

The right to health in Saudi Arabia

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Introduction

Saudi Arabia is located in the Middle East, and borders with both the Persian Gulf and the Red Sea. The capital city is Riyadh, and the Kingdom is split into thirteen different provinces. Currently the population of the Kingdom is just over 28million, which includes around 5.5million non – nationals.¹ The majority of the expatriates are from South and Southeast Asia.² Saudi Arabia has an oil-based economy, and 45% of the GDP comes from the petroleum sector.³ In Saudi Arabia, the government is headed by the monarchy, and the current king and Prime Minister is King Abdullah. Due to this, there is a lack of democracy as the people cannot vote for their government. Instead the rule is passed down through the throne. As such, because the country is ruled by an absolute monarchy, Human Rights Watch concludes that overall human rights conditions are poor.⁴

As a result the Kingdom of Saudi Arabia faces general problems in the context of Human Rights, as they are lacking throughout the entire legal system. This is a major issue that has frequently been pointed out by International bodies and organisations.⁵ A main cause for concern is Saudi women's place in society, which results in a severe failure to protect a broad spectrum of rights. Saudi law does not protect many basic rights and the government places strict limits on freedom of association, assembly and expression. There are also serious concerns about; the deficiency of official accountability, arbitrary detention, mistreatment and torture of detainees, as well as restrictions on freedom of movement. It is common for Saudi judges to issue sentences of thousands of lashes for punishment. This is of great concern as the beatings lead to mental trauma and severe pain, but the victims do not receive medical treatment.⁶ In addition, Saudi Arabia is one of the five remaining countries in the

¹ CIA World Factbook, at <https://www.cia.gov/library/publications/the-world-factbook/geos/sa.html>, accessed 5th November 2008

² *Ibid*

³ *Ibid*

⁴ Human Rights Watch, World Report 2007, at <http://hrw.org/englishwr2k7/docs/2007/01/11/saudi14717.htm>, accessed 30th September 2008

⁵ Human Rights Watch, World Report 2008, at <http://www.hrw.org/englishwr2k8/docs/2008/01/31/saudia17618.htm>, accessed 5th November 2008 and Amnesty International, at http://www.amnesty.org.uk/news_details.asp?NewsID=17502, accessed 5th November 2008

⁶ Human Rights Watch, *supra* n 4

world that issues the death penalty to minors.⁷ Juveniles in Saudi Arabia can receive such a sentence from the age of 15, or the age of puberty. Two minors have been executed in Saudi Arabia since 2005, and throughout the five countries over 100 minors remain on death row.

Another significant social factor is that women continue to face serious obstacles to their participation in society. This is due to the fact that Saudi women must obtain permission from the man who is their legal guardian before they can do certain things. The legal guardian may be the father, husband or son of the woman, and permission is required in order to; work, travel, study, marry or access medical care.⁸ Officials regularly request permission from the legal guardian, even when it is not mandatory or stipulated under government guidelines. This is the case in hospitals, where some require a guardian's permission before women are admitted, or are allowed to consent to medical procedures for themselves or their children. A guardian may also be consulted before the woman is discharged, despite the fact there are national regulations to the contrary (see below under 'women's health').⁹ This is serious and affects not only a woman's right to access healthcare, but also the rights of children and adolescents. By failing to eliminate these discriminatory practices the Saudi government is failing in its commitment to guarantee women and girls their right to education, employment, freedom of movement, health and equality in marriage.

As there is a lack of commitment to human rights generally, the right to health is not greatly supported in Saudi Arabia. Although there have been various improvements, there has also been regression. Throughout the Kingdom there are various specialist hospitals, with excellent highly specialised equipment, but due to the lack of accountability, and reporting, there is a great lack of reliable information. This makes it impossible to get a clear picture of how effective the Saudi healthcare system is as a whole. There are also problems with women's and migrant worker's access to health care.

Legal Commitment to a right to health

The right to health is recognised in a number of international treaties and documents, but unsurprisingly Saudi Arabia is not party to many of these. The only international treaties that have been ratified by Saudi Arabia are the Convention on the Elimination of all forms of Discrimination against Women (CEDAW); the Convention on the Rights of the Child (CRC) (which both contain provisions on the right to health); the Convention against Torture (CAT); the International Convention on the Elimination of all forms of Racial Discrimination (CERD); and the International Convention on the Prevention and Punishment of the Crime of Genocide.¹⁰ Notably Saudi Arabia has not ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR) which is the main document for promoting social rights, such as health.

⁷ UN: Five Countries Responsible for All Executions of Juvenile Offenders Since 2005, Sept 10th 2008, at <http://hrw.org/english/docs/2008/09/08mena19777.htm>, accessed 1st October 2008

⁸ Sex Segregation Keeps Women Out of Public Life, April 21st 2008, at <http://hrw.org/english/docs/2008/04/21/saudi18598.htm>, accessed 1st October 2008

⁹ *Ibid*

¹⁰ Human Development Report 2007/2008, table 34 at, http://hdr.undp.org/en/media/hdr_20072008_en_complete.pdf, accessed on 10th Sept 2008 and www.unhchr.ch.

Due to this there is a lack of information on the protection of economic, social and cultural rights in Saudi Arabia, at an international level.¹¹ This shows a weak international commitment to human rights, not only economic, social and cultural, but also civil and political. Although CEDAW has been ratified, it has not yet been made fully operational as relevant laws remain to be adopted, and there have been no cases where the provisions of the Convention have been directly invoked in Court.¹² This is unsatisfactory, and highlights that even when important Conventions have been ratified, they afford little benefit to Saudis. At a regional level, Saudi Arabia ratified the Arab Charter on Human Rights in February 2008.¹³ However the Charter, which came into force on the 30th of January 2008, has often been the subject of criticism, as it is thought that the document is far from compatible with international human rights standards. In particular, Louise Arbour the High Commissioner for Human Rights has stressed that the Charter is incompatible with the international standards for women's, children's and non-citizens rights.¹⁴ This is of paramount concern within the current topic, as these are the groups in which health issues are most prevalent.

