them were married,** with a peak in Iraq of 64.3% of women being married. More details about early marriage and polygamy will be given in the SGBV section below. They are around 35% to be single, then around 2% widows, and less than 3% are divorced or separated.

Also, in the four countries studied, women were **mostly literate** : Palestine 98.9% of women were literate, Oman 95.5%, Algeria 84% and **Iraq 68.9%** only.

-> These figures have to be taken into consideration when defining a telemedicine service to ensure **equal** treatment and support to women in the region.

[23] All the MICS findings can be found on https://mics.unicef.org/surveys

Antenatal care

Percentage of women who have been followed at least once by trained health personnel was high: 95.3% in Algeria, 98.6% in Oman, 87.6% in Iraq, 98.7% in Palestine. The doctors were almost always the health professional to follow them during their pregnancies.

The majority of women were having more than 4 ANC during their pregnancies, and mostly in the first trimester.

	Algeria	**Oman**	**Iraq**	**State of Palestine**
	2018-19 MICS	MICS 2014	MICS 2018	MICS 2019-20
Percentage of women who have been followed at least once by trained health personnel	95.3%	98.6%	87.6%	98.7%
ANC by a doctor	90.2	90.1	87.5	93
No prenatal visit	3.3	1.4	12.1	1.2
1-3 visits	26.9	3.3	19.9	3.3
4 visits or more	69.8	93.8	67.9	94.8
8 visits or more	13.8	NA	22.2	72.7
Median month of pregnancy at first antenatal visit	2	2	3	1

- ➔ **The access to a trained health professional seems to be easy from the beginning of the pregnancy and women seem to be followed up regularly, and mainly by a doctor.**
- ➔ **Although the access is mostly provided in ANC, some indicators** like fundal height (only 58.7% in Algeria)**, or** tetanus vaccination (46.4% in Algeria, 62.8% in Iraq), **point to some quality flaws. More studies on the quality of these consultations (time spent with the couple, education, prevention, screening…) have to be made**

Deliveries

Most women gave birth in a health facility, and nearly all births have been attended by qualified assistance.

The **percentage of c-sections remains high**, mostly due to non urgent (iterative) c-sections. Complications reports (like hemorrhage, infection, eclampsia…) were rarely filled

-> More studies about deliveries (complications and outcomes) would be interesting to do, as regular access to health providers are effective, but some indicators show some weak outcomes. (MICS reports 2014-2019)

Postnatal care

Women stay 12h or more after their deliveries in Algeria (91.7%) and Oman (96.4%), and Palestine (60.5%) but less than 6h in Iraq for 47.1% of them.
A health examination after birth in the health center or at home was made in all these countries in a high proportion (between 76.7% in Iraq to 98.3% in Oman).

- ➔ **As for ANC and deliveries, the post natal care is done by a qualified professional (usually a doctor), and a health examination is done within 2 days of birth for both mothers and babies, but some indicators show that these care are lacking (skin-to-skin, weigh or temperature measurement, cord care, breastfeeding advices, or symptoms requiring care). The major issue which emerges from these data is the lack of quality services, but not access to a professional or a health structure. (MICS 2014-2019)**

STIs: The example of HIV

During the analysis of the MICS, **HIV information in the population appeared to be concerning in more than one aspect. Deep knowledge of HIV is, within the population studied, very low** as shown in the table below.
Information about the modes of contamination are rare, and misinformation leads to discrimination.
For example, 54.7% of Omani women think that sharing food with a person HIV+ can transmit the virus, 79.3% of Iraqi women wouldn't buy vegetables from a vendor HIV+, or only 32.8% of Palestinian women think an HIV+ child can go to school with HIV negatif children.
Although almost all women have prenatal consultations, almost none have received an HIV test and result.

- ➔ **Education about STIs in general, HIV in particular, seem very important from these surveys. Misinformation lead to discrimination and human rights violation.**
- ➔ **Online training for health professionals, and a telemedical service should propose education and counselling about STIs. A website lmarabic.com (love matters arabic) is culturally appropriate, and well designed to answer this issue. A partnership would be interesting to put in place.**

	Algeria	Oman	Iraq	State of Palestine
	2018-19 MICS	MICS 2014	MICS 2018	MICS 2019-20
HIV				
Deep knowledge	**10.1**	**9.8**	**4.9**	**6**
Percentage who know that HIV cannot be transmitted by:				
Mosquito bites	32.1	44.6	24.8	38.1

