CULTURE AND SOCIETY

INTRODUCTION

Social and cultural norms profoundly affect equity within political and economic structures and the conditions of daily life throughout the Eastern Mediterranean Region, and these, as outlined throughout this report, shape health and lead to health inequities. Across the Region, economic and political arrangements, and experiences in daily life, closely relate to dominant religious beliefs, gender norms, and attitudes towards migrants and refugees. So important are these social and cultural arenas to “building back fairer” that without progress on these fronts, reducing inequities in health in all the areas covered by this Commission is unlikely.

There is great potential for social and cultural norms to bring positive change to the Region. Religious leaders can support healthy practices and attitudes, and faith-based organizations can support progress in health and the social determinants of health for many marginalized groups across the Region. Strengthening these approaches will therefore be hugely beneficial. Greater gender equity directly supports a range of desirable outcomes in key social determinants of health, including education, employment and income, improved living conditions, and stronger economies and overall levels of development. More positive attitudes towards refugees and migrants in the Region will not only enable better health and social determinants of health for refugees and migrants, but can also unleash economic benefits for host nations.

While religion, gender equity and attitudes towards refugees and migrants are important in every region in the world, they are particularly significant factors in the WHO Eastern Mediterranean Region. Although the Region is diverse and social norms vary across it, similarities exist which allow some degree of generalizability, with important caveats related to national and local contexts.

In the Eastern Mediterranean Region, religion is integral to identities, behaviours and attitudes that have important effects on people’s health and social determinants of health, although there are variations in the support for health provided by religious belief and religious organizations. Religion can be a powerful ally to the Commission’s central themes of health equity, fairness and dignity, and religious leaders can be influential contributors to societal endorsement for this agenda and in implementing our recommendations. Gender norms and roles also vary across the Region, with differing levels of equity in countries, but overall, there is a need to improve levels of gender equity, which would benefit health and levels of social and economic development.

Attitudes towards refugees and migrants are complex in the Region. Many countries have welcomed millions of refugees fleeing conflict and provided them with refuge and safety, while other countries actively recruit economic migrants to fill their labour shortages and provide employment and some level of economic security. But migrants and refugees are generally not afforded the same services and resources as citizens and attitudes towards refugees are increasingly hostile, as resources and employment opportunities are scarce in many host countries and the numbers of refugees is growing rapidly. This damages the prospects, and health, of the many refugees and migrants living in the Region and there are signs that the situation may deteriorate further as a result of the COVID-19 pandemic.

RELIGION AND IDENTITY AND HEALTH EQUITY

Religion is a fundamental structure of daily life for many individuals, communities and nations throughout the Eastern Mediterranean Region, and is an important driver of health and the social determinants of health. This section focuses on opportunities for religious leaders and faith-based organizations to positively influence health and the social determinants of health. Studies have demonstrated that religion is a source of social support, social control and social capital, which all influence individual and community behaviours and sense of empowerment in ways that affect health (1).
Faith-based organizations provide important social and health-related services and play a strong advocacy role, influencing governments and leaders and affecting policy and resources (2). Religious leaders are very influential within the Region, and given their respected voices within their communities, different organizations have sought their assistance to promote human rights and social justice messages.

However, organized religion and spirituality are not always associated with positive health outcomes; they can be harmful and, in some settings, have been associated with harmful practices, as well as with conflict and violence (1). This can lead to stigma regarding antenatal care visits for pregnancies that occur outside of marriage, sexually transmitted infections and care-seeking after sexual assault (3, 4). HIV is sometimes linked with moral transgression and seen as a punishment from God, and individuals living with HIV may therefore not seek lifesaving treatments (5). While negative outcomes are sometimes attributed to organized religion, it is important to distinguish between religion and the misuse of religious identity by some leaders and followers to promote their own religious interpretations.

While this chapter draws attention to the positive role of religious leaders and faith-based organizations, such roles must be a part of an integrated strategy to secure broader societal support and action for health equity. The strategy outlined in this report supports the mainstreaming of human rights principles in all facets of life, alongside zero tolerance of any violations under the pretext of cultural specificity and misinformed religious interpretations.

While Islam is the predominant religion throughout the Eastern Mediterranean Region, other faith groups are present and religious diversity exists within each group. Overall, of the nearly 600 million people living in the Region in 2010, an estimated 96% were Muslim, 3% Christian and 1% were categorized as other (6). Given the predominance of Islam throughout the Region, this chapter presents most of its examples from Islamic religious practices and faith-based organizations.

**RELIGION AND HEALTH**

Global evidence shows that regular attendance of religious groups is associated with lower blood pressure (7), lower all-cause mortality risk, and reduced likelihood of chronic pain and other physical health ailments, as well as lower alcohol use and smoking prevalence (7–9). Involvement with organized religion and strong spiritual beliefs are also associated with better mental health outcomes, including enhanced coping skills and reduced loneliness, anxiety, depression and suicide (10–12). Furthermore, spiritual or religious support can strengthen self-esteem and a sense of belonging and empowerment, helping people to deal effectively with stress and traumatic life experiences (13).

Beyond the health benefits of involvement with religious organizations and having religious beliefs, different religious groups utilize many mechanisms to regulate behaviours which directly and indirectly influence health and the social determinants of health. Faith-based programmes often include religiously-tailored health messages, grounding the intervention in a religious perspective and the relevant scripture (14). Research has indicated that religious individuals might have more trust in religiously-tailored health messages compared with non-tailored messages (15–17). Religious leaders often lead discussions on topics related to health and the position worshippers should take on the issue and have played key roles in health initiatives promoting tobacco control, smoking cessation and abstinence from alcohol (see Box 6.1), as well as in family planning advocacy and denouncing female genital mutilation (FGM) (see Box 6.2).

**Box 6.1. Alcohol use and religion**

In Islam, alcohol use is prohibited, and one positive health outcome is the relatively low prevalence of alcohol use disorders in the Eastern Mediterranean Region. In 2017, the global prevalence of alcoholism globally was 14.6 per 1000 people compared to 9 per 1000 people in the Eastern Mediterranean Region (18). Similarly, the prevalence of foetal alcohol spectrum disorder is lower among children and youth in the Eastern Mediterranean Region (0.1 per 1000 people) than globally (7.7 per 1000 people) (19).
Box 6.2. FGM and religion

Many religious institutions and religious leaders within the Eastern Mediterranean Region have denounced FGM (20), stating that it is not an Islamic practice and that no female should undergo such a procedure — although such announcements have had variable effects on reducing FGM (21, 22). Although the practice is primarily driven by cultural traditions rather than religious ones, religion has been used to rationalize the practice in some contexts and to promote its prohibition in others (23, 24).

The position of the WHO Regional Office for the Eastern Mediterranean on FGM is clear: “FGM is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person’s rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death” (25).