Despite the lack of commitment to human rights at the international level, there appears to be some commitment at a national level. This can be seen in the Basic Law of Saudi Arabia, also known as the basic system of governance, which is a charter divided into nine chapters. Chapter five refers to rights and duties. The main rights that are covered are economic, social and cultural rights, such as; welfare rights, science and culture, education and environment and nature. In addition to this the right to health care is referred to in article 31 which declares that, 'The state takes care of health issues and provides health care for each citizen'.¹⁵ This creates problems for non-citizens as they are not protected by this provision. In contrast, article 36 of the same document which covers arrest and imprisonment, provides security for all citizens and residents within its territory.¹⁶ This would imply that article 31 applies to citizens only, and citizenship is governed by Regulations, defined by statute.¹⁷ Although these rights exist, they are protected in accordance with the Islamic Shari'ah and not by international human rights standards. Considering the lack of commitment to the various international treaties and the issues considered in the introduction, this creates doubts as to how effective and extensive the rights in chapter five of the basic law actually are.

Health Policy and Financing

¹¹ At, <http://www.escri-net.org>, accessed on June the 16th 2008. When carrying out a country search on this site, no information was provided for Saudi Arabia.

¹² Committee on the Elimination of all forms of Discrimination Against Women, Fortieth Session 14 Jan – 1 Feb 2008, Concluding comments on Saudi Arabia

¹³ <http://www.saudiembassy.net/2008News/News/RigDetail.asp?cIndex=7698>, accessed 30th September 2008

¹⁴ International Humanist and Ethical Union, at <http://www.iheu.org/node/2998>, accessed 30th September 2008

¹⁵ The Basic Law of Saudi Arabia, at http://www.mideastinfo.com/documents/Saudi_Arabia_Basic_Law.htm, accessed on 17th June 2008

¹⁶ *Ibid*

¹⁷ *Ibid*, Article 35 referring to citizenship

In Saudi Arabia, the health service is in general publicly funded. The percentage of GDP spent on health was 3.4% in 2005.¹⁸ In the same year the percentage of private GDP spent on health was 0.8%.¹⁹ The government expenditure on health as a percentage of total expenditure on health was 76.2, and private expenditure was therefore 23.8.²⁰ This is higher than the percentage of GDP spent on health in the neighbouring country of the United Arab Emirates, where public expenditure was 2% of GDP and private expenditure was 0.9% of GDP.²¹ In addition, this can be compared with other public expenditure within Saudi Arabia, in order to get an insight into the priorities of the government. In 1991 5.8% of GDP was spent on education, while 14% was spent on defence.²² However this has improved over time with the expenditure on defence almost halving, as in 2005 only 8.2% was spent on defence and 6.8% of GDP was spent on education.²³ There has been an improvement over the years, and it is hoped that the government continues to move in the same direction. Whilst the percentage spent on education is lower than that spent on defence, it is relatively higher than government money spent on health at 6.8% compared with 3.4%. Saudi Arabia could greatly improve its health system by investing more money in this, and less on defence.

Despite the disproportionate expenditure on health, the government appears to have a fairly positive health care strategy, and looks to be constantly improving its health system. The Health System is monitored and improved by the Ministry of Health, and the progress made in this area, as well as other socio-economic factors has been vast over the past thirty years.²⁴ However, despite the progress already made there are still many further developments required which will become apparent as the system is explored further.

Availability, accessibility, acceptability and quality

The 'AAAQ' is an element that is enshrined in General Comment 14 on the highest attainable standard of health.²⁵ The concepts of 'availability, accessibility, acceptability and quality' are used to decipher whether the highest attainable standard of health is being reached. Accessibility covers a wide range of aspects, and as a result has four overlapping dimensions; affordability, information accessibility, physical accessibility, and non-discrimination of health services.

¹⁸ Taken from world health statistics 2008, at <http://www.who.int/countries/sau/en/>, accessed 11th Sept 2008

¹⁹ Human Development Report 2007/08, *supra* n 10

²⁰ World Health Organization, Core Health Indicators, at http://www.who.int/whosis/database/core/core_select_process.cfm?country=sau&indicators, accessed 11th Sept 2008

²¹ Human Development Report 2007/08, *supra* n 10

²² *Ibid*

²³ *Ibid*

²⁴ Country Cooperation Strategy for WHO and Saudi Arabia 2006 – 2011, at http://www.who.int/country_focus/cooperation_strategy/ccs_sau_en.pdf accessed 10th September 2008

²⁵ General Comment No.14 E/C.12/2004/4, was made by the Committee on Economic, Social and Cultural Rights, to explain the standards required by Art 12 of the ICESCR, the right to the highest attainable standard of health. Although Saudi Arabia is not a party to the ICESCR it is relevant to compare the standard of health care to the general comment in order to get an idea of whether the system reaches sufficient international standards. General Comment 14 is available at, [http://www.unhcr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En), accessed 16th October 2008

