

# Breaking the Silence and Saving Lives:

## Young People's Sexual and Reproductive Health in the Arab States and Iran

Policy Report

Bonnie L. Shepard and Jocelyn L. DeJong

**International Health and Human Rights Program  
François-Xavier Bagnoud Center for Health and Human Rights  
Harvard School of Public Health**



**© 2005 by Bonnie L. Shepard and Jocelyn L. DeJong**

# Breaking the Silence and Saving Lives:

## Young People's Sexual and Reproductive Health in the Arab States and Iran

### Policy Report

#### Authors:

**Bonnie L. Shepard**, M.Ed., M.P.A., International Health and Human Rights Program, François-Xavier Bagnoud Centre for Health and Human Rights, Harvard School of Public Health & Social Sectors Development Strategies, Inc.

**Jocelyn L. DeJong**, M.Phil., Ph.D., Institute for Development Policy and Management, University of Manchester & American University of Beirut

This review on which this report is based was supported by a grant from UNICEF's Middle East and North Africa Regional Office against funds made available to it by Joint United Nations Programme on HIV/AIDS (UNAIDS), for HIV/AIDS-focused activities, on the request of the country offices. The study was conducted in partnership with the regional offices of UNAIDS, United Nations Population Fund (UNFPA), World Health Organization (WHO) and the International Federation of the Red Cross and Red Crescent Societies (IFRC). The recommendations in this report are the sole responsibility of the authors, and do not necessarily represent the views of the sponsoring agencies.

# POLICY REPORT BREAKING THE SILENCE AND SAVING LIVES: YOUNG PEOPLE'S SEXUAL AND REPRODUCTIVE HEALTH IN THE ARAB STATES AND IRAN<sup>1</sup>

*“We emphasize the need to break the silence, doing so from the pulpits of our mosques, churches, educational institutions, and all the venues in which we may be called to speak. We need to address the ways to deal with the HIV/AIDS epidemic based upon our genuine spiritual principles and our creativity, and armed with scientific knowledge, aiming at the innovation of new approaches to deal with this dangerous challenge.”*

From: The Cairo Declaration of Religious Leaders in the Arab States in Response to the HIV/AIDS Epidemic, December 2004

## General Introduction

Never before have there been so many young people in the Arab countries and Iran. The age group 10–24 years now comprises approximately one third of the total population of the region. There are significant positive trends in attention to young people's needs for health and development. Many countries in the region have made notable progress in increasing access to primary, secondary and tertiary levels of education for young people, with important strides in increasing access for young women. This progress has positive effects for the health and development of young people and for gender equality. Across the region, age at marriage has been rising for both sexes for a number of social and economic reasons. This rise in the age of marriage is especially beneficial for young women, since it reduces the physical health risks from early childbearing, the mental health consequences of early separation from families of origin, and the social isolation that has been documented in association with too-early marriage. Rising marriage age is often associated with opportunities for education and employment that were closed to previous generations of women.

## New and Unmet Needs

The growing numbers of unmarried people – both young people who are delaying marriage and those who do not marry at all – mean that policy needs to adapt to protect their health and well-being. When the lower age at puberty (resulting from better nutrition) is combined with a later age at marriage, it is clear that young people face health, development, and social stigma risks – including those associated with increasing premarital sexual activity and rising sexually transmitted infection rates in the region, including HIV.

These risks are heightened by several factors:

- > Young people's lack of information about their sexual and reproductive health (SRH), and a lack of access to services.
- > A generation gap due to rising educational levels and urbanization, combined with greater exposure to the norms of global culture, deprives young people of the counselling and support they need from adults to face these risks and stay healthy.
- > Young people's unemployment in the region is the highest in the world at 25.6 per cent according to the ILO, frustrating efforts to achieve an adequate standard of living for increasing numbers of educated young people, with multiple negative consequences both for young people themselves and for their societies.

Despite considerable evidence of unmet needs among young people, the literature reviewed for this document, as well as expert opinion, confirm that there has been insufficient policy attention to the needs of this group in the region. This policy silence translates into inadequate services and lack of information. Across the region, young people report that they have insufficient access to information about their own physical and social development, including their sexual and reproductive health, whether from parents, teachers or health services. Even though there is evidence that parents are many young people's preferred source of information, mothers and fathers often feel ill-equipped to address the information needs of their sons and daughters on these sensitive topics. Sex education curricula are rare and, where they do exist, quite often sexual and reproductive health sections of the curriculum are neither taught nor included in tests by teachers who are unprepared or embarrassed to teach them. Government health services do not create appropriate channels for addressing the particular needs of this age group nor do they create a climate in which young people, and particularly unmarried young people, are welcome. Private health services and pharmacies become the default resource, although only for those who can afford them and are prepared to face the perceived risk of judgmental attitudes from providers.

