Situational Analysis of Women and Girls in the MENA and Arab States Region: Pillar 1 Health and Wellbeing Key Messages and Recommendations

OVERVIEW

The region has made significant progress on improving key general health indicators and strides are made to align national priorities with the SDGs agenda, however, emergencies and conflict settings continue to have significant health impacts on populations and are stilling and reverting progress. Conflicts are also the main drivers for food insecurity and malnutrition within the region. Non-communicable diseases have replaced nutritional disorders and communicable diseases as major causes of women's death and disability. The region has made significant progress on improving key general health indicators including lowering maternal and under-5 mortality, decreasing disease burden, and increasing life expectancy. 14 of the 21 countries have reached the SDG indicator of reducing maternal deaths to less than 70 per 100,000 and female life expectancy at birth increased in all countries (from an average of 68 years in 1995 to 71.31 years in 2019). However, Sudan, Djibouti, and Yemen remained above global estimate for U5 Mortality.

Continue fostering a rights-based and people-centred approach to health and focus on the four essential elements of the right to health: availability, accessibility, acceptability and quality.

POLICY GAPS

The right to health has been adopted into domestic or constitutional laws in most countries of the region, and governments throughout the region have made institutional changes and begun to align national priorities with the SDGs, including launching voluntary national reviews. There is lack of dedicated mental health legislation in 50% of the countries within the region, and a lack of national policies and plans in 30% of the countries which indicates that a large proportion of women are likely left without prevention and response services. Securing adequate and appropriate sexual and reproductive health care for every woman and adolescent girl hinges on the realization of reproductive rights, which are often overlooked. Barriers to SRHR are present in laws, policies including codes related to sale, procurement, or facilitation of contraception, and laws related to child marriage and FGM practices. While all countries in the region have signed the Convention on the Rights of Persons with Disabilities, operationalization and implementation of this instrument is very limited.

Addressing the health disparities and inequities through addressing the social determinants of health and focus on 'whole-of-society' approach that's ensures the engagement of women in decision making in reference to health service provision and accountability.

SYSTEM BARRIERS

Health services remain fragmented and often supply driven; most health systems continue to focus largely on curative health services instead of primary and preventative care and pay little attention to the social determinants of health. While advancements have been made regarding safe motherhood programmes, lack of integration between maternal and neonatal health remains a major challenge and services related to maternal health, health family planning, and the prevention and treatment of sexually transmitted infections and HIV/AIDS are not fully integrated within primary health care. Issues of human resources, supplies, public-private divisions, verticalization of health programmes and the lack of universal health coverage are sited as major barriers to SRHR in the region. The region also characterized by limited mental health services, inadequate antiretroviral treatment (reaching 38% of those in need), and low priority of screening for reproductive cancers which is practiced at a limited scale in the public sector.

Ensure that services provision includes the dimensions of universal health coverage in terms of better access to services with focus on access in rural areas and innovative telemedicine approaches and securing equitable access to health information, in addition to financial protection to those most vulnerable including women and girls

NORMS

There is little consistent, robust data on the issue of norms and practices relating to health care decisions and information and access to services within the region. However, data from some countries indicate limited levels of autonomy in decisions about women and girls own health (between 9.4% and 40% of decisions regarding a woman's own health are made by the woman herself). Stigma and discrimination limit access to and utilization of services for mental health issues, HIV testing, and menstrual health needs. Knowledge of HIV prevention remains extremely low with marked contrast between males and females. Discriminatory sociocultural norms affect women's control over assets and resources, as well as their decision-making power within households, communities and institutions, thus comprising their socioeconomic empowerment, their food security and their nutrition.

Build gender and adolescent-responsive health systems, to provide quality non-discriminatory and integrated youth-friendly health services with an adolescent and gender-competent workforce.