Affordability

Historically, the health system was publicly funded by the government. However, providing free medical care to all was beginning to place a great financial burden on the state, as there is no tax system. In order to improve the situation the Shoura Council²⁶ passed a law in 2004 to implement mandatory health insurance for all foreign workers in the Kingdom.²⁷ The law is to be implemented in a three-phase initiative. The first phase covers all foreign workers working in large companies, and the second covers workers in small establishments. Both these phases have now been implemented. The third phase will cover all remaining foreign workers. The first stage probably had little if no adverse effects on these workers, as their employers are large companies that will generally provide the employees with affordable insurance. However, it was estimated that there are 8 million migrant workers in the Kingdom,²⁸ which is around 28% of the current population,²⁹ and many are subjected to poor working conditions. As such it seems inconceivable that these workers will be able to afford private medical health insurance. Due to this many will have to revert to out-of-pocket expenditure and may stop seeking health care altogether. Referring to General Comment No 14 on the right to the highest attainable standard of health,³⁰ this breaches the aspect of accessibility, in particular affordability and non-discrimination, as healthcare will no longer be economically accessible for many migrant workers. In their strategy report, WHO considers that the impact on the group is as yet unclear but “the poorest could have their overall health significantly threatened”.³¹

Information accessibility

Another aspect of the ‘AAAQ’ that Saudi Arabia is having problems meeting is a feature of the concept of accessibility: the so-called ‘information accessibility’. WHO believes the country needs to establish an efficient National Health Information System (NHIS).³² There are many reasons for this, one of which being that the current available data for morbidity and mortality are not considered very accurate. This is a major hindrance for organisations when they are trying to decipher the wellbeing of the population, and has also been an obstacle for this author in completing an accurate report. The role of a satisfactorily updated NHIS would be of great value in providing good data for decision making within Saudi Arabia, and would be of major assistance to organisations such as WHO.³³ WHO considers that the development of the NHIS can be assisted through improvements in telecommunications. Such developments are expected to support the efficiency of the NHIS and play an imperative role in improving medical services in rural areas. The theory is that such a system will help

²⁶ The Shoura Council is a non – elected parliament, whose members are appointed by the King. The legislative role of the council was increased in 2003. Due to the councils role and the fact there are no elections held, this again raises questions of basic human rights standards.

²⁷ C Emery, “Turning to the Private Sector”, *Middle East Health Magazine*, at <http://middleeasthealthmag.com/may2005/feature1.htm> accessed 30th September 2008

²⁸ Human Rights Watch World Report 2008, *supra* n 5

²⁹ The current population is around 28,146,656, CIA World Factbook at, <https://www.cia.gov/library/publications/the-world-factbook>, accessed 4th November 2008

³⁰ General Comment No.14 E/C.12/2004/4, *supra* n 25

³¹ WHO, country co-operation strategy, *supra* n 24

³² *Ibid*

³³ This would assist WHO in making reliable observations and conclusions on the Country when reporting, and make the data available more accurate

to reduce the number of referrals to tertiary medical facilities, and reduce the wastage of resources, such as drugs. It is believed progression in these fields will eventually ensure equality and quality in the health services provided.³⁴ Further, a NHIS would develop appropriate indicators which currently do not exist, for monitoring the performance of the health system in Saudi Arabia.

Physical accessibility

A further concern is the physical accessibility of health care. It is recommended that primary health care centres should be appropriately situated throughout a country and a citizen should not live more than one hour away from their closest medical centre. Saudi Arabia is a member of the Gulf Council Cooperation – “2009 for primary health care promotion”,³⁵ and has implemented a family practice residency programme, to integrate care at primary health centres. The Kingdom has embarked on a vast expansion of the primary care network, with particular emphasis on; reorganisation of the infrastructure, strengthening of the referral system, integration of preventative programmes and coordination with other health sectors.³⁶ Despite this however, it is not known to the present author what percentage of the Saudi population live within suitable proximity to their nearest primary healthcare centre. According to WHO, 900 additional primary health care centres are required if an equitable service is to be delivered.³⁷ These additional care centres would hopefully solve the problem of overcrowding in city health clinics, which adversely affects the quality of health care. Such centres could also provide accessible clinics for those living in remote areas. There has also been concern about the physical accessibility of mental health care as prior to 1983; there was only one hospital which provided this type of treatment. There have been many developments in this field however, and the next step is to integrate mental health care into primary health care. Once this step is complete, the concept of physical accessibility will hopefully be fulfilled in the context of mental health (see below in the section on ‘mental health’).

General Health of the Population

The World Bank places Saudi Arabia in the ‘Upper middle income’ group, which would raise the assumption that there is a fairly high standard of living within the Kingdom.³⁸ This is mainly due to the oil industry, which brings the majority of the countries wealth, as Saudi Arabia is the largest exporter of petroleum in the world.³⁹ In 2005, 1.63% of families in Saudi Arabia were living in extreme poverty.⁴⁰ Although this figure is not ideal, it is low in comparison to the neighbouring country of Yemen where 10.7% of the population is living in extreme poverty.⁴¹

³⁴ WHO, country co-operation strategy, *supra* n 24

³⁵ http://www.emro.who.int/rd/annualreports/2007/chapter2_4.htm, accessed 11th September 2008

³⁶ *Ibid*

³⁷ WHO, country co-operation strategy, *supra* n 24

³⁸ Millennium Development Indicators: World and Regional Groupings, at http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Data/Regional/asia_western.htm, accessed 3rd October 2008

³⁹ CIA World Factbook, *supra* n 29

⁴⁰ UNDP report Saudi Arabia 2006, at <http://www.undp.org.sa/pages/mdg/mdgintro.php>, accessed 3rd October 2008

⁴¹ Millennium Development Goals Report Yemen, at <http://www.mpic-yemen.org/dsp/mdgs/GOAL%20ONE.pdf>, accessed 5th November 2008