Singling out sexual and reproductive health for attention, however, is not to ignore the imperative of addressing the needs of young people in their entirety. Young people, as people of any other age, do not compartmentalise their lives. Moreover, a focus on sexual and reproductive health **problems** ignores the positive aspects of this period of young people's lives as identities are forged, relationships fostered and, for many, families are begun. Indeed, media images of young people in the Arab countries and Iran as somehow 'politically dangerous', both within and outside the region, has obscured the need for positive attention to their needs, perspectives and aspirations.

Indeed, international evidence shows that the most effective strategies to protect young people's health enhance protective factors such as education; access to livelihoods; closeness to trusted adults; and meaningful participation in the family, as well as in religious and civic life. Protection of young people's health thus demands attention to their development, and a multisectoral approach that includes – but is not restricted to – the health sector. Information, education and skills-building for both health and development during this crucial stage for young people can instil healthy, positive attitudes and lifestyles that promote well-being throughout the life cycle and for future generations.

The following sections of this report summarise the main arguments and evidence supporting investment in programmes and policies that protect young people's sexual and reproductive health (YPSRH). These arguments and evidence break down into the following categories: international human rights law; national development concerns; public responses to young people's needs; risks associated with the growing generation gap in the region; and prevention of HIV and infertility. The report concludes with the main policy, programme and research recommendations arising from consideration of international and regional evidence in the literature on young people's sexual and reproductive health.

## **Protection of Young People's Survival, Development, and Health Mandated by International Law**

**The Arab States and Iran have ratified international human rights treaties<sup>2</sup> by which they incurred obligations to promote and protect the survival, development and health of young people, as well as to eliminate discrimination against women.**

All young people, universally and without any discrimination, hold the human rights to survival, development and health. Even when health risks arise from disapproved social behaviours, including premarital sexuality or substance abuse,<sup>3</sup> governments still have a positive obligation to fulfil the human rights of these young people and protect them from harm by providing the necessary information, education, and services they need to survive, develop and stay healthy.

All countries in this study are parties to the Convention on the Rights of the Child (CRC), all but four are parties to the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW),<sup>4</sup> and all but five are parties to the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social, and Cultural Rights (ICESCR).<sup>5</sup> All Arab countries in this study are parties to the Arab League Charter on Human Rights,<sup>6</sup> which endorses many principles of both the ICCPR and the ICESCR. It enjoins States to “ensure to all individuals within its territory and subject to its Jurisdiction the right to enjoy all the

rights and freedoms recognized herein ... without any discrimination between men and women” (Article 2), and declares the right of young persons “to be afforded the most ample opportunities for physical and mental development” (Article 39). By ratifying these international treaties, the Arab countries and Iran have agreed to bring their national policies and programmes in line with the standards and obligations of international human rights law.

Most countries in the region have agreed to be bound by CEDAW and the CRC with qualifying declarations and reservations.<sup>7</sup> Most of these declarations or reservations indicate that Shari’a law, and national laws or customs, may take precedence in certain situations, particularly regarding the provisions in these treaties that enshrine equality of men and women in general, or in the family and inheritance rights. Comments to these countries by the relevant UN treaty monitoring bodies have consistently urged governments to reconsider these reservations to ensure conformity with international legal standards.<sup>8</sup>

## The Right to Health

The right to health is defined in the ICESCR as the right to the enjoyment of the highest attainable standard of physical and mental health. This right pertains to all aspects of adolescents’<sup>9</sup> reproductive and sexual health.

The human rights treaty bodies publish their interpretation of the content of human rights provisions in the form of general comments on thematic issues. In 2000, the Committee on Economic, Social and Cultural Rights produced a General Comment on the right to the highest attainable standard of health<sup>10</sup> that includes both reproductive health in general and, in particular, adolescents’ reproductive health and participation in decisions concerning their health. One implication of the following quote from the General Comment is that States should review their legislation to ensure that it allows young people confidentiality and privacy in access to SRH services.

