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Communication

Beyond the Veil of Homogeneity: Addressing the Variability of Women's Health and Policy Gaps in the Middle East

Sohier Elneil [1,*], Gayathri Delanerolle [2,3], Vindya Pathiraja [4], Tharanga Mudalige [4], Lanka Dasanyake [4], Nirmala Rathnayake [2,4], Thamudi Sundarapperuma [4], Damayanthi Dassanayake [5], Abirame Sivakumar [6], Mohammad Haddadi [7], Helen Felicity Kemp [8], Cristina Laguna Benetti-Pinto [9], Daniela Angerame Yela [9], Fred Tweneboah-Koduah [10], George Uchenna Eleje [11], Peter Phiri [3,12] and Nihal Al-Riyami [13]

[1] University College London, London, United Kingdom
[2] University of Birmingham, Birmingham, United Kingdom
[3] Hampshire and Isle of Wight Healthcare NHS Foundation Trust, Southampton, United Kingdom
[4] University of Ruhuna, Matara, Sri Lanka
[5] University of Peradeniya, Kandy, Sri Lanka
[6] University of Jaffna, Jaffna, Sri Lanka
[7] Tehran University of Medical Sciences, Tehran, Iran
[8] Menopause Inclusion Collective, Scotland, United Kingdom
[9] University of Campinas, UNICAMP, Brazil
[10] Narh-Bita Hospital, Tema, Ghana
[11] Nnamdi Azikiwe University, Awka, Nigeria
[12] University of Southampton, Southampton, United Kingdom
[13] Sultan Qaboos University, Muscat, Oman
* Correspondence: sohier.elneil@ucl.ac.uk

Abstract

Women's health in the Middle East is often framed through a homogenous lens that overlooks deep variability shaped by economic status, migration, legal systems, and sociopolitical contexts. While the United Nations (UN) Sustainable Development Goals (SDGs) provide a blueprint for health equity and gender empowerment, implementation across the region is fragmented. While wealthier countries have made significant gains in maternal health and access to healthcare, substantial gaps remain in reproductive, mental, and chronic disease care, especially in conflict zones and under-resourced settings. Migrant women, who are vital for the functioning of key sectors of Gulf economies, face systemic exclusion under restrictive labour and immigration policies such as the kafala system. These women are denied basic health rights despite contributing to economic growth, which is often pursued at the expense of equitable healthcare access. Policy narratives promoting economic reform rarely align with gender-sensitive health system investment, creating a paradox where growth fails to translate into improved outcomes for all women. This critical summary calls for dismantling structural inequities, strengthening inclusive health systems, and embedding intersectional approaches into national policies. Without urgent reform, the SDGs risk reinforcing rather than reducing the disparities faced by diverse groups of women across the Middle East.

Keywords: middle east; women's health; health policy; sustainable development

Background

Despite growing recognition of the unique challenges faced by women in global health, the diversity of women's health experiences in the Middle East remains poorly characterised and

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inconsistently addressed in policy (Hussein et al., 2018, Zurayk et al., 1997, Abboud et al., 2022, Sholkamy, 2022). The tendency to treat Middle Eastern women as a monolithic group often filtered through orientalist or reductionist lenses obscures complex variations in their health needs, risks, and access to care. This variability is shaped by intersecting determinants such as nationality, ethnicity, religion, refugee status, socioeconomic position, and levels of autonomy, factors that demand more nuanced, context-sensitive health interventions and policies. The health experiences of women in the Middle East are far from uniform, with significant differences observed across countries such as Oman, Saudi Arabia, Jordan, Iran, Bahrain, the United Arab Emirates (UAE), and Lebanon (East and Jassim, 2023, Mousa et al., 2021, Wikan, 1991) underscoring the need for more nuanced and context-sensitive health interventions and policies. This diversity is evident in the prevalence of various health conditions, influenced by factors including nationality, socioeconomic status, and cultural practices (Table 01).