ACCESS INEQUALITY

53% of people in the region had access to basic health services below the global (population weighted) coverage of 64%. Access to health is especially inequal for rural women, women in conflicts and emergencies, as well as people living with disabilities (50% cannot afford health care). Long travel distances, lack of female health providers and concerns about entering health-care facilities alone, are among the underlying norms that affect access and utilization. Across the region, access of young people, particularly unmarried young people to SRHR services, remain limited. Lack of financial resources is another major barrier, where public health insurance usually covers only between 30 and 40% of the population; women from the wealthiest quintile between 46% and 62% more likely to deliver in a health facility than those from the poorest wealth quintile.

Ensure essential services are provided to vulnerable populations including women's and girls in fragile countries in the region and those of humanitarian complex settings including maintaining these services amid the current COVID-19 preparedness and response.

MENTAL HEALTH

The region has experienced a steady increase in mental health disorders. Within the region 33% of women felt stressed to a point where ´everything seemed like a hassle either ´often' or 'most of the time' and anxiety disorders and depressions is highly prevalent amongst girls 10 -19 years. Female youth in crisis-affected areas of the region exhibited a higher prevalence of mental health issues than male and refugees with disabilities were twice as likely to report psychological distress than refugees without. COVID-19 pandemic introduced additional mental health strains (and associated strains on services) in all countries. Mental health services are extremely limited within the region, with intra-regional disparity in dedicated human resources and the number of mental hospitals (per 1000,000 population) is higher than global median in only three countries. Women and girls face major barriers in accessing services, programming, and information. Approximately 70% of NGO-run shelters in the region follow the practice of not accommodating women with mental health issues and cultural stigma around mental health often prevents both access to services and effective treatment.

Advance mental health legislations and policies and expand access and quality of available medical, mental health and psychosocial support services, including to address violence against women and girls

SEXUAL AND REPRODUCTIVE HEALTH PROGRESS

Reduction in maternal mortality outperforms the global average; decreased from 238 (2000) to 156 (2015) per 100,000 live births, compared to a world average of 216 and the region is yet to reach the goal for lifetime risk of maternal death among 15 years and plus females. 13 of the 21 countries have reached at least 90% skilled birth attendance (Yemen and Somalia report levels below 75%) and roughly 78% of ever married women aged 15-49 reported having their reproductive needs for family planning satisfied with modern methods. Antenatal care is lower in rural and poor areas; estimated 65% of women receive postnatal care. However, in similar areas in the LDC subregion women are most likely to receive no postnatal care at all. Abortion, especially unsafe abortion, is a neglected public health topic despite two in five pregnancies being unplanned, of which one half ending in abortion. Qatar and Tunisia have CSE in schools, with other countries (Djibouti, Egypt, Jordan and Syria) providing some form of sexuality education outside the school context.

Ensure provision of integrated benefit packages which deliver services including the whole continuum of care at all ages with focus on maternal health, family planning, and the prevention and treatment of sexually transmitted infections, HIV/AIDS and GBV services, and strengthen cross-sectoral coordination to improve efficiency including aadvocating for comprehensive sexuality education in education – both in formal and non-formal settings.

ADOLESCENT HEALTH

Data and evidence on adolescent health continues to be a gap throughout the region. Collective violence is among top five causes of death and anxiety disorders and depressions are among the top five causes of DALYs among young girls 10 -19 years. Across the region, young people, particularly unmarried young people, remain highly neglected populations in terms of access to SRHR services and education. Reluctance to teach sexuality has meant that young people often rely on the internet or peers for information, which may be inaccurate. In conflict-affected countries, younger females (15 – 29) are less likely to have their family planning needs met than older cohorts. Given the increasing trends in child marriage, the prevention of unintended pregnancies and reduction of adolescent childbearing is crucial to the health and well-being of these young women. Women and girls affected by VAWG are growing in the region, adolescent girls in emergency contexts raise concerns of sexual abuse and exploitation particularly for those with disabilities.

Address insufficient data on adolescent health and nutrition by prioritizing key health indicators, allocating adequate resources to relevant quantitative and qualitative research gaps, and enhancing effective data management with focus on sex and age disaggregation.

