Women's Strong Desire For Better Health In Muslim Majority Countries

By Karl Feld, Veronica Gardner and Janet Lee

The need to advance the empowerment of women in Muslim majority countries is globally recognized. A keen interest has been taken in the fundamental right to health for women in Muslim majority communities. Muslim women experience greater disadvantages in health, particularly in risks connected to pregnancy and reproductive functions. Despite the transparency of the connection, little is known regarding the barriers in women's health as it relates to religious and cultural beliefs.

Survey research has a role to play in providing Muslim women with a public voice where custom and culture do not permit them their own. It can be used to inform and shape empowerment policies from the perspective of each population. The Women In Muslim Countries (WIMC) study[1] is designed to measure women's empowerment in actual daily practice, providing a deep look into the oft-perceived gap between current public policy and empowerment initiatives and actual practice on the personal and local level. The answers are intended to yield a metric for promoting excellence in public policy by informing policymakers on women's attitudes about the affects of policy initiatives, as well as a measure of the degree of effectiveness of those policies. A full list of questions and more detailed methodology is provided in Appendix A.

The advantage of research across countries is the ability to discover commonalities of behavior and attitudes towards health. Quantification of these attitudes can identify help health issues, ascertain the best methods to address them, inform policymakers, and evaluate program initiatives

WIMC data reveals that better health is one of the strongest desires of women in these countries. From the answer choices given, better health consistently ranks with more money/greater income and better education as a top priority for increased happiness (Appendix B, Table 1). In Bangladesh, family planning is reported by more women as a priority than better health. In Iran, as many women said no change was necessary as selected better health.

Women in wealthier countries, such as Saudi Arabia and Turkey, emphasize better health over any other priority. This suggests that a shift to a focus on health priorities coincides with improved economic conditions and education among women.

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[1] WIMC is sponsored and managed by D3 Systems (**http://www.d3systems.com/public/public/**wimc.asp) and is currently conducted in 22 Muslim majority countries of the world.

Although within countries WIMC data indicates there is less consistency of prioritizing health, within age groups there is a definitive trend (Appendix B, Table 2). Women place more focus on their health as they age. Given that older age is a risk factor for several diseases such as late-onset diabetes and cancer, this trend of age is not unexpected.

Taken in conjunction with the observation of increased rates of chronic disease in these countries, this finding suggests women who prioritize health would like the means to counter and treat diseases which affect the older female population. However, it also suggests that preventive strategies, such as breast cancer screening and improving dietary habits and physical activity, may require more effort among the younger population as health is not as much of a priority (UNDP, 2005).

A more pertinent question related to disparities in health included in the WIMC study is: “Do you believe you’ve ever been denied health care you needed because you are a woman?” Although the question is based on perceived discrimination, the responses to this question provide deeper insight into the heterogeneous discrimination against women face within these Muslim-majority countries.

Five countries in particular as of this writing—Egypt, Afghanistan, Pakistan, Iran and Turkey—have significant proportions of women who believe they are not receiving necessary healthcare due to their gender (Appendix B, Table 3). Further investigation also reveals specific groups within these countries who may be facing more discrimination than others.

Across countries almost one third of women educated less than 5 years, are more likely to perceive unequal access to healthcare due to their gender (Appendix B, Table 4). In Egypt, Turkey and Iran, the less educated a women is, the more likely she perceives being denied access to healthcare. In Egypt, 67% of women, who have 0 to 5 years of education, say they have been denied. In Turkey and Iran, those denied is approximately a third among the least educated.