Obesity and Overweight

Obesity rates among women in these countries are notably high but vary considerably. For instance, in Saudi Arabia, a 2014 survey reported that 33.5% of women aged 30–70 were overweight, and 60% were obese (Althumiri et al., 2021). In the UAE, obesity prevalence among women was approximately 39.81% between 2014 and 2020 (Okati-Aliabad et al., 2022). Lebanon also exhibits high obesity rates among women, with a prevalence of 29.53% (Mallat et al., 2016). These figures highlight the significant burden of obesity, which is a major risk factor for numerous non-communicable diseases. The current global obesity epidemic has been accompanied by an increase in the incidence of several types of cancer, with a notable increase in gynecological cancers. This trend is particularly alarming in Middle Eastern countries, where the shift towards a more Westernized lifestyle has contributed to the increased prevalence of both obesity and cancer (Daneshvar, 2025)

Type 2 Diabetes Mellitus (T2DM)

The prevalence of T2DM is alarmingly high in the region. In Saudi Arabia, the prevalence reaches up to 31.6%, while in Oman, it stands at 29%, and in Bahrain, 25.5% (Mairghani, 2022, El-Kebbi et al., 2021, Fallatah, 2020). The UAE also reports a high prevalence of diabetes at 19.2%. These elevated rates are closely linked to the high prevalence of obesity and sedentary lifestyles.

Breast Cancer

Breast cancer is the most common cancer among women in the Middle East. In 2019, the age-standardised incidence rate in the Middle East and North Africa (Casas) region was 37.5 per 100,000 women, with an age-standardised death rate of 15.2 per 100,000 (Azadnajafabad et al., 2023, Manzano et al., 2024, Zahedi et al., 2020). Notably, women in Arab countries tend to present with breast cancer at a younger age and more advanced stages compared to their Western counterparts (El Saghir et al., 2007, Najjar and Easson, 2010, Al-Shamsi et al., 2023).

Maternal Mortality

Maternal mortality ratios (MMR) also vary across these countries. For example, the MMR in the UAE has shown improvement over the years, reflecting advancements in maternal healthcare. However, disparities persist, with some countries in the region still experiencing higher MMRs, underscoring the need for targeted maternal health interventions. For instance, In the United Arab Emirates, the maternal mortality ratio (per 100 000 live births) has improved by 17 deaths per 100 000 live births from 19 [12 - 31] in 1985 to 3 [2 - 4] in 2023 (Khorrami et al., 2019, Who, 2024). In Yemen, the maternal mortality rate increased from five deaths per day in 2013 to 12 deaths per day in 2019, one factor being the war that limited access to basic resources such as food and water (Haza'a et al., 2024).

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Gestational Diabetes Mellitus (GDM)

The prevalence of GDM has seen changes over the decades. Between 2000 and 2019, countries like Iran, Oman, and Saudi Arabia experienced an increase in GDM prevalence by 4% to 8%. Conversely, Bahrain, Qatar, and the UAE observed a decrease of 4% to 2% during the same period. These trends indicate shifting risk factors and the impact of healthcare interventions (Al-Rifai et al., 2021).

These epidemiological statistics underscore the heterogeneity of women's health issues in the Middle East. Addressing this variability requires nuanced, context-specific health policies that consider the unique sociocultural and economic factors influencing women's health in each country.

Intersecting Health Challenges

Women in the Middle East face a unique health burden arising from both non-communicable and reproductive health challenges. High rates of obesity, diabetes, cardiovascular disease, and depression often coexist with underdiagnosed reproductive health conditions such as endometriosis, polycystic ovarian syndrome (PCOS), and menopause-related complications. Mental health remains deeply stigmatised and underfunded, especially for young women navigating restrictive gender norms or survivors of conflict-related trauma.

The prevalence of noncommunicable diseases (NCDs) among women in the Middle East is alarmingly high (Aggarwal et al., 2020). Obesity rates have surged due to lifestyle changes, including unhealthy eating habits and reduced physical activity. For instance, a study highlighted that the prevalence of obesity among adults in the Middle East has paralleled rises in diabetes, cardiovascular diseases (CVDs), and certain cancers (Okati-Aliabad et al., 2022). Specifically, young Middle Eastern women who are overweight or obese face a higher risk for developing atherosclerotic cardiovascular disease and its associated risk factors like hypertension and type 2 diabetes (Hammoudeh et al., 2024). Mental health disorders are prevalent yet significantly under-addressed. The region has experienced a steady increase in mental health disorders, with 33% of women reporting frequent stress, and anxiety disorders and depression being highly prevalent among girls aged 10-19 years. The stigma surrounding mental health, especially for young women contending with restrictive gender norms or those who have endured conflict-related trauma, exacerbates the situation. For example, in 2020, approximately 198,797 adults in Gaza were estimated to have moderate or severe mental health disorders, with trauma from violent incidents leading to a sense of despair and anxiety (Abudayya et al., 2023).