The current life expectancy at birth is 74.6 years for females, and 70.3 years for males.⁴² This is slightly lower than other neighbouring states with similar economies such as the United Arab Emirates, where female life expectancy is 81 years, and male life expectancy is 76.8 years.⁴³ However, considering that between 1970 and 1975 the average life expectancy in the Kingdom was 53.9 years, there has been a considerable increase since then.⁴⁴ On the whole, Saudi Arabia has made a massive improvement in socio-economic development over the past thirty years, with considerable progress in the fields of health, education and housing. There has also been a vast decrease in many communicable diseases such as cholera. However, due to changing lifestyles the country now has major problems with diabetes, hypertension, cancer and road traffic accidents.⁴⁵

Women's Health

Saudi Arabia is a party to the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW), which under Article 12 gives women the right to access all health care services. In particular, it refers to access to reproductive health. This is emphasised in paragraph two of the article; where states should 'ensure women receive appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during lactation'. It appears that these rights are not fully effective in the Kingdom considering that women may often require permission from a male guardian before they seek medical care. Concern for this and other important factors can be seen in the CEDAW Committee Report of April this year;

'The Committee expresses concern about the lack of information and data on health problems ..., as well as access by women and girls from rural areas and non – Saudi nationalities to adequate health care services. The Committee expresses concern that women may require permission of their male guardian to access health facilities.'⁴⁶

All these factors are extremely important if the right to the highest attainable standard of health is truly to be fulfilled within the Kingdom. The committee also referred to the Beijing Declaration, because Saudi Arabia has yet to produce a national action plan to promote this. In contrast, the Committee is positive about the high standard of basic social services within the Kingdom, especially the provision of Government funded health care.

When evaluating women's access to health care the paramount concern is maternal health. This is highlighted in various documents such as General Comment 14, which

⁴² Human Development Report 2007/08, table 28, *supra* n 10

⁴³ *Ibid*

⁴⁴ *Ibid*, table 10

⁴⁵ WHO, country co-operation strategy, *supra* n 24

⁴⁶ Committee on the Elimination of Discrimination Against Women, Fortieth Session 14 Jan – 1 Feb 08, CEDAW/C/SAU/CO/2 Concluding comments of the Committee on Saudi Arabia, available at http://www2.ohchr.org/english/bodies/cedaw/docs/CEDAW.C.SAU.CO.2_en.pdf, accessed 5th November 2008

urges states to reduce maternal mortality.⁴⁷ This is advanced further in goal five of the Millennium Development Goals, which aims to improve maternal health overall.

Access to healthcare during pregnancy and delivery/ maternal mortality

In general, maternal health in Saudi Arabia is good, and the majority of women receive adequate pre-natal and post-natal care. In 1999 only 87% of women were receiving maternal healthcare, but by 2003 this had increased to 96%.⁴⁸ The percentage of births attended by skilled health personnel was also high in 2003 at 96%, which is an increase from 88% in 1990.⁴⁹ Following this, it is unsurprising that maternal mortality rates are relatively low, as maternal care and attended births are important attributes in preventing maternal mortality. In 2003, the maternal mortality rate was 14 per 100,000 live births.⁵⁰ This is relatively low and can be compared with United Arab Emirates where maternal mortality rates are higher at 54 per 100,000 live births.⁵¹ However, in relation to these conclusions one has to remember that information relating to mortality rates is not always accurate, so maternal mortality rates may be higher.

Access to Reproductive Health Services and Information

Paragraph 34 of the General Comment on the right to health urges states to refrain from; limiting access to contraceptives and other means of maintaining sexual and reproductive information, including sexual education and information.⁵²

According to WHO, the contraceptive prevalence rate in 2003 was as low as 32%.⁵³ However this is an increase from 1996, when the contraceptive prevalence was only 21%, of this 69% were using contraceptive pills and 24% IUD's.⁵⁴ No data appears to exist on the unmet demand for contraception. The lack of data and the existence of such a low contraceptive prevalence rate are most likely related to the general lack of protection allocated to women's rights. If women are required to get permission from their husband's or male guardian before gaining information about or being given contraceptives, then they can not exercise their right to free and informed choice. This is also not complying with the aspect of acceptability, which requires that all health facilities are designed to respect confidentiality.⁵⁵ The lack of usage of contraceptives could be a combined result of male guardians refusing permission to let the women use contraceptives, and women not wanting to approach their guardians to ask for permission about matters which are personal to them. As a result, if contraceptive use is to increase, the community will have to alter its attitude towards women. The only way to do this is to abolish the practice of requiring guardian approval. This will be an

⁴⁷ General Comment No.14 E/C.12/2004/4, at para 21, *supra* n 25

⁴⁸ Millennium Development Goals Report Saudi Arabia 2005, p45, at <http://www.un.org/summit2005/MDGBook.pdf>, accessed 12th June 2009

⁴⁹ *Ibid*

⁵⁰ WHO, country co-operation strategy, *supra* n 24

⁵¹ Mortality Country Fact Sheet 2006, at http://www.who.int/whosis/mort/profiles/mort_emro_are_unitedarabemirates.pdf, accessed 5th November 2008

⁵² General Comment No.14 E/C.12/2004/4, *supra* n 25

⁵³ WHO Country Profiles, Saudi Arabia at <http://www.emro.who.int/emroinfo/index.asp?Ctry=saa>, accessed 16th September 2008

⁵⁴ WHO, country co-operation strategy, Source: Saudi Arabia Family Health Survey 1996, *supra* n 24

⁵⁵ General Comment No.14 E/C.12/2004/4, *supra* n 25

exceptionally hard task to fulfil as this practice is deeply embedded in the culture of the Kingdom.