Additional research is needed to identify the most effective actions to reduce FGM, but Egypt’s recent initiatives that have combined the use of informed religious leaders with criminalization of FGM (see Box 6.3), are promising for potential expansion within the Region (26).

Box 6.3. Reduction of FGM in Egypt: a collaborative effort between religious leaders, United Nations agencies and WHO

A collaboration between faith-based organizations, religious leaders, the Egyptian government, United Nations agencies and WHO was established in Egypt to end FGM. Prominent religious institutions made public statements and rulings forbidding FGM and rejecting it as part of Islamic law (26). The Egyptian government imposed a complete ban on FGM in June 2007, while also promoting a television campaign with UNFPA and UNICEF to persuade parents to abandon the practice (26). Egypt has seen declines in FGM in recent years, which have been attributed to these actions (27).
In some communities, religion has been used to justify restricting women’s rights and limiting access to contraception (28). Given the importance of religious norms and beliefs in sexual and reproductive health promotion, United Nations bodies such as UNFPA have prioritized collaboration with religious leaders and institutions to improve the success of programmes to improve family planning and reproductive health. One example of such an initiative is the role that religious leaders and institutions have played in promoting national family planning programmes in the Islamic Republic of Iran, Syrian Arab Republic and Yemen (see Box 6.4).

**Box 6.4. Reproductive health and family planning in Islamic Republic of Iran, Syrian Arab Republic and Yemen**

In the Islamic Republic of Iran, religious leaders have played a crucial role in implementation of the national family planning programme (29, 30). In 1988, the High Judicial Council announced that family planning did not have any Islamic barriers. The Iranian family planning programme had three primary goals: 1) encourage birth spacing; 2) discourage pregnancies for women under 18 years old and above 35 years old; and 3) discourage parents from having more than three children. The goal of the programme was to enhance the physical and social well-being of women, children and the broader Iranian society. The programme saw remarkable success – the population growth rate decreased from 3.9% in 1986 to 1.2% in 2000 and total fertility decreased from 6.8 children per household in 1984 to 2.1 children per household in 2000. The success of the programme has been widely attributed to the support of the Islamic clergy after their deliberation and endorsement, which developed a widespread norm that established birth control as a religious duty as much as a social one.

Before 2008, UNFPA partnered with the Ministry of Awqaf (Ministry of Religious Endowments/Religious Affairs and Religious Guidance) in the Syrian Arab Republic to produce a booklet on Islamic perspectives on family planning, after conducting training workshops with imams on issues related to reproductive health. Together, they promoted television programmes that discussed both reproductive health and gender issues from an Islamic viewpoint (31).

In the early 2000s in Yemen, UNFPA partnered with the Ministry of Awqaf to improve sexual and reproductive health services for adults and adolescents, and mobilized imams and religious leaders to promote family planning in mosques. UNFPA identified engaging religious leaders at the national level in discussion about population, gender, and sexual and reproductive health as essential for the project design and implementation (31, 32).

Tobacco control and smoking cessation efforts have been promoted by some religious institutions and leaders in collaboration with WHO and its Member States. Authorities in Saudi Arabia restricted tobacco use in and near the two holy mosques in Mecca and Medina, which led to the nomination by the WHO Regional Office of the two cities for the global Tobacco-Free Cities project in 2002 (33). In 1988, the WHO Regional Office published a report on the Islamic ruling on smoking that included the views of Islamic scholars toward the practice (34). This publication resulted from a request by the Egyptian Ministry of Health and Population, following the nation’s fatwa on smoking (33). These examples of collaborative efforts could be expanded to other health and social determinants of health issues.
Religious leaders can also support disease control programmes, including vaccinations and screening for diseases, as they are often well trusted by local communities (see Box 6.5). These roles will be vitally important in the management and prevention of COVID-19 infection.

**Box 6.5. Islamic Advisory Group for Polio Eradication**

Since 2014, the Islamic Advisory Group for Polio Eradication (IAG) has worked with Muslim religious scholars and groups, donor countries and organizations to eradicate polio in endemic countries, including Afghanistan and Pakistan, and in outbreak countries such as Somalia. In 2017, the IAG expanded their work to cover mother and child health and immunizations. The IAG is a valuable part of the work being undertaken to address vaccination hesitancy and refusal and to fight misinformation. They work with religious leaders and local communities to urge parents to vaccinate their children, assuring families that the vaccinations conform to Islamic rulings (35).

**RELIGION AND THE SOCIAL DETERMINANTS OF HEALTH**

Religious organizations and leaders influence the social determinants of health through their advocacy, influence with worshippers and the direct provision of and support for essential social services such as humanitarian aid, education and welfare support for individuals living in poverty. Given the low levels of social protection and service provision funded and organized by national governments across the Region, provision of these services plays an important role in supporting population health and outcomes across a range of social determinants of health. The WHO considers faith-based organizations to be important actors within civil society “for collective action around shared interests, purposes and values, generally distinct from government and commercial for-profit actors”.

Education is influenced by the practices and rules of religion, and religious leaders can play a critical role in shaping participation in education by promoting or discouraging the education of girls (36, 37) (see Box 6.6).

**Box 6.6. Religious leaders promoting female education in Afghanistan**

In Afghanistan, training for religious leaders was conducted by UNICEF in 2003 and by the Women’s Islamic Initiative in Spirituality and Equality in 2009–2010 to improve access to girl’s education and awareness of women’s rights (38, 39). The training resulted in over 300 Friday sermons at mosques, reaching nearly 120,000 congregants, that promoted women’s education, reduction of child marriage, improved understanding of inheritance, ownership and property rights, and encouraged women’s political and social participation (39).
Islamic Relief and Muslim Aid are prominent actors in the humanitarian aid sector in the Eastern Mediterranean Region, providing emergency response support, food aid, clean water and sanitation facilities (40, 41).

Donors, nongovernmental organizations and United Nations agencies have, at times, supported faith-based organizations that are working to improve food security. One of the benefits is their focus on providing meals that take into consideration religious rules, practices and norms (42). Box 6.7 describes previous partnerships between WFP and faith-based organizations in Somalia and the Syrian Arab Republic. Donor support is often provided to large, well-known faith-based organizations, such as Islamic Relief Worldwide (42, 43). Donors are less inclined to partner with faith-based organizations for more sensitive programmes, such as those to improve sexual and reproductive health services.

**Box 6.7. WFP collaboration with the Aga Khan Development Network in Syrian Arab Republic and Muslim Hands in Somalia**

WFP prioritizes working collaboratively with international and local nongovernmental organizations, including faith-based organizations, who often have a deep understanding of the communities WFP works in and a long-term presence that improves sustainability (44).