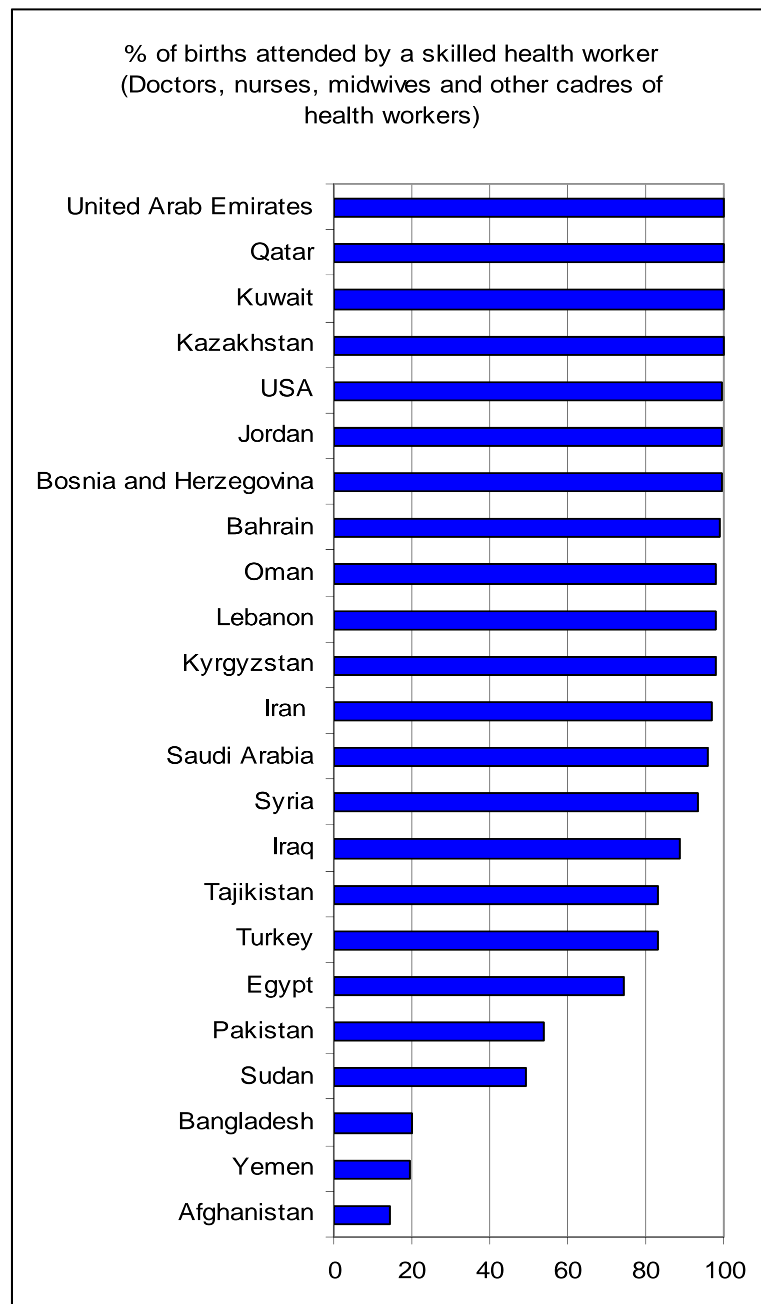
In addition, within these countries there are disparities related to marital status. In Afghanistan (48.4%), Pakistan (41.9%) and Turkey (31.4%), women who are widowed or divorced are more likely to report being denied health services.

When asked whether rights would be effectively protected within sharia (Islamic law), almost half of the women in Afghanistan who responded “Not at all protected” believed they were denied health services. In Pakistan and Turkey, approximately a third who believe their rights would not be protected within Islamic law also believed they were denied healthcare for being a woman.

Reproductive Health

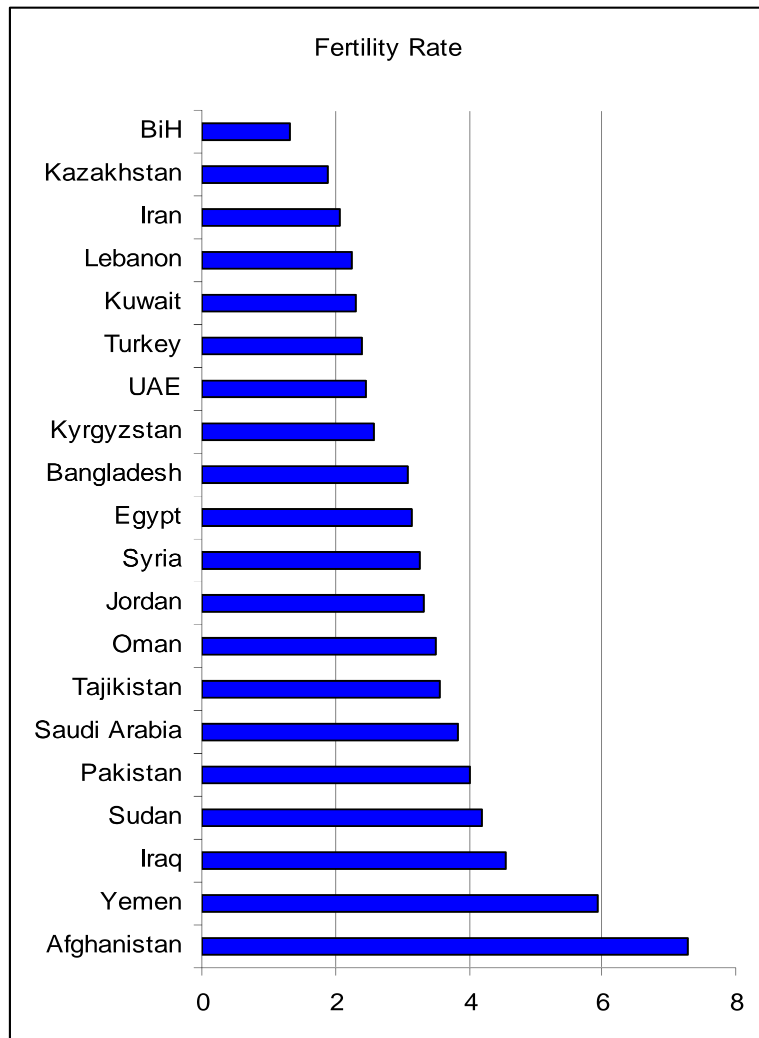
Women in Muslim majority countries, especially in the least developed countries, are suffering from high rates of morbidity and mortality related to pregnancy and reproductive functions. In Afghanistan, 1,900 deaths occur for every 100,000 live births, which is second only to Sierra Leone for highest maternal mortality in the world (WHO, 2004). Addressing this is crucial to reducing the number of maternal deaths by three quarters by 2015; a target for monitoring the achievement of Millennium Development Goal No. 5.