PHYSICAL ACTIVITY AND NON-COMMUNICABLE DISEASES

While the region has witnessed a decrease in DALYs for causes such as diarrhoea and respiratory infections in recent years, ischaemic heart disease, major depressive disorders and diabetes have become more widespread. Unhealthy diets – along with physical inactivity – are key contributors to the burden of non-communicable disease in the region where several countries demonstrate highest rates of physical inactivity, obesity, and diabetes in the world (26.9% of men and 43.5% of women). Adolescents perform poorly in engaging in adequate physical activity, this is true globally but is worse in the region with a rate of 87% (84.3% boys and 89.9% girls).

Address the major increase in non-communicable diseases by ensuring gender-responsive research, policies as well as adequate access to training facilities.

COVID-19

Restrictions on movement and social distancing measures have limited households' access to work, regular income, remittances, markets, schools and healthcare in the region. Lower income/savings depletion and decreased government capacity to respond to a second and third wave may worsen poverty and inequality, and lead to deterioration of household food security while increasing people's health needs.

Ensure essential services are provided to vulnerable populations including women's and girls in fragile countries in the region and those of humanitarian complex settings including maintaining these services amid the current COVID-19 preparedness and response.

Situational Analysis of Women and Girls in the MENA and Arab States Region: Pillar 1 Food Security, Nutrition and WASH Key Messages and Recommendations

OVERVIEW

The triple burden of malnutrition (undernutrition, overweight or obesity, and micronutrient deficiencies), is clearly visible among women and girls in the region, particularly in countries affected by protracted crises such as Yemen and Syria. 11% of the population reported that they experience severe food insecurity, which is estimated to be 56 million people. Cross-cutting issues of conflict and climate change also impact food security and nutrition status. There is a specific gender dimension to food security and nutrition, vulnerable women and girls experience a greater risk of malnutrition than men, and more girls die of malnutrition than boys. Across the region, and particularly in countries affected by conflict, female-headed households are the most susceptible to food insecurity and the most likely to resort to negative coping mechanisms that increases their protection and security risks.

Address existing social and economic barriers to women's food security and nutrition by ensuring their equal entitlements, access to and control over assets, resources and services (financial and non-financial), and by enhancing their access to decent employment, livelihood opportunities, and social protection. Special attention should be dedicated to support women and girls in conflict-affected areas, women refugees and IDPs.

POLICY GAPS

Governments within the region have established laws and policies to address food insecurity and nutrition. While analyses around laws and policies influencing food security specifically are lacking, a range of policy statements and recommendations have been made over the past decade addressing key issues around nutrition. 89% of countries in the region have nutrition policy, 53% reporting policies relating infant and young child nutrition, and 17% had costed operational plans. Other examples of laws and policies include fortifying staple foods with micronutrients, micronutrient supplements, promoting exclusive breastfeeding and school feeding. The lack of policy coherence and sectoral coordination, coupled with limited institutional capacities, also prevents the formulation and implementation of gender-responsive food security and nutrition policies. While limited implementation, 17 countries in the region put some of the provisions of the International Code of Marketing of Breast-milk Substitutes into law. At national level, several countries have recognized the right to water in their constitutions; 13 countries ratified the Arab Charter of Human Rights which refers to the right to water and sanitation. Women's inadequate access to land remains an obstacle for improvement of both food security, agricultural productivity and access to water.

Allocate adequate resources for the adoption of gender-transformative approaches in food security and nutrition-related policies and programmes, to tackle the discriminatory social norms and gender roles that limit women's control over income and assets, and their decision-making power within households and communities.

SYSTEM BARRIERS

Supplementation and food fortification was implemented widely across the region. 21 countries are implementing vitamin and mineral supplementation for pregnant women (iron and folic acid), while 8 eight countries report provision of supplements to women of reproductive age (folic acid and iron) and 16 report the provision of supplements to children (vitamin A, iron, micronutrient powder, zinc and iodine). 16 countries report fortification of salt, 12 countries report fortification of wheat flour, six report fortification of oil, and one country reports fortifications of sugar. 17 countries had some coverage of wheat flour fortified with iron and folic acid, which is mandatory in 11 countries. There is limitation in the sex and age disaggregated data on hunger and food insecurity in the world and in the region.