The Aga Khan Development Network, a faith-inspired organization, has worked in six areas in the Syrian Arab Republic since 1999 (45) and has contact with local networks to reach those most in need of food assistance (46). In 2016, a partnership between the Aga Khan Development Network and WFP benefitted 60,000 people each month through nutrition and school snack programmes (47). In 2018, over 10,000 metric tonnes of food aid was delivered and over 1.5 million litres of water storage capacity installed (45).

WFP collaborated with Muslim Hands, an international nongovernmental organization, between 2013 and 2016 in southern Somalia to reduce hunger in communities affected by conflict and drought (47). Muslim Hands provided in-depth knowledge of local communities, which allowed them to mobilize and build irrigation canals and provide technical guidance and non-food supplies, while WFP provided food to address the immediate hunger needs of the communities. The irrigation systems more than doubled agricultural production by 2016, improving food security and providing a surplus income for families. WFP noted access to social services such as a health care and education improved, especially for women and children, after the installation of the irrigation systems.

There are, however, challenges in partnering with faith-based organizations. It is important that equity and human rights principles underlie all actions adopted by this influential group of stakeholders. Principles of citizenship, equality, non-discrimination, dignity and tolerance need to be incorporated into an integrated strategy involving those faith-based organizations that seek social engagement and support advocacy for the equity agenda.

Governments, United Nations agencies, WHO and secular nongovernmental organizations should carefully evaluate the contribution of faith-based organizations to the social sector, establishing whether their contributions are independent of their political agendas and vetting potential organizations as project collaborators. An example of a faith-based organization that was vetted according to criteria developed by UNICEF is described in Box 6.8.
While religion has a well-documented and important influence on health and the social determinants of health, its inclusion in reports, documents and resolutions by WHO, United Nations agencies and governments has been limited. UNFPA has been the primary agency within the United Nations system that has prioritized engagement with religious leaders and communities to achieve their goals, publishing reports that examine the influential role of religion and culture in their work (31, 32, 50). The United Nations Inter-Agency Task Force on Religion and Development (now known as the United Nations Inter-Agency Task Force on Engaging Faith-Based Actors for Sustainable Development) has published Guidelines for engaging faith-based organizations (FBOs) as cultural agents of change (51), reported on their engagement with faith-based organizations (52–54) and engaged religious leaders in the SDG process (42).

**Box 6.8. Establishing partnerships between UNICEF and Al-Markaz al-Islami to improve social determinants of health in Jordan**

Al-Markaz al-Islami is affiliated with the Islamic Center Charitable Society and has been operating for many years across Jordan (48). The majority of their funding is from private donations by wealthy Jordanians and larger charities from the Gulf. They primarily serve recent refugee arrivals, offering essential relief items such as clothing, food, household items and cash (48).

UNICEF requires that its partners adhere to strict criteria, including child protection, before establishing collaborations (48, 49). Potential partner organizations are assessed for their current policies and systems using an external audit firm, which includes examining whether the organization is affiliated with terrorist groups or activities that violate human rights (48). After this review, Al-Markaz al-Islami began their partnership with UNICEF in 1996 to provide informal education and psychosocial activities for child refugees living in Jordan (48). The partnership allows UNICEF to reach some of the hardest-to-reach populations, such as children living independently without parental care (48).

UNAIDS (55), UNFPA (32) and UNICEF (56) have published international guidelines and advisory documents to support collaboration with faith-based organizations in development (42). However, clear guidelines and replicable examples of effective collaboration between United Nations agencies, WHO, ministries of health and governments specific to the Eastern Mediterranean Region should be established and circulated in local languages.

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**GENDER AND HEALTH INEQUITIES IN THE REGION**

Gender is a key social determinant of health for both men and women. Gender norms and inequities affect outcomes in all areas covered by this report. Gender inequities have a critical influence on inequities in health, education, employment, income, likelihood of experiencing harm from conflict, intimate partner violence, access to power, money and resources, and capacity to lead a dignified, healthy life. Deep-seated inequities in attitudes towards men and women include expectations about the family roles and domestic tasks that girls and women should perform, what girls and women should aim for in life, and how they should shape their identity. They include norms about the appropriate age of marriage and number of children to have, domestic roles and the appropriate level of education, and affect political and community influence, decision-making and levels of autonomy among women.

These largely unquantifiable but pervasive gender cultures and norms profoundly affect every facet of life for women and girls. They manifest in: much lower employment rates, despite the improvements in participation in education in the Region; limited political involvement, leadership roles and community influence and involvement in decision-making; much
higher rates of caring for family members; lower levels of income and access to social protection mechanisms throughout life; and high levels of gender-based violence (57). These gender norms and expectations are also differentiated by socioeconomic factors; women with more education and higher economic positions may have greater involvement in the paid labour force and in decision-making, for instance. Gender inequities mostly affect and damage girls and women, but boys and men are also negatively impacted by gender norms and biases. These are reflected, for example, in risk-taking and health-harming behaviours, being expected to be involved in conflicts and to meet cultural expectations around status and income, and stereotypical masculine identities that can undermine their physical and mental health and that of those around them. Gender norms and biases also have an influence on men and boys’ experience of health care and their access to it (57).

The Gender Inequality Index was introduced by UNDP in 2010, and is a “composite measure which is reflective of the inequality in achievements between women and men in three dimensions” that include reproductive health, empowerment and the labour market (58, 59). The Gender Inequality Index ranges from 0 to 1, and the closer the Index is to 1, the higher the inequalities there are between women and men. In 2018, sub-Saharan Africa, South Asia and the WHO Eastern Mediterranean Region had the highest levels of gender inequality as measured by the Index compared with other regions (Fig. 6.1). These high levels of gender inequality harm the development and progress of countries in the Region (60).

Fig. 6.1. Mean Gender Inequality Index, by region, 2018

Note: The Gender Inequality Index value was not available for Somalia, Djibouti and the occupied Palestinian territory and are therefore not included in the Eastern Mediterranean Region average.
There are wide variations in gender inequality among countries in the Eastern Mediterranean Region, as shown in Fig. 4.2. The value of the Gender Inequality Index ranges from a low of 0.11 in the United Arab Emirates to 0.83 in Yemen, which is the highest level of gender inequality among countries with available data.

**Fig. 6.2. Gender Inequality Index, by country, 2018**

Note: The Gender Inequality Index value was not available for Somalia, Djibouti and occupied Palestinian territory.


In the Eastern Mediterranean Region, understanding of gender roles differ between men and women and between countries. Data from surveys in Egypt and Lebanon in 2016 using the Gender-Equitable Men (GEM) Scale\(^1\) show that women have more equitable views about gender roles than men, indicating that women wish to resist some of the prevailing gender norms and attribution of gender roles in Egypt and Lebanon (61). There are also differences in views about gender roles which relate to levels of wealth and education, area of residence, employment status and age (see Fig. 6.3–6.10). Being female, having higher levels of wealth and education, living in cities and being younger, all increase support for greater gender equity. These differences in understanding and appetite for greater equity, while only from surveys in two countries, provide support for increasing female levels of education in order to increase support for gender equity, with all the associated benefits to health and development that would bring.