Although, the rate of births attended indicates improved health coverage for most Muslim majority countries, the least developed have less than a quarter of births attended by trained personnel (WHO, 2006). This is not necessarily tied to income levels. More often it is based on level of effective supervision of pregnancy which is enshrouded in traditional and cultural beliefs (UNDP, 2005).



Source: Skilled Attendant at Birth, 2006 Global Estimates Geneva, Department of Reproductive Health and Research, World Health Organization, April 2006.

Although perceptibly decreasing, the fertility rate in most Muslim majority countries is still above the global average (Figure 2). These rates have been hypothesized to be influenced by religion but could also be easily linked to poverty and underdevelopment in these nations. Healthcare may not be readily available to mothers and infants in the countries affected most by high fertility rates. The effect of infertility, miscarriage, and unwanted pregnancies on women has not been thoroughly explored—effects which may lead to divorce, emotional burdens and social pressures. In some cases of infertility, women resort to dangerous treatments such as electric cauterization, dilation, curettage, and inflation of the fallopian tubes which can potentially lead to serious health results (UNIFEM, 2004).



Source World Population Prospects: The 2004 Revision. New York, United Nations, 2005.

Obesity and cancer

Changes in lifestyle, especially in the wealthier countries, have invited a slew of chronic diseases such as cancer, hypertension, late-onset diabetes and heart disease. A major risk factor for these conditions is obesity. An alarming observation specifically for women in Muslim majority countries is that they have higher rates of obesity than men, when in most developed countries where these diseases are rampant, it is quite the opposite (UNDP, 2005). Rates of cancer screening in Muslim majority countries are lower compared with the general population. Particularly with breast cancer, the leading cancer among women in Arab countries, misconceptions of screening and the disease have lead to late diagnoses and advanced symptoms (El Saqhir et al, 2007; Tarabeia et al, 2007). Much media attention has been paid to the

effects of breast cancer among Muslim women. Shame, embarrassment and stigmatism based on Islamic beliefs reportedly affect screening behaviors for early detection (MSNBC, 2007).

Conclusion

Survey research has an important role to play among women in Muslim majority countries by providing an outlet to voice attitudes and beliefs regarding their health. Particularly in regards to reproductive health and family planning, where traditional and religious beliefs may have led women to be misinformed or constricted access to valuable health services, research can drive efforts to address concerns and communicate health information more actively and effectively. Through our data, we have made blanket observations in general attitudes towards health. But with more intense research efforts across Muslim majority countries, we can discover health issues which affect Muslim women, how to address these issues comprehensively, and identify perceived and actual obstacles to achieving the better health so many desire.

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Appendix A: *Methodology*

The Women In Muslim Countries study (WIMC) conducts nationally representative quantitative research in 22 Muslim majority countries on an biannual basis. For this specific report, we have included collected data from 16 countries as of May 2008: Afghanistan, Bangladesh, Bosnia (Federation only), Egypt, Iran, Iraq, Jordan, Kazakhstan, Kosovo, Kyrgyzstan, Lebanon, Pakistan, Saudi Arabia, Syria, Tajikistan, and Turkey. The study was conducted either face-to-face or via CATI from March to May of 2008. Each country's sampling frame is designed to provide the best possible representation of the attitudes and experience of the entire national population of that country's women. In all cases, the sample was two-stage, and stratified randomly. In the case of Egypt, the sampling frame was limited to urban areas only.