The total fertility rate has been decreasing and in 2004 was down to 3.7.⁵⁶ This has fallen from 4.3 in 2003, and from as high as 6.5 in 1993.⁵⁷

Abortion

Abortion is generally illegal in Saudi Arabia, with a very narrow exception.⁵⁸ The law states that an abortion may only be performed to save a pregnant woman's life, if the pregnancy is less than four months old and it is proven beyond doubt that the continued pregnancy greatly endangers the mother's health.⁵⁹ The pregnancy is thought to greatly endanger the mother's health, if it could cause death, or damage to her physical or mental health.⁶⁰ Abortion is not permitted for any other reason such as foetal impairment, rape or incest. In excess of four months, abortion is only permitted if a panel of approved specialists state that continuation of the pregnancy will result in the mother's death, and all other means to eliminate the danger have been exhausted. Additional requirements for abortion at any stage in pregnancy are: that it must be performed in a Government hospital; a panel of three medical specialists must sign a recommendation before the abortion can be performed; and written consent must be gained from the patient as well as her husband or guardian.⁶¹

There is little statistical data available on abortions in the Kingdom. However, a study suggests that there are very few legal abortions carried out in the State. It is suggested that in 2006 only five Saudi residents obtained a legal abortion, and that all five abortions were carried out in another country.⁶² Due to the lack of reliable statistical data on this subject it is difficult to develop any clear conclusions on abortion in Saudi Arabia. However, in light of the strict law and the lack of accurate data there may be a large number of illegal abortions being carried out. This will create risks to the mother's health, and can increase maternal mortality rates. Consequently, this may suggest that the maternal mortality rates are inaccurate, as they are relatively low.

HIV/AIDS

In Saudi Arabia, AIDS was a taboo subject for many years and due to this very little statistical data was published. However, this is no longer the case as statistics are now published, free health care is issued to nationals and the authorities are urging compassion towards victims of the disease.⁶³

⁵⁶ WHO Country Profiles, *supra* n 53

⁵⁷ WHO, country co-operation strategy, *supra* n 24

⁵⁸ Saudi Arabia, Abortion policy, at

<http://un.org/esa/population/publications/abortion/doc/saudiarabia.doc>, accessed 4th October 2008

⁵⁹ Rules of Implementation for Regulations of the Practice of Medicine and Dentistry, Ministerial Resolution No. 218/17/L of 26 June 1989, Article 24

⁶⁰ Saudi Arabia, Abortion policy, *supra* n 58

⁶¹ *Ibid*

⁶² Historical Abortion Statistics, Saudi Arabia, at <http://www.johnstonsarchive.net/policy/abortion/ab-saudiarabia.html>, accessed 4th October 2008

⁶³ UNDP Saudi Arabia – HIV/AIDS, at http://www.undp.org.sa/pages/ourwork/new/hiv_aids.php, accessed 10th October 2008

Nearly 10,000 HIV/ Aids cases have been reported in the Kingdom since 1986, but only 23 percent of reported cases are Saudi nationals.⁶⁴ These citizens, who are eligible for free health care, now receive anti-retroviral drugs at no cost. This creates a problem, as the expatriates who account for over three quarters of reported cases are not entitled to free health care. As a result, expatriates are almost always sent home after the initial treatment.⁶⁵ Although health insurance for expatriates is now mandatory and some of the private health insurance providers may cover the cost of HIV treatment, many migrant workers will not be able to meet the cost of the insurance. In addition, potential expatriates undergo extensive screening before entry gaining entry into Saudi Arabia. This includes HIV screening, and those who test positive are denied access to the Kingdom.⁶⁶ The reason for this is mainly due to the fact that there is still a stigma attached to the disease, which results in discrimination. This will prevent people from seeking testing and treatment, thus rendering the available data inaccurate.⁶⁷

Of the reported cases, 78.4 percent of the victims were infected through sexual intercourse, while the other 21.6% accounts for mother child transmission, needle sharing and transfusion of blood.⁶⁸ This is unsurprising, as contraceptive prevalence rates were as low as 32% in 2003.⁶⁹ It is not known to the present author what proportion of this, if any, is use of condoms. The vast majority of patients suffering from HIV/ Aids in the Kingdom are between 15 and 49 years old.⁷⁰ In 2005, 63 people died as a result of Aids.⁷¹

Child Health

Saudi Arabia is party to the Convention on the Rights of the Child (CRC). This is important in the realm of health, as article 24 lays out a wide range of standards which should be reached to ensure that a child's right to health is wholly fulfilled. Under the Article, Saudi Arabia is obliged to make quality health care accessible to all children. This immediately creates a problem as non Saudi workers' children, without legal residence do not have access to health services.⁷² This point was noted by the Committee on the Rights of the Child. The Committee also displayed concerns about the nutritional status of infants and children; this includes both obesity and malnutrition.⁷³ A further concern to the Committee is the insufficient information provided by the State in relation to adolescent health, reproductive health and mental health.⁷⁴

⁶⁴ *Ibid*

⁶⁵ *Ibid*

⁶⁶ WHO, country co-operation strategy, *supra* n 24

⁶⁷ UNDP Saudi Arabia – HIV/AIDS, *supra* n 63

⁶⁸ *Ibid*

⁶⁹ WHO Country Profiles, *supra* n 53

⁷⁰ UNDP Saudi Arabia – HIV/AIDS, *supra* n 63

⁷¹ WHO Country Profiles, *supra* n 53

⁷² Committee on the Rights of the Child, Forty-First session, CRC/C/SAU/CO/2 17th March 2006, at page 14 Concluding comments, Saudi Arabia, available at [http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/CRC.C.SAU.CO.2.En?OpenDocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/CRC.C.SAU.CO.2.En?OpenDocument), accessed 10th June 2009