At the same time, maternal health metrics vary significantly. While countries like the United Arab Emirates and Qatar have made gains in maternal care, others, including war-affected Yemen and parts of Syria, struggle with extreme fragility in services (Ladadwa et al., 2024, Abdalla, 2018). In refugee-hosting countries like Jordan and Lebanon, displaced women often face profound barriers to accessing sexual and reproductive healthcare, compounded by legal, financial, and linguistic challenges. Addressing these intersecting health challenges necessitates a comprehensive approach that includes:

- Public Health Campaigns**:** Raising awareness about NCDs and reproductive health issues to promote early detection and lifestyle modifications.
- Healthcare Access**:** Improving access to healthcare services for timely diagnosis and management of both NCDs and reproductive health conditions.
- Mental Health Services**:** Expanding mental health services and integrating them into primary healthcare to reduce stigma and provide support, especially for vulnerable groups such as young women and conflict survivors.

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- Policy Interventions: Implementing policies that promote healthy lifestyles, including regulations on food quality, urban planning that encourages physical activity, and education reforms that incorporate physical education for girls.

The Impact of UN Sustainability Goals on Women's Health in the Middle East

The United Nations Sustainable Development Goals (SDGs), particularly SDG 3 (Good Health and Well-being), SDG 5 (Gender Equality), and SDG 8 (Decent Work and Economic Growth), aim to address the systemic inequalities that disproportionately affect women's health worldwide. In Middle Eastern countries however, the translation of these goals into tangible improvements in women's health is uneven and complicated by socio-political, economic, and cultural dynamics (United Nations, 2015).

Progress and Gaps in Achieving Health Equity

While the SDGs have pushed several Middle Eastern countries to improve maternal health services, reduce fertility rates, and expand access to contraception, structural barriers remain. In countries such as Jordan, Lebanon, and the UAE, investments in women's healthcare have aligned with the SDGs to reduce maternal mortality and expand primary health access (Daher-Nashif and Bawadi, 2020). Yet, in conflict-affected or conservative settings like Yemen, Syria, and parts of Iraq, progress is stunted due to weakened health systems, political instability, and entrenched gender norms. Women's mental and reproductive health remains underfunded and understudied across much of the region. Taboo topics such as menopause, endometriosis, or sexual health receive minimal attention, resulting in delayed diagnoses and poor quality of life for affected women. While SDG 5 calls for an end to discrimination and violence against women, implementation often lacks the legal and institutional support needed to protect women's health rights.

SDG 8 (decent work and economic growth) promotes economic growth and decent work, which, in theory, can provide the financial resources and infrastructure necessary to improve women's health. In developing Arab countries, like Saudi Arabia and the UAE, economic diversification has created new employment opportunities for women, improved access to private health services, and led to lifestyle shifts that benefit women's health outcomes (Alzaaqi et al., 2025). However, economic growth alone does not guarantee equity. Furthermore, economic reforms focused on growth may not always prioritise investment in gender-sensitive health services, especially in patriarchal systems where women's needs are deprioritised.

Migrant labour forms the backbone of economic growth in the region, yet this growth is sustained by a health system that externalises responsibility for the well-being of these workers. While the private healthcare sector thrives, often subsidised or expanded as part of economic diversification efforts, this rarely benefits low-income migrant women, who remain structurally excluded or forced to pay out of pocket for even basic care. There is a fundamental tension between the SDG aim of inclusive economic growth (SDG 8) and the reality of exploitative labour practices. Economic Economic gains are rarely reinvested in equitable health infrastructure or protections for the very workers fuelling this growth (Chigbu and Nekhwevha, 2023).

A critical gap remains in linking economic policy with health policy. For example, while economic liberaliastion may increase employment opportunities, without robust social protection, maternity leave, or workplace safety regulations, these gains do not translate into better health outcomes for women. Women's unpaid care burden remains high, particularly in lower-income and rural areas, further limiting their ability to benefit from economic development.

Cultural and Political Constraints

Efforts to implement the SDGs are often filtered through conservative socio-cultural lenses that restrict open discourse around women's health. In several Middle Eastern countries, legal restrictions

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and societal norms continue to limit women's autonomy over their bodies, including decision-making about reproductive health (Alomair et al., 2020). These constraints are compounded by weak civil society engagement, limited data transparency, and political will that is often more rhetorical than action-oriented. This disparity is further compounded by limited gender-sensitive data, societal stigma, and restricted access to health services, particularly for older women.