Ensure the sex and age disaggregation of data on hunger and malnutrition and provide support to regional and national strategies and programmes through intersectional gender and age analyses. This should be done in a manner that explores intrahousehold dynamics and roles in food security and nutrition, and addresses hunger and malnutrition through a lifecycle approach.

NORMS

Roles and responsibilities associated with food security, nutrition and water management largely fall on the shoulders of women and girls in the region due to gender social norms. Women and girls gendered responsibility for household's water collection can involve long walks that expose them to protection and security risks. The lack of engagement of men and boys in food preparation exacerbates women and girls' unpaid domestic chores and restricts women. Limited knowledge about what constitutes appropriate complementary feeding, often results in poorer nutritional outcomes for women and their children. In terms of dietary intake, the region features a marked gender gap detrimental to girls and women. Girls in Yemen often have the least access to food at mealtimes due to cultural norms that determine who within a family eats first. In the South Darfur region of Sudan a mistaken belief is prevalent stating that male infants needed to be fed solid foods starting at three months, as opposed to six months for female infants. Lack of physical activity and mobility in public spaces due in part to cultural norms that constrain women's and girls' movement outside the house and de-emphasize the importance of physical education for girls in school contribute to the high rates of obesity and overweight status in women in the region.

Engage women, men, girls, and boys through social behavioural communication change initiatives that seek to engage all groups equitably utilizing gender transformative approaches that change stereotypical gender roles associated with food security and nutrition and acknowledge the valuable contributions of women and girls to food security, food production, preparation, and distribution.

AT RISK GROUPS

Most individuals who experience hunger in the MENA region are located in the five countries currently in conflict; Iraq, Libya, Syria, Sudan, and Yemen. Individuals living in poverty are more likely to have insufficient water and sanitation facilities and are at greater risk of experiencing food insecurity, hunger, and have a lower nutrition status as their economic access to food is compromised. Employment in agriculture sector accounts for 1/3 of total female employment in the region mainly through informal work sectors. As such, water scarcity jeopardizes women and adolescent girl's income opportunity, amplifying economic vulnerability while also risking food insecurity. Mothers with a low level of education and a low income are more likely to have stunted children due to their limited knowledge and capacity to obtain food that will provide a diverse and nutritious diet.

Enhance the access of rural women to and control of agricultural assets (land, in particular) and facilitate their exposure and uptake of nutrition-sensitive agricultural practices and technologies through targeted and accessible capacity building programmes.

Situational Analysis of Women and Girls in the MENA and Arab States Region: Pillar 1 Food Security, Nutrition and WASH Key Messages and Recommendations

FOOD SECURITY

There is a specific gender dimension to food security and nutrition. Despite the key roles women play in food systems, they tend to experience a greater risk of food insecurity than men, and more girls die of malnutrition than boys. Across the region, and particularly in countries affected by conflict, female-headed households, rural and refugee women, and women living with a disability are the most susceptible to food insecurity and the most likely to resort to negative coping mechanisms.

Address existing social and economic barriers to women's food security and nutrition by ensuring their equal entitlements, access to and control over assets, resources and services (financial and non-financial), and by enhancing their access to decent employment and social protection. Special attention should be dedicated to support women and girls in conflict-affected areas, women refugees and IDPs, whose access to resources and services is particularly compromised.