⁷³ *Ibid*, at page 11

⁷⁴ *Ibid*, at, page 12

Infant health/mortality rates

The infant mortality rate within the Kingdom has dropped drastically in the past thirty years. In 1970 it was as high as 118 per 1000 live births, but in 2005 that had dropped to 21 per 1000 live births.⁷⁵ However, this is still higher than other countries in the region, such as the United Arab Emirates where the rate is 8 per 1000 live births. The country with the lowest rate is Israel, which is in line with western countries such as the UK, where infant mortality rates were as low as 5 per 1000 live births in 2005.⁷⁶ It should also be noted that the rates for Saudi Arabia may not be accurate, and could in fact be higher than stated due to the lack of information on adolescent health, and the lack of appropriate healthcare for non-Saudi workers' children. It is not known to the present author whether infant mortality rates are higher within this portion of the population, or indeed whether there are significant differences between the rural and urban population in this area.

In Saudi Arabia, nutrition is overseen by primary health care and preventative healthcare programmes. However, Saudi Arabia is facing a double problem of under-nutrition in some groups and obesity in others.⁷⁷ A particularly important problem within this context is the low level of breastfeeding, with as many as 80% of children weaned by one month.⁷⁸ This practice was encouraged through the commercial promotion of milk substitutes. The government is addressing this problem by restricting milk substitute advertising, and has started a 'baby-friendly hospital' initiative in nine hospitals.⁷⁹

Immunisation

The rate of immunisation in Saudi Arabia is relatively high, with over 95% of one year olds immunised against most diseases. In 2005, 96% of infants received their BCG, DPT and OPV, while 97 percent received their measles and hepatitis B vaccines.⁸⁰ The incidence of malaria has decreased substantially since 1990, and in 2000 the figure was as low as 32 per 100,000 of the population. This dropped further in 2003 to only one per 100,000.⁸¹ It is expected that malaria will be eradicated completely by 2010.⁸² However, these statistics might not be entirely accurate as non-Saudi workers children, or illegal immigrants may not be included in the figures.

Prison Health

There have been many allegations of poor standards and ill treatment of prisoners in Saudi Arabia, especially from Human Rights Watch (HRW). The organisation has collected accounts of 12 deaths in custody that allegedly resulted from ill treatment and treatable illnesses.⁸³ In one prison, several prisoners independently told HRW that

⁷⁵ Human Development Report 2007/08, table 10, *supra* n 10

⁷⁶ *Ibid*

⁷⁷ WHO, country co-operation strategy, *supra* n 24

⁷⁸ *Ibid*

⁷⁹ *Ibid*

⁸⁰ WHO Country Profiles, *supra* n 53

⁸¹ UNDP Report 2006, *supra* n 40

⁸² *Ibid*

⁸³ Saudi Arabia: New Video Confirms Torture in Prison (Human Rights Watch, 24/07/2007) at <http://hrw.org/english/docs/2007/04/27/saudia15774.htm>, accessed 13th October 2008

two inmates had died solely because of inadequate medical care.⁸⁴ It is also alleged that a detainee's infant died in a deportation centre from severe cold and lack of milk.

A human right's activist in Saudi Arabia has recently been arrested by the secret police for alleging that the conditions in prisons were less than satisfactory.⁸⁵ In his report he wrote that the prisoners described the prison as overcrowded, dirty and lacking in health care. He also reported a case in which an ear infection left untreated, due to the absence of a doctor, had resulted in bleeding to the ear of one inmate.

There is little documentation on Saudi prisons, as the Government does not publish reports of the investigations it carries out. This is a major cause for concern and highlights the probability of torture and bad conditions in prisons. The arrest of the human rights activist emphasises further human rights infringements as this violates the right to freedom of expression, and the right to liberty. This raises the serious issue of whether basic human rights are given any protection or value within Saudi Arabia.

Mental Health

Prior to 1983, mental health care in Saudi Arabia was provided in one hospital only, which meant that patients had to travel long distances in order to obtain mental health care. This often resulted in delays when seeking care and also raised problems during discharge into the Community.⁸⁶ This is not in compliance with the above-mentioned 'AAAQ', as it does not fulfil the aspect of 'physical accessibility'.⁸⁷ However, since 1983 smaller hospitals, and out-patient clinics have been set up all over the country, and the next phase is to further integrate mental health care with primary health care.⁸⁸ In their Country Co-operation strategy for 2006-2011, WHO recommends that the Ministry of Health collaborates with the Ministry of Education and other organisations to assist them in improving mental health care.⁸⁹

A National Mental Health programme was adopted in 1989 and this consists of various strategies and objectives. The programme is principally aimed at issuing mental health care through primary health care, as this is thought to be the best method for such treatment. Although there are around 500 psychiatrists in Saudi Arabia, only 78 of these are Saudi Nationals, while the others are expatriates.⁹⁰ As such, most primary health care physicians and nurses are not Arabic speakers, but all other staff are Saudi nationals which makes communications with psychiatric patients possible.⁹¹ It is thought that growth of Saudi speaking physicians would greatly improve the overall health and understanding of the population about medical issues.