Limited Educational Opportunities for Women

Access to education is a fundamental determinant of health, yet in many parts of the Middle East, women and girls still face systemic barriers to educational opportunities. Cultural norms, early marriage, economic constraints, and restrictive gender roles continue to hinder girls' education, particularly in rural or conflict-affected areas. This educational disadvantage extends far beyond the classroom, it significantly impacts women's health literacy, economic independence, and decision-making capacity. Without adequate education, women are less likely to access health information, recognize symptoms of conditions like menopause, cystocele, or chronic illnesses, and seek timely medical care. They may also lack the confidence or societal power to advocate for their own health needs, contributing to delayed diagnoses and poorer health outcomes. Educational gaps further reinforce the cycle of dependency and silence, particularly around stigmatized issues like urinary or sexual dysfunction during midlife.

Legal and Structural Exclusion from Health Systems

Migrant women, many of whom are employed as domestic workers or in low-wage service roles, frequently operate outside the protections of national labour laws. Under the *kafala* (sponsorship) system still prevalent in many states, their legal residency and employment are tied to individual employers, severely restricting their autonomy and access to healthcare. Despite economic reliance on their labour, host countries often exclude them from universal health coverage frameworks or provide only minimal emergency services. This exclusion directly undermines SDG 3 (Health and Well-being) and SDG 5 (Gender Equality), reinforcing a tiered health system where nationality and class determine access. For example, migrant women report barriers in accessing sexual and reproductive health services, face routine surveillance, and may avoid healthcare altogether due to fear of deportation, job loss, or lack of privacy (Alraddadi et al., 2024, Lorenzini, 2021).

COVID-19 and the Visibility of Structural Injustice

The pandemic exposed and amplified pre-existing inequalities across societies. Migrant women, particularly those in domestic roles, were often confined indoors without pay, care, or recourse. Reports of abuse and denial of medical care surged during lockdowns. Yet, despite international attention, many of these structural issues have resurfaced in post-pandemic recovery plans, which continue to prioritise economic recovery over rights-based health reform (Almasri, 2022).

Gendered Exploitation and Health Consequences

Migrant women are exposed to gender-based violence, poor housing, long working hours, and limited legal recourse factors that have profound physical and mental health consequences (Tastsoglou, 2025). Studies have documented high levels of anxiety, depression, and post-traumatic stress disorder among female domestic workers in countries like Lebanon and Kuwait (El Hajj, 2021, Abuhadra et al., 2023). Many suffer in silence due to language barriers, social isolation, and the criminalisation of complaints against employers. Despite SDG commitments to reduce inequality (SDG 10), little progress has been made in dismantling systemic drivers of exploitation. Where protections exist, they are rarely enforced, and grievance mechanisms are weak or inaccessible

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Moving Beyond Symbolism

A critical view of the SDGs in the Middle East reveals a pattern of selective adoption and symbolic compliance, where countries report progress without addressing root causes of gender-based health disparities. Achieving meaningful change requires moving beyond indicators to structural reform, ensuring that economic growth is inclusive, that health systems are gender-responsive, and that legal frameworks protect women's bodily autonomy and rights (Sweileh, 2024).

While the UN SDGs provide a valuable framework for improving women's health in the Middle East, progress is constrained by socio-political realities, economic disparities, and cultural resistance. Economic growth has supported some gains, particularly in urban and high-income settings, but without deliberate, gender-sensitive health and labour reforms, such growth risks widening rather than closing existing gaps. A more integrated approach linking sustainable development, equitable economic policy, and health system reform is essential for improving women's health outcomes across the region (Al Mokdad, 2025, Sweileh, 2024).

Gaps in Policy and Practice

Current national policies rarely reflect the real diversity of Middle Eastern women's lived experiences. Many health systems operate under patriarchal norms that limit women's decision-making power regarding their own care. In some states, women require male consent to access certain services; in others, unmarried women are denied contraception or gynaecological screening due to moralistic policies (Alhosain, 2018).

Even where women's health strategies exist, they often frame health through a narrow biomedical or maternal lens, without addressing chronic conditions, ageing, or the broader determinants of health such as mobility restrictions, legal inequities, or gender-based violence. Additionally, data disaggregation by gender, ethnicity, and migration status is weak, impeding the development of targeted responses.