Sharing food with someone with HIV	40.6	54.7	25.6	52.5
Do not know any specific ways of mother-to-child transmission of HIV	35.6	10.2	16.4	20
Percentage of women who do not buy fresh vegetables from an HIV-positive trader or vendor	54.1	28.6	79.3	68.9
Believe that a child living with HIV should be able to attend school with HIV negative children	47.3		23.8	32.8
Think if the teacher is HIV + can teach their children		47.9		
Received antenatal care from a health professional during the pregnancy of the last live birth	95.3	98.6	87.6	98.7
They were given an HIV test, accepted and given the results and health information or post-test HIV counseling	**2.5**	**6.2**	**2**	**2.3**

Contraception

Contraception is mentioned in national statistics only for "married women" between 15-49 years, transcribed in the MICS[24]. The contraception is translated as "spacing of births" in the Omani MICS for example, or other words such as "family planning". The term "limitation of births" was not recorded. In the table below, we can see the different contraceptives used on a representative sample of population of four countries in the region :

	Algeria	**Oman**	**Iraq**	**State of Palestine**
	2018-19 MICS	MICS 2014	MICS 2018	MICS 2019-20
Number of households	31 325	38 828	20 214	10 080
Percentage of currently married women aged 15-49 who use (or whose partner uses) a method of contraception				
No method	**46.4**	**70.3**	**47.2**	**42.7**
Female sterilization	0.4	3.4	3	1.8
Male sterilization	0.1	0.2	0.1	0.3

[24] MICS analysis on Algeria, Oman, Palestine and Iraq can be found in Annex A

IUD (Intra-uterine device)	2.4	2.7	8.8	26.1
Injectables	0	3.9	3.9	0.9
Implants	0.3	0.1	0.2	0.2
Pills	39	5.5	16	6.9
Male condom	2.1	2	3.2	5.3
Female condom	0	0.2	0.1	0.1
Diaphragm / foam / jelly	0	0.1	0.1	0.1
LAM (Lactation Amenorrhea Method)	0.7	0.8	0.8	1.2
Periodic abstinence	5.1	1.7	1.5	4.4
Withdrawal	2.8	8.7	15.1	9.8
Any method	**53.6**	**29.7**	**52.8**	**57.3**

The main contraception in these four countries is "no method", followed by pills and IUD and withdrawal.

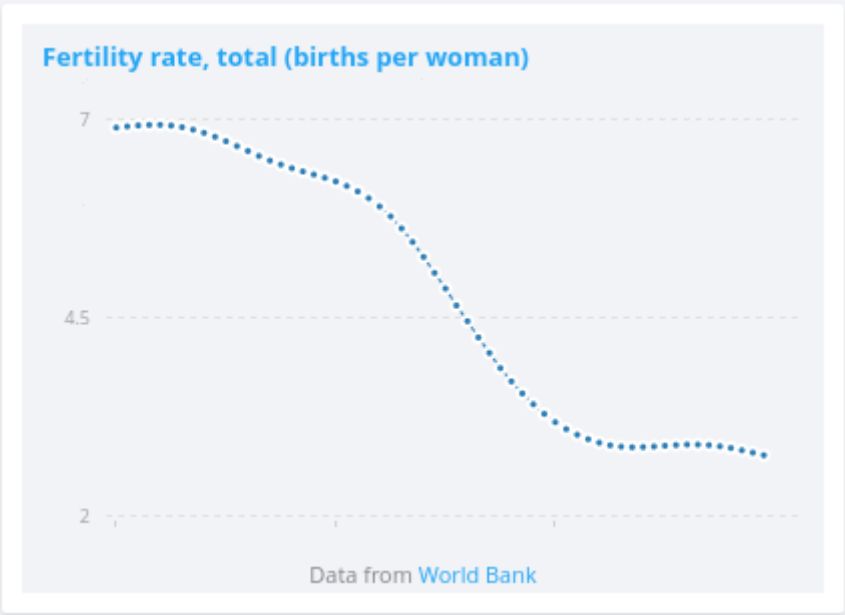
	Algeria	**Oman**	**Iraq**	**State of Palestine**
Percentage of currently married women age 15-49	2018-19 MICS	MICS 2014	MICS 2018	MICS 2019-20
Satisfied contraceptive needs	53.7	NA	52.8	57.3
Unmet need for contraception	**14.1**	**17.8**	**14.3**	**12.9**
Fertility rate	2.8	2.9	3.6	3.8

These results show only the satisfied and unmet needs for contraception for "married women" in reproductive ages, which means **these numbers may not show all the women sexually active in these countries.**

Fadoua Barkhane[25], executive director of the Moroccan Family Planning Association, says : "*Ministry of Health and other institutions studies have shown that boys become sexually active at 16 and girls at 18. On average, men get married at 31 and women at 28. So there is more than a 10-year gap here of potentially unsafe sexual practices that are not even officially recognized in law. What are we saying? That no one is doing anything for 10 years? We need to open our eyes.*"

Around 15% of married women have unsatisfied contraception means, and a fertility rate that dropped in all the MENA countries. According to data from the World Bank, the fertility rate in MENA dropped from 6.9 the 1960 to 2.8 in 2019, as shown in the graphic below.