Modes and Sample Size by Country

Country	Mode	Women Only *n*
Afghanistan	Face-to-face nationwide	1,175
Bangladesh	Face-to-face nationwide	753
Bosnia (Fed Only)	Face-to-face nationwide	572
Egypt	Face-to-face seven main cities and suburbs	500
Iran	CATI nationwide	1,003
Iraq	Face-to-face nationwide	1,093
Jordan	Face-to-face nationwide	500
Kazakhstan	Face-to-face nationwide	1,121
Kosovo	Face-to-face nationwide	538
Kyrgyzstan	Face-to-face nationwide	1,027
Lebanon	Face-to-face nationwide	508
Pakistan	Face-to-face nationwide	960
Saudi Arabia	CATI nationwide	514
Syria	CATI nationwide	505
Tajikistan	Face-to-face nationwide	999
Turkey	CATI nationwide	490
TOTAL		12,258

Appendix B*: Tables*

Table 1: If you could change one thing to make your life happier, what would it be?

		Egypt	Jordan	Afghan	Iraq	Kosovo	Pakis	Saudi Arabia	Bangla	Iran	Turkey	Leban	Bosnia	Kazakh	Kyrgyz	Tajiki	Syria
Per Capita GDP in USD		4,200	5,100	800	2,900	4,400	2,600	13,600	2,300	8,700	9,000	10,000	**6,600**	**10,400**	**2,000**	**1,600**	**4,900**
More money/greater income	Count	256	351	404	256	153	302	54	329	125	93	308	212	471	305	241	79
	%	51.2%	70.2%	34.4%	23.4%	28.4%	31.5%	10.5%	43.7%	25.5%	9.3%	60.6%	37.1%	42.0%	29.7%	24.1%	15.60%
No change necessary	Count	0	0	26	69	14	37	71	34	46	179	23	40	17	42	56	58
	%	.0%	.0%	2.2%	6.3%	2.6%	3.9%	13.8%	4.5%	9.4%	17.8%	4.5%	7.0%	1.5%	4.1%	5.6%	11.50%
Better health	**Count**	**148**	**53**	**222**	**190**	**263**	**207**	**160**	**53**	**38**	**412**	**75**	**222**	**329**	**374**	**249**	**150**
	%	**29.6%**	**10.6%**	**18.9%**	**17.4%**	**48.9%**	**21.6%**	**31.1%**	**7.0%**	**7.8%**	**41.1%**	**14.8%**	**38.8%**	**29.3%**	**36.4%**	**24.9%**	**29.70%**
Better education	Count	46	63	309	156	64	208	142	199	187	176	44	54	79	86	190	139
	%	9.2%	12.6%	26.3%	14.3%	11.9%	21.7%	27.6%	26.4%	38.2%	17.5%	8.7%	9.4%	7.0%	8.4%	19.0%	27.50%
Better house	Count	28	23	149	189	17	127	46	13	26	72	37	15	161	144	200	43
	%	5.6%	4.6%	12.7%	17.3%	3.2%	13.2%	8.9%	1.7%	5.3%	7.2%	7.3%	2.6%	14.4%	14.0%	20.0%	8.50%
Larger family	Count	12	7	27	23	13	13	16	8	17	8	10	18	38	33	22	6
	%	2.4%	1.4%	2.3%	2.1%	2.4%	1.4%	3.1%	1.1%	3.5%	.8%	2.0%	3.1%	3.4%	3.2%	2.2%	1.20%
Smaller family	Count	10	3	37	15	1	57	1	83	11	5	1	0	6	16	16	14
	%	2.0%	.6%	3.1%	1.4%	.2%	5.9%	.2%	11.0%	2.2%	.5%	.2%	.0%	.5%	1.6%	1.6%	2.80%
Other	Count	0	0	0	191	10	2	22	33	21	38	1	9	3	11	12	11
	%	.0%	.0%	.0%	17.5%	1.9%	.2%	4.3%	4.4%	4.3%	3.8%	.2%	1.6%	.3%	1.1%	1.2%	2.20%
Refused	Count	0	0	0	2	0	4	0	1	10	1	4	0	7	3	3	2
	%	.0%	.0%	.0%	.2%	.0%	.4%	.0%	.1%	2.0%	.1%	.8%	.0%	.6%	.3%	.3%	0.40%
Don't Know	Count	0	0	1	2	3	3	2	0	9	19	5	2	10	13	10	3
	%	.0%	.0%	.1%	.2%	.6%	.3%	.4%	.0%	1.8%	1.9%	1.0%	.3%	.9%	1.3%	1.0%	0.60%
Total	Count	500	500	1175	1093	538	960	514	753	490	1003	508	572	1121	1027	999	505

Source: GDP taken from the CIA World Factbook, 2006. 2005 Serbian GDP has been used for Kosovo as no Kosovo data is available. Afghan data dates from 2004.