\(^1\) The GEM Scale ranges from 0 to 3, with 0 being the most inequitable and 3 being the most equitable (61).
**Fig. 6.3. GEM Scale score in Egypt by sex and wealth, 2016**


**Fig. 6.4. GEM Scale score in Egypt by sex and education level, 2016**

Fig. 6.5. GEM Scale score in Egypt by sex and residence, 2016

![GEM Scale score in Egypt by sex and residence, 2016]


Fig. 6.6. GEM Scale score in Egypt by sex and age group, 2016

![GEM Scale score in Egypt by sex and age group, 2016]

Fig. 6.7. GEM Scale score in Lebanon by sex and wealth index, 2016

![GEM Scale score in Lebanon by sex and wealth index, 2016](image)


Fig. 6.8. GEM Scale score in Lebanon by sex and education, 2016

![GEM Scale score in Lebanon by sex and education, 2016](image)

Fig. 6.9. GEM Scale scores in Lebanon by sex and employment position, 2016


Fig. 6.10. GEM Scale score in Lebanon by sex and age group, 2016

In the previous section, we outlined those religious practices and attitudes that can be supportive or undermining of health and health equity. Many of these practices and attitudes also inform views about gender roles. Whether rooted in religious beliefs or not, cultural and social beliefs that stereotype the roles of women and men in society may hinder development and limit the lives and health of populations. Taking action to improve gender equity and support human rights is one of the most direct and potent ways to reduce health and other inequities overall (62).

Abundant evidence shows that female education and paid employment support family, community and population health and improve a range of outcomes which are beneficial for health and social and economic development. The World Bank has outlined that women who are better educated are more likely to be knowledgeable about health care and nutrition and to marry later, and the children of better educated women are usually healthier (63). An average child gains an extra 0.32 years in school for each additional year of their mother’s education (64, 65), and better educated women are more likely to be engaged in the formal labour market and to have higher incomes (63). Drawing on data from the World Bank, Bourne (2014) (64) outlined that the return on every year of secondary education for a girl correlates to as much as a 25% increase in their wages, which reduces household and community poverty (63). UNICEF has shown that there is 0.37 percentage point increase in GDP for every percentage point increase in female education and this can help to support national development (66).

So strong is the evidence of the benefits of female education and employment for development, social progress and health that it may be the most powerful and readily available health improvement and development strategy. Female education and employment also lead to reductions in family size, with data suggesting that women with higher levels of educational attainment are likely to have fewer children (67).

In other chapters we outline gender inequities related to specific social determinants of health such as experiences in the early years, education, employment rates, income, access to social protection, and environmental and living conditions. In this chapter we set out inequities not covered in other chapters, including caring roles and gender-based violence in the Region.

CARING ROLES

All over the world women are usually the main providers of informal, unpaid care for family members. This is particularly evident in the Eastern Mediterranean Region due to social and cultural norms which place women in the role of family caregiver, reinforced by the low levels of availability of early years services and those for adults who need care and for older people (62).

Unpaid care work refers to “all unpaid services provided within a household for its members, including care of persons, household and voluntary community work” (68). Fig. 6.11 shows how women, based on data from 2014, spent more time on unpaid care work in all regions when compared to men, with the widest difference seen in the Middle East and North Africa region.
In Chapter 10 on healthy aging, we outline data on gender inequities in responsibilities for caring for older family members – a situation which limits women’s opportunities for employment, community roles and other possibilities for social empowerment and participation. The low levels of affordable service provision for older people makes these caring roles essential. Women also largely have responsibility for other domestic tasks and for looking after children. A report based on data from the IMAGES MENA survey in Egypt, Morocco and the occupied Palestinian territory indicates that nearly 80% of men and just over 60% of women surveyed were in support of the idea that taking care of the home and cooking for the family is the most important role for women (61). The specific results are outlined in Fig. 6.12. In each of the surveyed countries or territories, a higher proportion of men than women agreed with this statement.
In many countries, women’s low levels of participation in the labour force relate to expectations and requirements that they will undertake unpaid caring roles and domestic duties and they are financially dependent on their husbands (68, 69).

All these factors lead to and reinforce high levels of gender inequity in the Region. Changing these expectations is important and needs to be undertaken in conjunction with provision of accessible and affordable services in the early years and for older people and those in poor health. However, shifts in attitudes and greater provision of services will still be inadequate to reduce longstanding gender inequities. Protections from discrimination and exclusion on the basis of gender need to be enshrined in law and based on the principles and actions outlined in the SDGs and human rights legislation, discussed in following chapters. Legislative mechanisms to enshrine greater gender equity need to be adhered to, with sufficient sanctions for organizations or individuals who contravene them.

**GENDER-BASED VIOLENCE IN THE REGION**

Gender-based violence is an umbrella term for any harmful act that is perpetrated against a person’s will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private (70). According to the 1993 United Nations Declaration on the Elimination of Violence against Women, violence against women refers to “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life” (71). Gender-based violence is widespread globally, and particularly high in the Eastern Mediterranean Region (72, 73). Analysis shows that gender-based violence is related to levels of gender inequity in society, and while occurring in every socioeconomic demographic, it is higher among less educated and poorer communities and increases physical and mental health inequities (74, 75).
Intimate partner violence is a form of gender-based violence and is the most common type of violence against women. It refers to “any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship” (76). The health consequences of intimate partner violence have been widely documented and include death, disability, NCDs, devastating mental health consequences, worse reproductive and sexual health outcomes and worse outcomes for babies and children (77, 78, 79). Besides adverse health effects, violence against women costs them and their families large sums of money for health services, days lost from work, damaged property, missed school days by children and other impacts. A study in Egypt estimated the total cost of intimate partner violence for survivor women and their families in 2016 to be 2.17 billion Egyptian pounds i.e. approximately US$ 12 700 000 (80, 81).

Intimate partner violence is culturally tolerated in many parts of the world, including in the Eastern Mediterranean Region where there are a number of countries with insufficient legislation to reduce intimate partner violence. There are a range of institutional elements which have been highlighted as driving factors of gender-based violence, including power and control structures that are male-dominated, social and cultural attitudes about women, and systemic gender discrimination, all of which are present in the Region to varying degrees (82).

On a regional level, based on WHO data from 2010, it is estimated that the Eastern Mediterranean Region has the second highest rates of intimate partner violence (37%) globally, very close to the region with the highest rates, South-East Asia (37.7%), although data from only five countries and territories were available, namely Egypt, Iran (Islamic Republic of), Iraq, Jordan and the occupied Palestinian territory (79). Rates of intimate partner violence are likely to be even higher than reported as there is considerable underreporting; it is frequently hidden and regarded by many as private, and in some cases even legitimate. Women are often reluctant to report intimate partner violence to the police for fear of retaliation by their husband and of losing their children or because they have no source of income to support themselves if they get a divorce (81, 83). OECD data for countries with available data show that the percentage of women in the Region in 2019 who had experienced physical and/or sexual violence from an intimate partner at some time in their life, ranged from around 10.4% in Lebanon to 85% in Pakistan, as shown in Fig. 6.13.

