This level of exploration and understanding requires broad but locally oriented research agendas backed by a vibrant civil society that promotes evidence based health and shields scientific inquiry from dominant social and political doctrines. More research is also needed in "taboo" areas associated with major health problems—for example, domestic violence, mental health, and the health of special groups (such as Palestinian refugees and Kurdish minorities). The taboos may be unwritten but their impact at government level is strong. In authoritarian regimes health ministries have little incentive to present "bad" or politically loaded data or work on such data obtained from other sources, especially as they are not held accountable for failing to do so by independent bodies or a free press.

Against this bleak background, multiple conflicts are tearing the Middle East apart and delaying all aspects of development. These conflicts are used by national governments and outside powers alike to divert public attention from developmental failures. They nourish narrow interests and result in suffering and despair, driving people to regroup along ethnic, religious, and tribal loyalties, which undermine the state's status and erode the community's spirit and trust. Health, along with all facets of life in this turbulent region, can only be improved if nations recognise the importance of investing in science, health, education, and culture. In the long run this is the only way they can provide their populations, rich or poor, with the means to assert their rights and assume responsibility for their own destiny.

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Sexual and reproductive health of women

Both informed choice and access to services are needed

Access to sexual and reproductive health services is central to achieving good maternal and child health but its importance extends beyond this. Sexual and reproductive health engenders a sense of wellbeing and control over one's life, along with an ability to enjoy basic human rights. A broader understanding of sexual and reproductive health was promoted at a development conference—the Cairo International Conference on Population and Development in 1994.[1] Three articles in this week's *BMJ* draw together the latest evidence and the challenges ahead for women's health in the Middle East.[2–4]

Elements of sexual and reproductive health are included in three of the eight millennium development goals: reducing child mortality, improving maternal health, and combating HIV and AIDS. Sexual and reproductive health is important in reaching the other goals.[5]

Countries of the World Health Organization Eastern Mediterranean Region (EMRO) have adopted targets set by the millennium development goals; however, the 2005 Millennium Project reports that West Asia is off track for most of them.[6] This area contains several countries that belong to the EMRO region (Arab Gulf States, Iraq, Jordan, Lebanon, Syria, and Yemen). North Africa, which also includes several countries in the EMRO region (Egypt, Libya, Morocco, and Tunisia) is moving in the right direction, but needs to accelerate progress to achieve the goals.

Improving maternal and newborn health is still a challenge for disadvantaged countries in the region. The proportion of deliveries attended by skilled birth attendants is as low as 22% in Yemen, 14% in Afghanistan, and 34% in Somalia.[7] In this issue Bhutta and colleagues show that many maternal and child deaths in the region could be prevented by scaling up community based maternal and newborn care services.[2]

The use of contraceptives in married women aged 15-49 varies widely among countries in the EMRO region, from 9.9% in Sudan to 63% in Lebanon and Morocco.[w1] For cultural reasons, contraceptive surveys in countries of the region do not include unmarried women.

Key areas of sexual and reproductive health, such as prevention of sexually transmitted infections including HIV, unsafe abortion, and the promotion of sexual health are still largely missing in many countries in the EMRO region. The number of unsafe abortions in the region for the year 2000 is estimated to be 2.6 million and to cause 11% of all maternal deaths.[8] An article in this issue by DeJong and El-Khoury shows that young people's reproductive and sexual health needs are largely unmet.[3] No country from the EMRO region participated in a WHO

Analysis and Comment pp 839, 849, 851

References w1-w3 are on bmj.com

BMJ 2006;333:816–7

multicentre study on sexual relations among young people in developing countries.[9]

Improving sexual and reproductive health requires action by areas of society beyond the health sector. Poverty and sex inequality increase the vulnerability of women to sexually transmitted disease and HIV infection. Early child bearing and high fertility are barriers to improving the educational and economic status of women and young people.[w2]

The Arab human development report emphasised that sexual discrimination is paralleled by prejudice against the young.[10] Patriarchal dominance and discrimination is worst when the two prejudices overlap—as in the case of young females. Religion is often used to rationalise old cultural traditions and social prejudices, as in the case of female genital cutting.[11]

Powerlessness shapes people's health and life. Alleviating poverty is one route to empowerment, and access to information and services is another. Supply of information and services is, however, not enough. Young people need to be seen as assets, not problems. They should not be denied access to education and services in the hope that they will remain ignorant about sexual health issues that society would rather sweep under the carpet. Information and education does not encourage promiscuity, it helps young people to make responsible decisions to prevent unwanted pregnancies and sexually transmitted disease.[w3]

In this issue, Obermeyer reviews the evidence about HIV in the Middle East and North Africa.[4] Given the still relatively low prevalence of HIV and AIDS in most of the countries in this region, we have a window of opportunity to prevent what will otherwise be an epidemic, when the disease spreads beyond the high risk groups.[12] The cost of ignoring this window of opportunity will be high. Sexually active people must be given information and the ability to act on it through provision of services otherwise the opportunity will be lost. Preaching abstinence alone is not enough. The millennium development goals in the Middle East will not be achieved if women and young people are powerless.

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Humanitarian aid: some political realities

Humanitarian agencies must tackle political and logistical obstacles to their work

Analysis and Comment p 843

The scale of current humanitarian crises in the World Health Organization Eastern Mediterranean Region (EMRO) is vast and the legacy of past wars persists. Around 60% of the world's refugee population have fled EMRO countries,[1] and the region is host to half of the world's refugees. The Palestinian territories, Afghanistan, Iraq, and Sudan are four of the five main sources of refugees globally, while the Palestinian territories, Pakistan, Iran, and Syria are the world's major hosts of refugees. Many of these people have been "warehoused" for decades in long term camps. In addition, over a third of the 21 million "internally displaced persons"—people who have been forced from their homes but have not crossed national borders—are in EMRO countries. These are startling statistics for a region that contains only 8% of the world's population.

Recent crises have highlighted problems faced by the global humanitarian aid community. These include the difficulty of achieving interagency coordination, poor documentation of humanitarian need, and the lack of security for aid workers. Each illustrates the close link between politics and humanitarian action.

In 1991 the United Nations set up the Office for the Coordination of Humanitarian Affairs (OCHA) to improve interagency cooperation. After a review of its work the "cluster approach" was introduced in 2005 to

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