NUTRITION PROGRESS

Slightly less than 25% of the countries of the region have a high or very high prevalence of stunting in children under 5 years of age. Undernourishment prevalence in the region stand at 13.2%. Rates are double that of the world average for developed countries. In conflict affected countries (27.7%) rates are five times higher than non-conflict countries and higher than least developed countries at the global level. In Syria, the prevalence of malnutrition among pregnant and lactating women more than doubled. Although undernourishment rates in the region are decreasing, prevalence of undernourishment began increasing in conflict-affected countries, and children still suffer high rates of iron and vitamin A deficiency and inadequate iodine status. Every country in the region has either moderate or severe rates of anaemia in women of reproductive age ranging from 23% In Kuwait to as high as around 79% in Yemen. The region is the second most obese region in the world, with 19.5% among adults (14.9% men and 24.3% women), and 8.2% among children 5-19 years (8.3% boys, 8.1% girls). Prevalence for timely breastfeeding initiation and exclusive breastfeeding for six months stand at 34% and 20.5% respectively. For both indicators, the region remains below the global average of 40%. Caesarean section and first-time motherhood correlated with reduced prevalence, while rooming-in and successful breast-feeding experience increased prevalence. Children from the poorest quintile are 1.6 times more likely to be breastfed at two years of age than children from the wealthiest quintile. Lack of knowledge and skilled support for mothers in conflict affected countries led to reduced rates.

Promote health literacy and nutrition and WASH education to improve the nutritional status of women and girls, households and communities, by ensuring that fathers and mothers are equally targeted by programmes and initiatives.

LACK OF EQUITBLE ACCESS TO WASH

Equitable access to safe Water, Sanitation and Hygiene (WASH) services has not been met in the region. These access issues are exacerbated in very impoverished and/or conflict-affected countries, and more generally there are gaps in access to services between rural and urban communities throughout the region. In Bahrain, Kuwait and Qatar 100% of the population have access to basic drinking water services while Djibouti (76%) , Somalia (52%), Sudan (60%), Yemen (64%) and Morrocco (87%) have constrained access. Lack of access to WASH services at schools for women and girls may lead to their missing school or dropping out altogether due to inappropriate security and hygiene in relation to menstrual health management needs. 1 in 5 schools in the region does not have access to hygiene services in school, a range of 74% to 83% have access to basic drinking water in schools and a range of 79% to 87% have access to basic sanitation in schools. In terms of safe places within the region, there is a lack of comprehensive usable data on WASH in health facilities, suggesting that countries do not systematically track the availability or quality.

Strive for equitable access to safe WASH services, especially in rural and conflict/emergency settings and ensure adequate resources for effective implementation. maintain health and education services and secure economic and empowering opportunities for women and girls in WASH sector.

EMERGENCY AND CLIMATE CHANGE

During crisis situations, gender-based water insecurity is amplified, especially for refugee or internally displaced women and girls who face major barriers in access to basic services that are essential to their and their families' health and well-being. In addition to accessing basic services, women-headed households experience financial burdens that further limit their abilities to purchase water. WASH interventions being delivered to women and children in conflict settings in low-income and middle-income countries revealed gaps in the current evidence on WASH intervention delivery in conflict settings, suggesting that the WASH needs of women and children have not or are not being sufficiently considered in the humanitarian response in many conflict settings. The MENA region is the most water scarce region in the world, including 15 of the most water-scarce countries worldwide. Climate change, recurrent droughts and scarceness of natural resources combined with recent years conflicts and humanitarian crisis is putting extreme pressure on WASH service provision impacting the most vulnerable populations, especially women and girls. Water scarcity can amplify domestic work burden on women and girls at both household and community level.

Address the disproportionate impacts of climate change on the food security and resilience of women and girls and promote gender equality and climate resilience in interventions related to the development of food systems.

Situation of Health and Wellbeing – Key Highlights

POLICIES/ LEGISLATIVE

The right to health has been adopted into domestic or constitutional law in many countries.