Fig. 6.13. Percentage of women who have experienced physical and/or sexual violence from an intimate partner at some time in their life, in selected countries in the Region, 2019 or latest available year

There are inequities in the prevalence of gender-based violence related to socioeconomic and demographic factors, including age of marriage, educational level, poverty, community norms and attitudes, women’s access to employment, and childhood experiences of violence (85–87). Those who are economically insecure or in chronic poverty are at a disproportionately higher risk of being subject to gender-based violence (88), as shown in Fig. 6.14 for Egypt.

Fig. 6.14. Percentage of currently married women who have experienced physical, sexual or psychological violence from most recent husband ever or within the past 12 months in Egypt, by wealth quintile, 2005

Additionally, women who are poorer and economically insecure tend to live in areas with weaker legal systems, higher levels of conflict and fewer support services (88), all of which means intimate partner violence is more likely to occur and less likely to be punished.

The Egypt Demographic and Health Survey (2005) study also found that prevalence of intimate partner violence against women was higher among women with lower education levels (Fig. 6.15).

**Fig. 6.15. Percentage of currently married women who have experienced physical, sexual or psychological violence from most recent husband ever or within the past 12 months, in Egypt, by education level, 2005**

Despite the high levels of intimate partner violence in some countries, and the harm that results, there is widespread tolerance of such violence in countries and territories in the Region, including from women (see Fig. 6.16). This damages efforts to reduce rates and is the result of pervasive gender inequities and cultural and societal beliefs about male and female power and identity (90, 91).

**Fig. 6.16. Percentage of women who agree that a husband/partner is justified in beating his wife/partner under certain circumstances in selected countries and territories in the Region, 2019 or latest available year**

The proportion of women who agreed that their husband is justified in hitting or beating his wife, for at least one specific reason, decreased with increasing level of education for all countries for which Demographic and Health Survey data on this indicator was available, as shown in Fig. 6.17. This again underscores the importance of female education for reducing health inequities.
Fig. 6.17. Percentage of women who agree that a husband is justified in hitting or beating his wife for at least one specific reason in selected countries in the Region, by education level, latest available year

![Percentage of women (%)](image)

Source: USAID’s DHS Program (92).

Box 6.9 provides an overview of analysis by WHO in 2013 of the prevalence, effects and drivers of intimate partner and non-partner sexual violence in the Eastern Mediterranean Region. The report refers to socioeconomic and cultural associations with intimate partner violence and makes proposals for action. Importantly, it suggests social norms regarding gender equity must shift and the underlying economic, social and cultural drivers addressed.

Box 6.9. WHO report on the prevalence and health effects of intimate partner and non-partner sexual violence

A WHO report in 2013 presented the results of the first systematic review of scientific data relating to the prevalence of violence against women by an intimate partner and sexual violence by someone other than a partner. Drawing on the evidence, the report highlights the need to address the sociocultural and economic factors which influence violence against women. The needed actions include: challenging social norms which support male authority and control over women and sanction or condone violence against women; reducing levels of childhood exposure to violence; reforming discriminatory family law; strengthening women’s economic and legal rights; and eliminating gender inequalities in access to formal wage employment and secondary education (79). The report also highlights the need for the health sector to have a greater role in responding to violence against women (79). Clinical and policy guidelines for the health-sector response to violence against women have been outlined by WHO, which emphasize the need to integrate issues related to violence against women into the clinical training of health professionals (79). Identifying opportunities for providing support for women and ensuring they have access to the services they need, including emergency services, is also highlighted as a key aspect in the response to violence against women (79).
Evidence shows that efforts to reduce violence against women should include the whole of society. Legal mechanisms, including criminalizing intimate partner violence, educating men and women about the harm that results from gender-based violence and practical steps to improve access to support services are all essential. As a first step, abiding by the United Nations Declaration on the Elimination of Violence Against Women is vital.

In most countries and territories of the Region, initiatives to combat intimate partner violence are still small scale and are not backed up by effective legislative and system support, and many women—particularly the poorest, least educated and those in rural and more isolated areas—are either not yet aware of, or do not have access to, such services (81).

Constitutional and legal steps to outlaw violence against women coupled with policies that support women’s financial independence and empowerment are important to reduce violence.

UNHCR has implemented cash assistance programmes in Lebanon and conducted an analysis of these to investigate their impact on the prevention and mitigation of, and response to, sexual and gender-based violence (93), as described in Box 6.10.


UNHCR investigated the impacts of three cash assistance programmes on sexual and gender-based violence in four locations in Lebanon (93). The programmes included a protection cash assistance programme and an emergency cash assistance programme, which offer financial support for protection incidents or vulnerabilities, and a multi-purpose cash assistance programme, which provides a one-off payment to support the basic needs of those who are living in poverty (93). Evaluations showed that the emergency cash and protection cash programmes assisted survivors of sexual and gender-based violence in moving away from their abusers and the multi-purpose cash programme was found to prevent or mitigate the risk of resorting to potentially harmful coping mechanisms, such as exploitative work. Overall, it was concluded from the results of the study that cash programmes can be effective risk mitigation and prevention tools that help to prevent women from persisting in or falling back into abusive situations (93). Some of the immediate impacts observed included being able to meet some basic expenditures, improved safety and relieving stress and anxiety.
An intervention to reduce gender-based violence in Pakistan is described in Box 6.11.

**Box 6.11. Programmes in Pakistan to address gender-based violence**

The Preventing Violence Against Women and Girls through Sport and Play programme was an intervention in Pakistan that ran until 2018, led by an international nongovernmental organization called Right to Play (94). Some of the key objectives of the programme were to increase the involvement of the community in supporting gender equality and addressing violence against women and to increase the capacity of organizations and authorities at community, local and national levels to reduce gender-based violence (94). Additionally, the programme provided teachers with training and a curriculum directed at challenging the acceptability of violence against women, and supported community-based organizations in taking action to support social change and a shift in attitudes regarding gender equality (94). Aga Khan University carried out an evaluation of the programme and concluded that it had made a significant impact on the gender attitudes and behaviours of participants (95). There was a 59% reduction in bullying for girls and a 33% reduction for boys, and a 66% decrease in corporal punishment in schools for girls and a 45% decrease for boys, and reported depression levels decreased by 10% for girls and 7% for boys (95).

WHO has also undertaken a number of actions to strengthen the ability of health systems in the Eastern Mediterranean Region to respond to gender-based violence, as outlined in Box 6.12.