Male Guardianship and Consent Requirements:

In several middle-easten countries, male guardianship systems are institutionalised, necessitating that women obtain permission from a male guardian—such as a father, husband, or brother—to access various healthcare services (Alshahrani, 2018). For instance, in Qatar, unmarried women under the age of 25 require their male guardian's consent to travel abroad, which can indirectly affect their ability to seek medical care internationally (Al Khalifa et al., 2024). Similarly, in Afghanistan, stringent policies mandate that women must be accompanied by a male guardian when traveling, leading to delays and denials of critical maternal healthcare, resulting in preventable maternal and infant deaths.

Access for Unmarried Women:

In Saudi society and other Muslim countries, modesty and purity are highly valued, especially for unmarried women. Asking about or seeking reproductive health services may be seen as inappropriate or shameful, reinforcing the idea that ignorance equals virtue (Alomair et al., 2021).

Legal Constraints on Reproductive Rights:

Legal restrictions further complicate women's access to reproductive healthcare. In the United Arab Emirates and most middle Eastern or Gulf countries, abortion is permitted only under specific circumstances, such as when the pregnancy poses a risk to the woman's life or in cases of lethal fetal abnormalities. Even in these situations, the procedure must be approved by a medical committee and performed within the first 120 days of pregnancy. Such stringent regulations can lead women to seek unsafe abortions, jeopardizing their health and well-being (Abdelbaqy, 2021). In Iran, access to abortion has become more restricted in recent years due to concerns about population decline and

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pressure from hardliners. In many cases, such as those involving severe fetal anomalies, a judge's approval is required in addition to the consent of a Muslim doctor. Furthermore, contraceptive medications have become less accessible than they were in the past (Haddadi et al., 2025b). Moreover, many reproductive methods, such as fertilisation using egg or sperm donors and surrogacy, are restricted or even prohibited in several countries, including the UAE and Turkey (Haddadi et al., 2025a).

Impact of Patriarchal Norms on Policy Implementation:

Patriarchal norms deeply influence the formulation and execution of health policies in the MENA region. These norms often result in limitations on women's physical mobility and autonomy, obstructing their effective access to and utilisation of healthcare services. Additionally, societal expectations and gender roles can deter women from seeking necessary care, particularly in areas related to sexual and reproductive health.

Gaps in Policy and Practice:

Despite international commitments to gender equality and women's health rights, national policies in many middle-eastern countries frequently fail to address the diverse experiences and needs of women (Al-Ali, 2003, Dalacoura, 2019). The lack of dedicated mental health legislation in 50% of the countries within the region, and the absence of national policies and plans in 30%, exemplify these gaps. Moreover, existing policies often do not adequately tackle the barriers posed by male guardianship and societal stigmas, leaving many women without access to essential health services.

Considerations for Policy Reform:

To bridge these gaps, it is imperative to:

- **Ensure Inclusive Access:** Develop and implement policies that guarantee all women, regardless of marital status, have access to comprehensive sexual and reproductive health services.
- **Enact Protective Legislation:** Introduce and enforce laws that protect women's health rights, including access to safe abortion services and protection against gender-based violence.
- **Address Societal Norms:** Implement public awareness campaigns to challenge and change harmful societal norms and stigmas that hinder women's access to healthcare.

Towards Equitable and Responsive Health Policy

A shift toward resilience-based, equity-driven healthcare is urgently needed. This must begin with inclusive policy development processes that involve women from diverse background including refugee communities, rural populations, and religious minorities. Investment in community-based health education, digital health tools, and gender-equity programs or initiatives (I think this is a better word) could amplify health-seeking behaviour and reduce stigma around reproductive and mental health.

Women's healthcare policies should be grounded in robust data systems that capture the heterogeneity of women's health profiles. Regional collaboration, for instance, through a Middle East women's health observatory or research network could enable the development of culturally congruent, evidence-based interventions and accountability mechanisms.

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Conclusion

The variability in Middle Eastern women's health experiences is not a challenge to be simplified, it is a reality to be embraced, studied, and acted upon. Effective policy must acknowledge the plurality of needs and center women's voices, particularly those marginalized within already fragile systems. Bridging the gap between policy rhetoric and lived reality is not just a matter of health equity it is an ethical imperative.

Supplementary Materials: The following supporting information can be downloaded at the website of this paper posted on Preprints.org.

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