[25] https://www.ippf.org/blogs/women-leadership-fadoua-bakhadda-morocco



Considering the low percentage of contraceptive use, the long gap between the first sexual intercourse and marriage, and the decrease from the 1980s of the fertility rate, suggestions can be made to understand these trends:

- Two sociologists proposed **a propension of "arrangements" between genders,** equivalent to non-penetrative sex, and "other than vaginal penetration" as the new way for young adults to have access to sexual relationships while preserving the female virginity. (Bakass & Ferrand, 2013)
- Even if abortion is restricted to the case of saving woman's life, abortion in safe settings although clandestine might be widespread.

(Orphans cannot explain this trend as the numbers are not corresponding to such a decrease 0.3% in Oman for example)

➔ **Contraception seems to be a major need for women in the MENA and the non-representation of all sexually active women in the surveys is a bias which could suggest a massive need for counselling, education and access to reliable contraception.**

➔ **No indicator about abortion were found in the MICS. Testimonies and the analysis of Women on Web data, have been added to this report to alleviate this bias.**

SGBV

Some key indicators can be found in the MICS analysed. Concerning **early marriage**, the proportion of marriage before 15 and 18 years old are **important** especially in Oman (18.1%), Iraq (24.8%) and Palestine (21.7%).

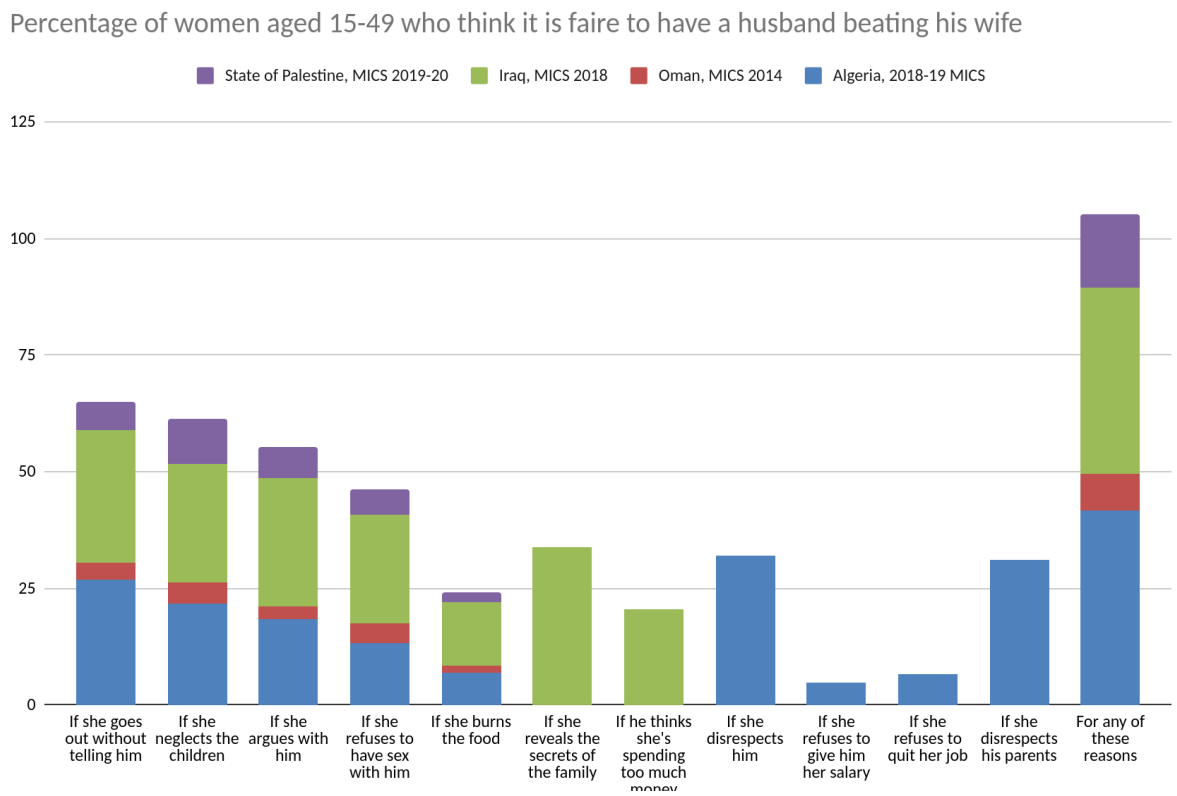
The **polygamous marriages** are accounting for around 4.5% of all the marriages in these countries.