**Box 6.12. Work by WHO to strengthen the capacity of health systems to respond to gender-based violence in the Region**

The WHO Regional Office for the Eastern Mediterranean provides technical and financial support to 10 countries and territories (Afghanistan, Egypt, Iraq, Libya, Morocco, occupied Palestinian territory, Pakistan, Somalia, Sudan and Syrian Arab Republic) to strengthen the health system response to violence against women and girls, focusing on six areas of work: policies, guidelines and tools; health workforce strengthening; community awareness; gender-based violence in emergency response, including COVID-19; enhancing data and research; and multisectoral coordination. The aim of the work is to enhance health care for gender-based violence survivors and reduce the stigma towards them. More than 5000 health providers have been trained in the Region.

A number of guidelines and tools have been developed to help to strengthen the capacity of service providers and boost multisectoral coordination to ensure comprehensive, survivor-centred care through a public health approach. The tools have been adopted by a number of countries in the Region (96). In 2021, the WHO Regional Office launched the Arabic versions of the Clinical management of rape and intimate partner survivors guideline and the RESPECT women: preventing violence against women framework. These two tools address prevention of, and response to, violence against women in the development and humanitarian sectors.
GENDER-BASED VIOLENCE AND REFUGEES AND IDPS

Women in conflict-affected settings are particularly vulnerable to gender-based violence. Conflicts exacerbate gender inequities and heighten the risk of violence and violations of a woman’s human rights (97). In some cases, gender-based violence has been used as a “weapon of war” and, in the Eastern Mediterranean Region, sexual violence related to conflict has been documented in Iraq, Libya, Syrian Arab Republic and Yemen (98, 99). According to the Vulnerable Women’s Project, “refugee women are more affected by violence than any other population of women in the world” (100) and they often have limited opportunities to access support, including social protection and safe access to services (101).

There are challenges in gathering data on gender-based violence among refugees, meaning that data are limited and sexual violence in this population is often underreported (102). However, a small study was conducted by the United Nations in 2017 to investigate the impact of conflict on gender-based violence in the Syrian Arab Republic (103), and found that 45% of women reported that violence against women was a problem among the refugee community in Lebanon and 37% reported the start of the crisis in Syrian Arab Republic had led to an increase in this violence (103). The study reported that “the actual and perceived fear of violence at the hands of both the host community and the refugee community often keeps them isolated in their households, and consequently prevents them from accessing available services” (103). A survey carried out by the International Rescue Committee (2002) with 200 women in Afghan refugee camps in Pakistan found that 79% of women reported that they had been beaten by their husbands (104). Frequently, health care workers in refugee camps have very little training in addressing cases of violence and further research is required in order to develop appropriate interventions (90).

Gender-based violence is an underfunded area of the humanitarian response, compared with other sectors (105). A study by VOICE and the International Rescue Committee found that the humanitarian funding allocated to gender-based violence was only 0.12% of the expenditure on humanitarian assistance between 2016 and 2018 (105) and increases in funding to reduce gender-based violence in emergency settings is needed.

COVID-19 AND GENDER-BASED VIOLENCE

There is emerging evidence showing that containment measures implemented in response to the COVID-19 pandemic increase the risk of gender-based violence (106) and significantly limit, or completely halt, access to support services for victims of gender-based violence (107). In response to the “horrifying global surge in domestic violence”, the United Nations Secretary-General emphasized the “importance of specifically supporting the rights of women and girls through the COVID-19 crisis, calling for a ceasefire on domestic violence and urging governments to put women and girls at the centre of their efforts to recover from COVID-19” (108, 109).

Between April and May 2020, the WHO Regional Office for the Eastern Mediterranean conducted a survey on the health system response to gender-based violence during COVID-19 in Afghanistan, Iraq and Somalia. The survey found that nearly 40% of health facilities, hospitals and mobile medical clinics responding to the survey indicated an increase in female victims of gender-based violence from the host, refugee and internally-displaced communities seeking assistance during the COVID-19 outbreak. A United Nations policy brief on the Arab region (2020) outlined that during the pandemic many services for women and girls who experience violence were halted or disrupted, and that women and girls had experienced an increase in violence and were feeling less safe in their communities (110).

According to the Jordanian Women’s Union, the three clinics which were used by the Union to support victims of violence had to be closed during the pandemic and the number of staff at the women’s shelters was reduced by 70% (106, 111). Specific actions that have been taken to address gender-based violence during the pandemic for different countries and territories in the Region are outlined in Box 6.13.
Box 6.13. Measures to address gender-based violence during the COVID-19 pandemic in the Region

Joint interagency efforts have been implemented at the regional level to both document and raise awareness of the impact of COVID-19 on gender-based violence for women and girls. In December 2020, a policy brief on Violence against women and girls and COVID-19 in the Arab region was published (110). In addition, 16 days of activism against gender-based violence and a joint regional media campaign were launched, which led to the production of an Arab celebrity awareness video that was published on United Nations social media accounts in the Region (112) and screened during the Secretary-General's event for the commemoration of the International Day for the Elimination of Violence against Women in New York in November 2020.

Different countries have implemented various measures to address gender-based violence during the pandemic. In Iraq, WHO developed guidance for both remote and face-to-face health care services for women who may have been subjected to violence in Iraq, which included the development of an updated referral pathway for each governorate (113). In Lebanon a domestic abuse hotline was launched by the National Commission for Lebanese Women. In addition, a nongovernmental organization (Abaad), in collaboration with the Government, distributed kits with leaflets containing support and helpline contact information, along with basic necessities, for women at risk of domestic violence (106).

In Morocco, a short film to raise awareness of gender-based violence in the context of the confinement measures introduced in response to COVID-19 was launched by the National Commission for the Support of Women Victims of Violence (106). An application for smartphones, designed by the National Union of Moroccan Women, was developed to allow victims of violence to be located in the event of a distress call. Additionally, an online platform was launched in the city of Guelmim to allow victims of violence to file complaints remotely during confinement (106).

In the Occupied Palestinian territory, 13 measures to ensure the safety of women who were victims and survivors of intimate partner violence during the pandemic were outlined in a decision by the Cabinet in the Authority, including a measure that included calls for the Government to consider services for victims of gender-based violence as essential services (106).

In Tunisia, a centre was opened by the Ministry of Women, Family, Children and Seniors to provide gender-based violence victims with a space where they could self-quarantine for 14 days before they were integrated into traditional shelters (106). Additionally, the national domestic violence helpline operating hours were extended to 24/7 and the National Union of Tunisian Women established a phone service to provide legal assistance to women who are victims or at risk of gender-based violence (106).
REDUCING GENDER INEQUITIES

Efforts to reduce gender inequity need to be made in the legislative and governance realms as well as through programmes to shift societal norms about gender roles, in partnership with religious organizations and education systems. Reducing widespread and longstanding gender inequities in education, employment, income and roles within families would significantly improve outcomes in the political and economic spheres and improve conditions of daily life for women and girls, as well as for men and boys. Gender equity is central to the SDGs and until greater gender equity is achieved, there will be limited progress towards the achievement of the SDGs in the Region. SDG 5 specifically relates to gender equality and aims “to achieve gender equality and empower all women and girls”. The Goal’s targets lend themselves to policy intervention and can achieve significant improvements in gender equity, particularly when accompanied by an effort to achieve societal buy-in and engagement with the equity agenda.