All countries in the region have signed the Convention on the Rights of Persons with Disabilities but implementation is still limited

Lack of dedicated mental health legislation in 50% of countries within the region and a lack of national policies and plans in 30% of the countries

Barriers to SRHR are present in laws and policies and prevent access to knowledge and services that contribute to equitable lives

All of the 21 countries adopted the ICPD Programme of Action in 1994

SYSTEMS/ INSTITUTIONS

Mental health services are extremely limited

Lack of data on MHH due to sociocultural norms and stigma

Limited access to health services including MHH (rural, adolescent girls, disability and emergency setting)

Limited access to postnatal services
Lack of integration between maternal and neonatal health

Health services are often focused on curative health services instead of primary and preventative care

Public health insurance covers only between 30-40% of the population

STD's and HIV/AIDS not fully integrated within primary health care

Countries have undertaken efforts to scale up sexualit education (Qatar and Tunisia)

NORMS

Limited levels of autonomy in decisions about women and girls own health

Increased care burden on women and girls due to gendered expectations

Sociocultural norms affects women's and girls' nutritional status as well as child feeding

Declining level of physical activity

Stigmatization and discrimination for mental health issues and support

Abortion, especially unsafe abortion, is a neglected public health topic

EMERGENCY SETTINGS

Gender-based water and food insecurity is amplified during crisis, especially for refugee or internally displaced women. Women may face major barriers in access to basic services that are essential to their and their families' health and well-being

ISSUES

- Antenatal care is lower in rural and poor areas; estimated 65% of women receive postnatal care
- 50 million girls are being cut
  - **Reduce of and infant mortality and MMR (14 of 21 countries have achieved SDG indicator of 70 per 100,000 live births)**
- 1 in 5 girls are married
  - 13 of the 21 countries reached 90% skilled birth attendance (Yemen and Somalia below 75%)
- Irregular use of contraceptive amongst unmarried women and girls
  - Adolescent girls and unmarried young women access to SRHR is limited
- Limited access to MHH
- Lack of access to information, female health providers and concerns about entering health-care facilities alone
- Adolescents physical activity is worse than global rates (84.3% boys and 89.9% girls)
- Evidence on adolescent health continues to be a gap throughout the region
- Increase of non-communicable diseases
  - Prevalence of obesity and diabetes among the highest worldwide
  - Anxiety disorders and depressions are among the top five causes of DALYs among young girls 10-19 years.
- MH and PSS have been exacerbated by the COVID-19 pandemic
  - 1 in 3 women in the region experience extreme levels of stress
  - Refugees with disabilities twice as likely to report psychological stress
- 70% of NGO-run shelters do not accommodate women with mental health issues.
  - 53% of people in the region had access to basic health services
- Only 46% of NGO services for PSS only accommodate elderly women.
- SRHR is minimally addressed in elderly time
- Inadequate antiretroviral treatment (reaching 38% of those in need)

Situation of Food Insecurity and WASH – Key Highlights

LEGISLATION/ POLICIES

The Arab Charter of Human Rights refers to the right to water and sanitation services under articles 38 and 39

No data available regarding existing laws and policies on food security

The lack of policy coherence and sectoral coordination prevents the formulation and implementation of gender-responsive food security and nutrition policies

89% of countries in the region have a comprehensive or topic-specific nutrition policy

79% of countries have a comprehensive nutrition policy that aims to address all forms of malnutrition

Several states have recognized the right to water in their constitutions

SYSTEMS/ INSTITUTIONS

Women's inadequate access to land remains an obstacle for improvement of both food security and agricultural productivity

Limitations in qualitative and quantitative disaggregated data for food security

Agriculture sector accounts for 1/3 of total female employment, mainly through informal work sectors

1 in 5 schools in the region does not have access to hygiene services in school

Equitable access to WASH services has not been met in the region (MHH, household responsibilities)

Limited consideration of WASH needs of women and children in the humanitarian response

74%-83% have access to basic drinking water in schools and a 79%-87% have access to basic sanitation

17 countries had some coverage of wheat flour fortified with iron and folic acid, which is mandatory in 11 countries

16 countries report fortification of salt, 12 countries report fortification of wheat flour, six report fortification of oil, and one country reports fortifications of suga

16 report the provision of supplemen to children (vitamin A, iron, micronutrient powder, zinc and iodi

SOCIAL NORMS

The triple burden of malnutrition is clearly visible among women and girls, particularly in countries affected by protracted crises