Persons with Disabilities

⁸⁴ *Ibid*

⁸⁵ Saudi Arabia: Release Leading Human Rights Activist (Human Right's Watch 21/5/2008) at <http://www.hrw.org/english/docs/2008/05/21/saudia18895.htm>

⁸⁶ WHO EMRO – World Health Day 2001, at <http://www.emro.who.int/mnh/whd/CountryProfile-Saa.htm>, accessed 13th October 2008

⁸⁷ General Comment No.14 E/C.12/2004/4, *supra* n 25

⁸⁸ WHO EMRO – World Health Day 2001, *supra* n 86

⁸⁹ WHO, country co-operation strategy, *supra* n 24

⁹⁰ WHO EMRO – World Health Day 2001, *supra* n 86

⁹¹ *Ibid*

According to General Comment No. 5 of the Committee on Economic, Social and Cultural Rights; States are to take positive action to reduce structural disadvantages, and to give appropriate preferential treatment to people with disabilities.⁹² This is in order to achieve the objectives of full participation and equality within society for all persons with disabilities. Although Saudi Arabia is not a party to the Covenant on Economic, Social and Cultural Rights, the Kingdom should still strive to fulfil these aims in order to advance human rights within the country. It is encouraging that Saudi Arabia ratified the recent UN Convention on Disability rights as well as its optional protocol in June 2008.⁹³ This is significant as disability is an important societal issue in Saudi Arabia. It is estimated that 3.73% of the population has a functional disability which limits their dependence.⁹⁴

In Saudi Arabia, the incidence of consanguineous marriages is high, and as a result the risk of disabilities associated with genetic causes is significant. In addition, the awareness of these inborn errors within the Kingdom, is very low. When filling out a questionnaire, over 50% of parents had no knowledge of the causes of their children's diseases, their symptoms and inheritance patterns.⁹⁵ Programmes are currently under way which aim to reduce the incidence of genetic diseases. The Ministry of Health has established 120 centres which screen for genetic diseases, and those who are positive are given counselling and advice regarding marriage.⁹⁶ It is not known to the author what action, if any, Saudi Arabia is taking to achieve the objective of full participation in society for the percentage of the population who already have a disability.

Migrant Health

Currently expatriates receive free preventative and emergency health services under the Ministry of Health, but regular health care has to be paid out of pocket or through private health insurance schemes.⁹⁷ As discussed above, this will soon change as all expatriates will have to be covered by health insurance in order to maintain residence. As this is a relatively recent progression it is unclear what the outcome of the legislation will be. However, it is certain that the poorest will have their health significantly threatened, and there will probably be an increased amount of illegal immigrants. This is due to the fact that a large amount of migrants may not be able to afford private health insurance. As this is now a requirement in order to maintain residence within the Kingdom many migrants will now have to reside illegally if they wish to remain in Saudi Arabia. This will result in employers exploiting illegal immigrants, which will increase poverty. This may also affect the overall health of the

⁹² UN Committee on Economic, Social and Cultural Rights, General Comment No.5 Persons with Disabilities, at <http://www.unhcr.ch/tbs/doc.nsf/0/4b0c449a9ab4ff72c12563ed0054f17d>, accessed 13th October 2008

⁹³ United Nations Enable, ratifications, at <http://www.un.org/disabilities/default.asp?id=257>

⁹⁴ Perriharris, Lorilewin, "Information package on disability studies", Centre on Human Policy, Syracuse University, New York, 1998, in Issues and Obstacles in Disability Rights in Saudi Arabia

⁹⁵ AlEssa M, Ozand P, AlGain S, "Awareness of inborn errors of metabolism among parents in Saudi Arabia", Annals of Saudi Medicine 1997; 17(5)

⁹⁶ WHO, country co-operation strategy, *supra* n 24

⁹⁷ *Ibid*

population as diseases such as malaria and tuberculosis may have increased prevalence, instead of being eradicated as predicted.

Occupational Health

Saudi Arabia has ratified thirteen of the International Labour Organisation Conventions, including the four main ones,⁹⁸ which cover prevention of child labour, and prevention of forced labour.⁹⁹ In the context of general safety, health and conditions at work, Saudi Arabia has implemented two regulations of the ILO.¹⁰⁰ In the sphere of labour rights an important breakthrough was made in 2002, when workers were enabled to defend their rights through trade unions for the first time.¹⁰¹ It is not known to the present author what other measures are being taken by Saudi Arabia to enforce the rights in the Conventions, or to what extent the occupational health of the nation is protected.

Access to safe water and adequate disposal facilities

In Saudi Arabia, the proportion of the population with sustainable access to safe drinking water is 95%, and 100% of the population have access to adequate sanitation facilities.¹⁰² Although the majority of the population has access to safe water, the consumption rates are very high at about 230 litres per day. International standards of consumption rates are between 150 – 200 litres a day,¹⁰³ which indicates that water consumption is in excess of recommended rates.

In January 2008, the Government became the owners of the National Water Company, and it is hoped that this will service all parts of the Kingdom in three years time.¹⁰⁴ The take-over is hoping to bring qualitative changes in water production and distribution in the country. The Ministry however, plans to raise the water tariff, which may prevent the poorest from being able to afford safe water. In addition the Ministry will create a special department to carry out public awareness campaigns to promote wise consumption of water and prevent wastage.¹⁰⁵ This will hopefully be effective and help reduce the high consumption of water within the Kingdom. Although, these measures could also increase health problems as poorer people, notably illegal immigrants, may no longer have access to safe water due to the increase in cost.