One of the nine core international human rights instruments relates to gender equality – the Convention on the Elimination of All Forms of Discrimination Against Women (114, 115). The Convention serves to “reaffirm faith in fundamental human rights and in the equal rights of men and women” and provides the basis for realizing these equal rights (115, 116). To date, all countries and territories in the Eastern Mediterranean Region are States Parties to the Convention, except Islamic Republic of Iran, Somalia and Sudan (117). A number of countries in the Region have stated reservations on particular articles of the Convention that impact on its effective implementation (118). OECD (2014) states that lifting reservations to the Convention provisions is needed “to enable genuine adoption of the principle of gender equality and close compliance gaps with international conventions in the area of gender equality and human rights” (119).

The Region is witnessing a number of positive and significant developments related to gender equity. These include explicit endorsement of gender equity at the highest level of political leadership, prioritizing gender equity and women’s empowerment as central in national development agendas, the formulation of strategies and implementation of legislative reforms and actions, and the establishment of “women’s councils”. This momentum should be built upon and strengthened through ensuring the effectiveness and adequacy of institutional, legislative and resource allocation reforms.

The monitoring, evaluation and accountability roles of women’s councils need to be supported and provided with additional resources and political leverage to influence reforms. In particular, these councils can monitor and support the achievements of the gender-related SDGs and compliance with the international commitments captured in the Convention on the Elimination of All Forms of Discrimination Against Women.

Improving societal ownership and partnerships towards gender equity is crucial for the success of government-level efforts and the realization of gender equity. The implementation of an integrated strategy to allow wider participation of stakeholders and community actors, and to harness the positive potentials of religion and culture, is needed.

ATTITUDES TOWARDS MIGRANTS

As set out in Chapter 4, the Eastern Mediterranean Region has the highest number of refugees and IDPs in the world and many countries in the Region host and provide refuge to them (120). There are enormous challenges in providing basic health care, housing, food, water and other essential services for refugees, as well as challenges in integrating refugees and securing their employment, and the rights and protections that are offered to citizens. Public attitudes towards refugees and migrants can further damage their situation and health and constrain governments’ capacities to support them (121).

Despite high levels of migration, there are limited studies on attitudes to migration in the Region. Available data about public attitudes towards employment opportunities for immigrants (referring to those who have entered a new host country) show that in many countries, respondents feel strongly that locals should be prioritized. These attitudes are particularly prevalent in countries in the Region and are likely to relate to the higher number of migrants and the high unemployment and rates of poverty in many host countries (122). Survey respondents often indicate more supportive attitudes when asked about refugees specifically.
Data from the Arab Barometer in 2019 (121) on opinions towards having immigrants and foreign workers as neighbours shows that 62% of respondents in Libya indicated that they would “dislike” or “strongly dislike” this, whereas in Tunisia only 15% of respondents indicated this (Fig. 6.18).

**Fig. 6.18. Opinions on having immigrants or foreign workers as neighbours, by selected country and territory in the Region, 2016 and 2019**

Being better educated, younger and wealthier tends to reduce negative sentiments towards immigrants and foreign workers, with a few exceptions, as outlined in Table 6.1 (121).

Table 6.1. Percentage who “strongly dislike” or “dislike” having immigrants or foreign workers as neighbours in selected countries and territories in the Region, by sociodemographic factor, 2018/2019

<table>
<thead>
<tr>
<th></th>
<th>Egypt (%)</th>
<th>Iraq (%)</th>
<th>Jordan (%)</th>
<th>Lebanon (%)</th>
<th>Libya (%)</th>
<th>Morocco (%)</th>
<th>Sudan (%)</th>
<th>Tunisia (%)</th>
<th>Yemen (%)</th>
<th>Occupied Palestinian territory (%)</th>
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<td>38</td>
<td>65</td>
<td>32</td>
<td>41</td>
<td>16</td>
<td>31</td>
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<td>28</td>
<td>38</td>
<td>74</td>
<td>40</td>
<td>36</td>
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<td>33</td>
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<td>18</td>
<td>38</td>
<td>9</td>
<td>22</td>
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<td><strong>Income situation</strong></td>
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<tr>
<td>Able to save</td>
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<td>25</td>
<td>22</td>
<td>43</td>
<td>50</td>
<td>21</td>
<td>50</td>
<td>13</td>
<td>33</td>
<td>27</td>
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<tr>
<td>Covers costs</td>
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<td>26</td>
<td>27</td>
<td>35</td>
<td>63</td>
<td>30</td>
<td>33</td>
<td>11</td>
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<td>Does not cover costs</td>
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<td>37</td>
<td>67</td>
<td>29</td>
<td>39</td>
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Source: Dennison et al. (2020) based on Arab Barometer Wave 4 and 5 data (2018/2019) (121).
Research into attitudes towards refugees is limited in the Region, Box 6.14 provides an overview of available research from Jordan and Lebanon on people’s attitudes.

**Box 6.14. Attitudes to refugees**

**Jordan**

A large number of Syrian refugees have arrived in Jordan and by June 2015, more than 620,000 Syrians were registered with UNHCR (123). The arrival of large numbers of refugees has placed increased pressure on the country’s economic and resource infrastructure and impacted on public sentiment towards refugees (123). A study conducted in 2015 found that 95% of Jordanian workers agreed that jobs were being taken by Syrians “to some extent” or “to a great extent” (123, 124). Additionally, 93% indicated that they thought that Syrians were suppressing wages for Jordanians and 40% did not believe that Syrians contributed to the Jordanian economy (123). This general negative public sentiment has impacted on the levels of support offered to Syrian refugees (123).

**Lebanon**

Lebanon has one of the highest per capita concentrations of refugees in the world and has received and been host to over a million refugees since 2012 (125). When the first wave of refugees arrived in Lebanon (during 2011–2012), a large majority of the local population felt sympathy for those who had fled their home countries (125). However, with increasing numbers of refugees arriving in the country an increased level of violence has been seen against this population (125). The proportion of surveyed Lebanese respondents who felt unsafe due to the presence of Syrian refugees rose from 25% in 2013 to 51% in 2017 (126). Economic conditions, intercultural interactions and security fears have been cited as factors influencing public attitudes towards hosting refugees (125).