Sociocultural norms affects women's and girls' nutritional status as well as child feeding

Lack of WASH services at schools leads to missing school and school-drop-out

Gendered expectations and female burden of water management

Water scarcity amplify domestic work burden on women and girls at both household and community level

Girls have less access to food at mealtimes due to cultural norms that determine who within a family eats first

EMERGENCY SETTINGS

Climate change, recurrent droughts and scarceness of natural resources combined with recent years conflicts and humanitarian crisis is putting extreme pressure on WASH service provision impacting the most vulnerable populations, especially women and girls. Water scarcity can amplify domestic work burden on women and girls at both household and community level

ISSUES

- Inadequate dietary intake
  - Breastfeeding initiation and exclusive breastfeeding for six months stand at 34% and 20.5%
- The region is the most water scarce region in the world, including 15 of the most water-scarce countries worldwide
- Slightly less 25% of the countries have a high or very high prevalence of stunting in children under 5 years
  - Children from the poorest quintile are 1.6 times more likely to be breastfed at two years of age
- Every country in the region has either moderate or severe rates of anaemia in women of reproductive age (23% Kuwait to 79% Yemen)
- Women-headed households experience financial burdens that further limit their abilities to purchase water
- 11% of the population reported that they experience severe food insecurity
  - Highest level in Iraq, Libya, Syria, Sudan, and Yemen
  - Eight countries report provision of supplements to women of reproductive age
- Female-headed households are the most susceptible to food insecurity
  - Prevalence of undernourishment and obesity stood at 13.2% and 28%, respectively
    - 21 countries are implementing vitamin and mineral supplementation for pregnant women
- Roles and responsibilities associated with food security and nutrition largely fall on the shoulders of women and girls
  - Women-headed households experience financial burdens that limit abilities to purchase water

ADOLESCENT HEALTH

Data and evidence on adolescent health continues to be a gap throughout the region. Collective violence is among top five causes of death and anxiety disorders and depressions are among the top five causes of DALYs among young girls 10 -19 years. Across the region, young people, particularly unmarried young people, remain highly neglected populations in terms of access to SRHR services and education. Reluctance to teach sexuality has meant that young people often rely on the internet or peers for information, which may be inaccurate. In conflict-affected countries, younger females (15 – 29) are less likely to have their family planning needs met than older cohorts. Given the increasing trends in child marriage, the prevention of unintended pregnancies and reduction of adolescent childbearing is crucial to the health and well-being of these young women. Women and girls affected by VAWG are growing in the region, adolescent girls in emergency contexts raise concerns of sexual abuse and exploitation particularly for those with disabilities.

Address insufficient data on adolescent health and nutrition by prioritizing key health indicators, allocating adequate resources to relevant quantitative and qualitative research gaps, and enhancing effective data management with focus on sex and age disaggregation.

PHYSICAL ACTIVITY AND NON-COMMUNICABLE DISEASES

While the region has witnessed a decrease in DALYs for causes such as diarrhoea and respiratory infections in recent years, ischaemic heart disease, major depressive disorders and diabetes have become more widespread. Unhealthy diets – along with physical inactivity – are key contributors to the burden of non-communicable disease in the region where several countries demonstrate highest rates of physical inactivity, obesity, and diabetes in the world (26.9% of men and 43.5% of women). Adolescents perform poorly in engaging in adequate physical activity, this is true globally but is worse in the region with a rate of 87% (84.3% boys and 89.9% girls).

Address the major increase in non-communicable diseases by ensuring gender-responsive research, policies as well as adequate access to training facilities.

COVID-19

Restrictions on movement and social distancing measures have limited households' access to work, regular income, remittances, markets, schools and healthcare in the region. Lower income/savings depletion and decreased government capacity to respond to a second and third wave may worsen poverty and inequality, and lead to deterioration of household food security while increasing people's health needs.

Ensure essential services are provided to vulnerable populations including women's and girls in fragile countries in the region and those of humanitarian complex settings including maintaining these services amid the current COVID-19 preparedness and response.