	Algeria,	Oman,	Iraq, MICS	State of

	2018-19 MICS	MICS 2014	2018	Palestine, MICS 2019-20
Early marriage				
Marriage before age 15	0.2	6.1	5.7	1.8
Marriage before age 18	3.9	18.1	24.8	21.7
Married women with polygamous husband	3.2	4.5	5.8	4.3

Female Genital Mutilation has been recorded only **in Iraq,** and **concerned 7.4% of the women interviewed. An encouraging indicator is the high percentage of Iraqi women who believe this practice should be discontinued (93.6%),** while only 0.5% of women with daughters less than 14 years mentioning they have undergone an FGM.

Another important SGBV aspect retrieved in the MICS, was the **attitude of women towards domestic violence. Women were justifying physical violence by men** (41.7% of Algerian and 39.9% of Iraqi) **Going out without telling the husband, neglecting the children or arguing with him for example being a justification for the man to beat his wife.**



➔ **Education on all SGBV forms would be necessary, and should be discussed across society. Religious leaders, media, artists, influencers on social media have to be included. Partnerships with the civil society accross the region on these topics are mandatory to work on an effective way to stop SGBV in all its forms.**

As stated by a participant of the survey, this violence is present in all social classes, and it has increased during the pandemic : "*Sexual and gender-based violence occurs at all levels of society and in almost all settings. The manifestations of these attacks are above all rising domestic violence, especially since the start of the pandemic and rapes*."[26]

Another participant wrote: "*it highly exists in so many forms which vary between early marriage, forced marriage, depriving of resources, sexual harassment, and assault. The reporting of rape cases is still not clear due to lack of disclosure and reporting but it is widely spreader in camps and overcrowded houses*."

➔ **A telemedicine service including SGBV care would be a good tool to quantify this violence, and permit more advocacy on the subject.**

Conclusion

By questioning the pertinence of a telemedicine service for SRH in the MENA region, the question of the context in which the telemedicine could take place emerged.

Effectively, telemedicine seems to be an efficient means in a number of countries, and seems as safe as other face-to-face medical services, acceptable to women, and cost-effective for health systems. Through this pandemic, telemedicine appears to be an effective tool to better answer to the needs of the population. It can be an option if it respects equality between women (rural, analphabets, different ages and communities) and if it respects the security of the data and confidentiality of the consultations. A proper networking of all the potential partners, hospitals etc. should be mapped and regularly updated to provide an accurate answer and safe option to women in need.

This new tool would help to answer a part of the SRH important challenges. Indeed, in 2019, the WHO regional office for the Eastern Mediterranean declared:
"*The main challenges to improving sexual and reproductive health and rights in the Region are: lack of national plans supporting the provision of sexual and reproductive health care; fragmented service delivery mechanisms; poor accessibility to care services among the population groups who need them most; poor quality of care; social and cultural barriers; lack of national policies fulfilling women's and girls' rights to achieving positive reproductive health outcomes; and instabilities and conflicts that have made the already inadequate infrastructure for sexual and reproductive health more fragile".*

[26] [Les violences sexuelles et sexistes se manifestent à tous les niveaux de la société et dans presque tous les milieux. Les manifestations de ces agressions sont surtout la violence conjugale montante notamment depuis le début de la pandémie et les viols.]

Telemedicine can therefore help address these issues, not only by answering them, but also, and maybe more importantly by quantifying them, publishing them, and helping advocate for a change.

As seen in this report, even if access to a health provider is possible in the region during and after pregnancy, the quality of the consultations nor the outcome (complications, deaths, women's satisfaction..) are analysed. Contraception access seems low while the fertility rate is dropping across the region, questioning the sexuality of young adults and abortion rates, even in countries where the legislation restricts it. The example of HIV prove that the lack of education leads to discrimination. The same ingredients leading to the same consequences, SGBV partial statistics and rare testimonies already show a serious public health problem.

The design of a telemedicine service should therefore ensure equality and security to women, improve their autonomy, but also improve justice by supporting research and advocacy to help sustainable improvement of women's health and rights in this region.