⁹⁸ Convention No.29: Forced Labour, 1930, Convention No. 100: Equal Remuneration, 1951, Convention No. 105: Abolition of Forced Labour, 1957, Convention No. 111: Discrimination (Employment and Occupation), 1958

⁹⁹ <http://www.ilo.org/public/english/region/asro/bangkok/arm/sau.htm>, accessed 15th Oct 2008

¹⁰⁰ Regulations for Rules and procedures for implementation of the Occupational Hazards Branch and implementing decisions [1985, CIS 97 – 3], Regulations for annuities and compensation payments rules and procedures [1984, CIS 97 – 2]

¹⁰¹ “Boost for Workers’ Rights in Saudi Arabia”, 18th April 2002, at http://www.ilo.org/global/About_the_ILO/Media_and_public_information/Press_releases/lang--en/WCMS_007782/index.htm, accessed 18th October 2008

¹⁰² UNDP Report 2006, *supra* n 40

¹⁰³ *Ibid*

¹⁰⁴ Kingdom Sets Up SR22Bn Water Company 24th January 2008, at <http://www.arabnews.com/?page=6§ion=0&article=106028&d=24&m=12y=2008>, accessed 4th October 2008

¹⁰⁵ *Ibid*

Environmental Health

Saudi Arabia is a party to many international Environment agreements, such as the Biodiversity Convention; the Climate Change Convention; the Climate Change Kyoto Protocol; the Desertification Convention; the Endangered Species Convention; the Hazardous Waste Convention; the Convention on the Law of the Sea; the Convention on Marine Dumping; the Vienna Ozone Convention, and the Convention on Ship Pollution.¹⁰⁶ The environmental issues currently facing Saudi Arabia are desertification, depletion of underground water resources (as the lack of perennial rivers or permanent water bodies has prompted the development of extensive seawater desalination facilities), and coastal pollution from oil spills.¹⁰⁷ All these issues affect health as water supplies are an underlying detriment to health. The over consumption of water within the Kingdom is also adding to the issues, but hopefully the new water policies will reduce the problems overtime.

At a national level, Saudi Arabia has developed a variety of strategies in order to improve the countries environmental issues. Notably in the context of this study, the Kingdom has adopted a National Health and Environment Strategy; a National Strategy and Action on desertification control; a national forests strategy; and a waste water reclamation and reuse system.¹⁰⁸ There are a total of 16 protected zones within the Kingdom, but unfortunately this covers only 4.2% of the countries area.¹⁰⁹ On the whole the UNDP is happy with the steps taken by the Kingdom to improve the environment, and notes that carbon dioxide levels are within the required limits in most Saudi cities. In considering future directions, UNDP's development report focuses on the water situation, and advises that consumption of water for all purposes will be confined to renewable sources, and that economically feasible renewable sources of water for agriculture and forestry are also developed.¹¹⁰

A major environmental issue which affected the health of the Saudi population was the impact of air pollution and trauma as a result of the Gulf War. One of the largest ever surveys carried out in the Middle East was conducted, to decipher whether communities that were exposed to high levels of air pollution from oil fires and the exhausts of military vehicles had more health issues than communities that were not subjected to such pollution.¹¹¹ The results of the survey indicated that citizens living in areas subject to high levels of pollution were two to three times more likely to suffer from respiratory conditions such as asthma and chronic bronchitis, with others suffering from cardiovascular disease.¹¹² From these findings projections were made to the year 2030. The projections suggest that exposures to the Gulf War will result in two million excess hospital visits and 23 million excess visits to primary health care centres.¹¹³ Whether or not these projections are accurate, it is conceivable that health

¹⁰⁶ CIA World Factbook, *supra* n 29

¹⁰⁷ *Ibid*

¹⁰⁸ UNDP Report 2006, *supra* n 40

¹⁰⁹ *Ibid*

¹¹⁰ *Ibid*

¹¹¹ "Researchers study health impact of 1990-91 gulf war on Saudi Arabia population", July 15th 2005, at http://www.jhsp.edu/publichealthnews/articles/2005/samet_gulfwar.html, accessed 10th October 2008

¹¹² *Ibid*

¹¹³ *Ibid*

requirements will be increased as a result of the Gulf War. This is placing extensive burdens on an already under funded and stretched health care system, for reasons which result solely from war.

Conclusions

At first glance the health care system in Saudi Arabia appears to be effective, well maintained and suitably distributed. Saudi Arabia has made a vast improvement in relation to its socio-economic development over the past thirty years, including in the area of health. Compared to neighbouring countries the country performs well when it comes to health expenditure and the overall health of the population.

Nonetheless there are some concerns as to whether these improvements benefit the Saudi society as a whole. For example, when it comes to the affordability of health care services, the question arises as to whether the current system is sustainable due to lack of further funding, as there is no tax system or social insurance system that covers the entire population. Currently, all that has been done to remove some of the burden from the under-funded sector is to require all expatriates to have private health insurance. Whilst this may remove some of the funding issues, it could also be detrimental to the health of the migrant population. No conclusions can be reached as yet as this is a relatively new concept so the impact is not yet clear.

Other issues facing the Kingdom are basic human rights issues, such as women's rights which are not fully protected as women still require permission from their male guardian. This affects their right to reproductive health, and has a negative impact on the accessibility of health care for women more generally. A further issue is freedom of expression, which was highlighted by the arrest of the human rights reporter. This may also have something to do with the lack of accurate data available, an issue that WHO has often highlighted in their reports.

A factor which prevents clear conclusions from being drawn is the lack of reporting. There are no sufficient and reliable data available on vital aspects so a dependable conclusion cannot be drawn on how satisfactory the current system actually is.¹¹⁴ Concern for this has been highlighted by WHO in their country co-operation strategy.

In a nation which gives such little respect for basic human rights, at present it does not seem ascertainable that the right to health can be fully respected in all aspects covered by this report. If protection of the right to health is to progress further, the Kingdom will have to change its attitude as a whole to human rights and resolve any issues that are preventing it from giving protection to these basic rights.

¹¹⁴ There are many aspects where data is lacking, such as; the number of the Saudi population who do not live within adequate distance to their nearest primary health care centre, abortion rates, which could inflict on maternal mortality rates, morbidity and mortality more generally, and the impact of the new private health insurance system on foreign workers.