However, an investigation into factors that influence attitudes towards Syrian refugees in Lebanon found that respondents who had contact with Syrians in Lebanon were significantly more likely to have positive attitudes towards refugees. Specifically, they were more likely to support the hosting of refugees, to consider hiring refugees or to allow one of their children to marry a refugee (125). Drawing on this finding, it was suggested that encouraging more contact between native and refugee populations could help to improve attitudes towards refugees in host communities.

Discriminatory behaviour towards migrants is a growing phenomenon in the Eastern Mediterranean Region and there are many reports of migrant workers, particularly unskilled migrant workers, being subject to abuse (127, 128). Components of this include a preference for temporary labour for migrants, preferential treatment for national citizens and “attitudes of disdain or even abuse towards those who are ‘visibly different’” (129). Additionally, unskilled migrants often work in informal and unregulated sectors, which makes this group particularly vulnerable to discriminatory behaviour as there are few, if any, legal protections for working migrants, compounded by a lack of union protections. However, there has been some discussion on actions to address this, as detailed in Box 6.15. An example of an intervention to shift attitudes towards migrants through education and closer integration is summarized in Box 6.16.
Low-skilled workers from outside the Arab region are particularly vulnerable to negative attitudes, discriminatory practices and racism. It is estimated that there are 2.1 million people in domestic work in the GCC countries and in Jordan and Lebanon (131), and the majority of these migrant domestic workers are from African and Asian countries, including Ethiopia, Indonesia, Kenya, Philippines and Sri Lanka (129, 131).

Migrant unskilled and semi-skilled workers are particularly vulnerable to maltreatment. Cheap labour has often led to the devaluation of workers, which can fuel their exploitation and abuse (127). Jureidini (2003) has outlined a number of factors which could influence xenophobia and maltreatment towards foreign female domestic employees in the Region, including prevailing views about the status of the workers, such as that the domestic service role is “inherently and traditionally a servile one” and that the “culpability of female employers in the abuse of domestic maids can ostensibly be linked to their assumed second-class status in Arab families” (129).

While the Region is host to the highest number of refugees and migrants in the world, who often suffer high levels of health and social determinants of health-related harm, there is an enormous gap in knowledge about their experiences and health outcomes, and they are often missed from official data and surveys. One of the challenges for the Region is to improve outcomes for these groups and this is even more challenging given increasing levels of hostility among the public. Regional bodies, such as WHO and national governments, need to work with the public to shift attitudes towards refugees and migrants through education and closer social contact. There is a case that humanitarian organizations, religious leaders and faith-based organizations should be much more involved in efforts to support positive attitudes towards migrants. In addition to efforts to change attitudes, there needs to be legislation to protect migrants from abuse. Compliance with human rights legislation will formalize the rights of migrants to live and work in ways which support better health.
SUMMARY AND RECOMMENDATIONS

Religious beliefs, gender norms and attitudes towards migrants shape the health of all people in the Region through direct impacts on health and through outcomes in the social determinants of health. Religious organizations and leaders have a key role to play in supporting health equity in the Region – a role that can be further developed to support the agenda laid out in this report. For those working to improve health and health equity in the Region, strengthening collaborations with religious leaders and organizations will be beneficial and can, with the right focus, support progress towards the SDGs and greater health equity. Scrutiny of religious organizations needs to be standardized and a set of criteria for partnership outlined, so that there is confidence that partnerships will be beneficial to health equity.

The Region is marked by significant gender inequity, the result of deep-seated cultures and long-standing beliefs about the roles of women and men in society. While there have been some signs of progress, there are still deep and persistent gender inequities, and these are particularly damaging for poorer, less educated women and those living in remote areas. These girls and women experience multiple and intersecting inequities related to their socioeconomic position and prevailing social and gender norms. Regulations and legal mechanisms to support gender equity are relatively weak in the Region and undermine prospects for progress. Adopting and implementing the United Nations Convention on the Elimination of all Forms of Discrimination Against Women is an essential step which must be accompanied by enforceable legislation on intimate partner violence and all forms of violence against women. Real progress on gender equity in the Region requires shifting gender cultures and norms. Partly this can be achieved through legislation, but it also requires education programmes and the representation of women at all levels of government and employment as well as their greater participation in decision-making, from household decisions to national and international governance. Our recommendations support such an agenda.

The Region is hosting millions of refugees, but providing sufficient support is enormously challenging and while there are opportunities for further economic integration, there are also drains on host countries’ resources. Migrants are not generally able to access the same levels of services and opportunities to work as host-country nationals. Since these exclusions damage the health and well-being of migrants, this Commission recommends that each country establish a clear path towards legal residence and nationality for migrants and implement the Global Compact for Safe, Orderly and Regular Migration, underpinned by social and legal rights. Further international support for those countries hosting large numbers of refugees is also required. There is some evidence of increasing hostility towards economic migrants, refugees and IDPs among residents in host countries – shifting attitudes requires positive promotion of integration and the economic benefit that migrants can bring to the host country and the Region as a whole. Schools and religious organizations have important roles to play in fostering positive attitudes towards migrants.
### Recommendations

1. **Strengthen collaboration with religious leaders and organizations to support health equity.**
   - Use the prominent role of religion to accelerate progress towards the SDGs and health equity and uphold human rights.
   - Strengthen religious organizations as participants in the ownership of the equity agenda.
   - Develop governance arrangements and scrutiny mechanisms for collaborations with faith-based organizations and religious leadership to promote health equity and action on the social determinants of health.

2. **Achieve progress in gender equity.**
   - All countries in the Region should ratify and comply with the Convention on the Elimination of all Forms of Discrimination Against Women.
   - Widen the participation of civil society in gender equity. Support the effective functioning of high-level womens’ councils, particularly in monitoring the achievement of gender-related SDG targets and compliance with the Convention on the Elimination of all Forms of Discrimination Against Women.
   - Develop education and religious programmes to reduce gender-based violence and enhance gender equity. Strengthen national legislation to criminalize intimate partner violence including marital rape.

3. **Eliminate discrimination against and exclusion of refugees, migrants and IDPs.**
   - Address social and legal needs of migrants including the protection of human rights, and promote public support for these measures.
   - Create a clear path towards legal residence and nationality for migrants and create mechanisms to monitor the implementation of the Global Compact for Safe, Orderly and Regular Migration.
   - Increase education programmes to foster greater tolerance and support for refugee and migrant communities, and increase the involvement of faith-based organizations in these programmes.

### Relevant SDG targets

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>SDG Targets</th>
</tr>
</thead>
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<td>4.7, 5.1, 5.2, 5c, 8.8, 10.2, 10.3, 10.4, 10.7</td>
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<td>2. Achieve progress in gender equity.</td>
<td>16.1, 16.6, 16.7, 16.9, 16.10, 16b, 17.14, 17.17</td>
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<td>3. Eliminate discrimination against and exclusion of refugees, migrants and IDPs.</td>
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