Table 2: If you could change one thing to make your life happier, what would it be?							
		Age Groups					
		18-24	25-34	35-44	45-54	55+	Total
More money/greater income	Count	876	1165	889	599	410	3939
	%	30.9%	33.9%	32.9%	33.6%	27.2%	32.1%
No change necessary	Count	162	198	159	101	92	712
	%	5.7%	5.8%	5.9%	5.7%	6.1%	5.8%
Better health	**Count**	542	741	671	545	646	3145
	%	19.1%	21.6%	24.8%	30.6%	42.9%	25.7%
Better education	Count	761	628	428	214	111	2142
	%	26.9%	18.3%	15.8%	12.0%	7.4%	17.5%
Better house	Count	245	392	319	197	137	1290
	%	8.7%	11.4%	11.8%	11.1%	9.1%	10.5%
Larger family	Count	68	81	55	36	31	271
	%	2.4%	2.4%	2.0%	2.0%	2.1%	2.2%
Smaller family	Count	80	96	62	27	11	276
	%	2.8%	2.8%	2.3%	1.5%	.7%	2.3%
Other	Count	76	94	100	49	45	364
	%	2.7%	2.7%	3.7%	2.8%	3.0%	3.0%
Refused	Count	2	13	4	5	13	37
	%	.1%	.4%	.1%	.3%	.9%	.3%
Don't Know	Count	19	26	18	8	11	82
	%	.7%	.8%	.7%	.4%	.7%	.7%
Total	Count	2831	3434	2705	1781	1507	12258

Table 3: Do you believe you've ever been denied health care you needed because you are a woman?																	
		Egypt	Jordan	Afghan	Iraq	Kosovo	Pakis	Saudi Arabia	Bangla	Iran	Turkey	Leban	Bosnia	Kazakh	Kyrgyz	Tajiki	Syria
Per Capita GDP in USD		4,200	5,100	800	2,900	4,400	2,600	13,600	2,300	8,700	9,000	10,000	**6,600**	**10,400**	**2,000**	**1,600**	**4,900**
Yes	Count	291	72	394	204	53	276	58	86	135	232	19	35	110	97	151	28
	%	58.2%	14.4%	33.5%	18.7%	9.9%	28.8%	11.3%	11.4%	27.6%	23.1%	3.7%	6.1%	9.8%	9.4%	15.1%	5.5%
No	Count	209	428	769	846	474	603	455	667	328	761	464	528	969	879	825	473
	%	41.8%	85.6%	65.4%	77.4%	88.1%	62.8%	88.5%	88.6%	66.9%	75.9%	91.3%	92.3%	86.4%	85.6%	82.6%	93.7%
Refused	Count	0	0	3	9	2	31	0	0	11	1	16	1	3	19	7	2
	%	0%	0%	0.3%	0.8%	0.4%	3.2%	0%	0%	2.2%	0.1%	3.1%	0.2%	0.3%	1.9%	0.7%	0.4%
Don't Know	Count	0	0	9	34	9	50	1	0	16	9	9	8	39	32	16	2
	%	0%	0%	0.8%	3.1%	1.7%	5.2%	0.2%	0%	3.3%	0.9%	1.8%	1.4%	3.5%	3.1%	1.6%	0.4%
Total	Count	500	500	1175	1093	538	960	514	753	490	1003	508	572	1121	1027	999	505

Source: GDP taken from the CIA World Factbook, 2006. 2005 Serbian GDP has been used for Kosovo as no Kosovo data is available. Afghan data dates from 2004.

Table 4: Do you believe you've ever been denied health care you needed because you are a woman?									
		Education Level							
		None to 5 Years	6 to 8 Years	9 to 12 Years	13 to 16 Years	17 or More Years	Refused	Don't Know	Total
Yes	Count	911	290	709	288	40	3	0	2241
	%	27.2%	18.3%	16.2%	11.1%	11.3%	25.0%	.0%	18.3%
No	Count	2351	1252	3539	2220	306	8	2	9678
	%	70.1%	78.9%	81.1%	85.9%	86.4%	66.7%	100.0%	79.0%
Refused	Count	18	16	36	32	3	0	0	105
	%	.5%	1.0%	.8%	1.2%	.8%	.0%	.0%	.9%
Don't Know	Count	75	28	82	43	5	1	0	234
	%	2.2%	1.8%	1.9%	1.7%	1.4%	8.3%	.0%	1.9%
Total	Count	3355	1586	4366	2583	354	12	2	12258