*“States should provide adolescents with safe and supportive environments where they can participate in decisions that affect their health, build life skills, acquire appropriate information, receive counselling and be able to negotiate the health behaviour choices they make. The realization of the right to health of adolescents is dependent on the development of youth-sensitive health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.”*

CESCR General Comment 14 (based on article 12 of the Convention) on the right to the highest attainable standard of health.

Article 24 of the CRC addresses adolescents’ right to health and health services in general, and Article 17 pertains specifically to their right to adequate information and educa-

## CONVENTION ON THE RIGHTS OF THE CHILD: ARTICLE 24

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. (24 1.)
2. (f) To develop preventive health care, guidance for parents and family planning education and services.
3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

tion on health: “[adolescents have the right to] access [to] information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health.”

Article 24 of the CRC, cited below, provides the most solid articulation of the legal basis for countries’ positive obligations to protect adolescents’ sexual and reproductive health and to provide the services needed to fulfil adolescents’ right to health. “States should ensure that appropriate goods, services and information for the prevention and treatment of STDs, including HIV/AIDS, are available and accessible.”<sup>13</sup> Article 24 also establishes governments’ obligation to protect adolescents from harmful traditional practices, such as female genital mutilation/cutting (FGM/C) and early marriage.

General Comment 3 on “HIV/AIDS and the Rights of the Child” from the Committee on the Rights of the Child<sup>11</sup> and General Comment 4 on “Adolescent health and development...”<sup>12</sup> both help to further clarify the obligations of governments for adolescent sexual and reproductive health.

These General Comments also point out young people’s right to participation in health programmes and policy-making, based on Article 12 of the CRC, and the positive obligation to eliminate discrimination against women, girls, and people living with HIV, based on Article 2.

*“In light of article 3, 17 and 24 of the Convention, States Parties should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and prevention and treatment of STIs. In addition, States Parties should ensure access to appropriate information regardless of marital status, and prior consent from parents or guardians. It is essential to find proper means and methods of providing information that are adequate and sensitive to the particularities and specific rights of adolescent girls and boys. To this end States Parties are encouraged to ensure that adolescents are actively involved in the design and spread of information through a variety of channels*

*beyond the school including young people serving organizations, religious community and groups and the media.”*

Paragraph 21, General Comment 4, “Adolescent health and development in the context of the Convention on the Rights of the Child.”

Other treaty bodies have reinforced these Comments on adolescents’ rights to sexual and reproductive health education and services. General Comments 12, 14, 15, and 24 of the CEDAW define the right to be free from violence, FGM/C, and discrimination against women in the prevention and control of HIV/AIDS.

The reporting process, through which governments provide information to these UN treaty monitoring bodies about their degree of compliance with their obligations under the treaties, provides important opportunities at the national level for governments to collect and analyze information on the status of adolescent sexual and reproductive health and gender issues within their countries. It also provides them the chance to receive suggestions from the treaty bodies as to priorities in moving forward.

The concluding comments and observations of the treaty bodies on these issues are also excellent advocacy tools for more attention to young people’s health and development in general.

With variations depending on the specifics of the country, the CRC Committee’s comments to countries of the Arab States and Iran have focused on a range of YPSRH and gender equity issues, including early and forced marriage, the lack of attention to adolescent health, rape laws, FGM/C, ‘honour crimes’, the need for increased access to secondary education, persistent discrimination against girls in secondary enrolment and achievement in a few countries, and other instances of discrimination or violence against women and girls.<sup>14</sup>

## **The Importance of Investment in Young People’s Health and Development**

**Helping young people make a healthy and successful transition to adulthood is perhaps the most important investment a society could make in its future development.<sup>15</sup>**

Investment in young people’s health and development, more generally, should be a central element in medium- and long-term strategies to achieve the Millennium Development Goals (MDG), as established by the 191 Member States of the United Nations in 2000. The following MDGs are all directly addressed through investments in young people’s sexual and reproductive health: (1) eradicate extreme poverty and hunger, (2) achieve universal primary education, (3) promote gender equality and empower

women (with the target of reducing gender inequities in education,) (5) improve maternal health, and (6) combat HIV/AIDS.

Young people's health and development programmes are the most neglected – yet arguably the most effective – strategy to reduce poverty and increase well-being, not only for young people themselves, but also for future generations.<sup>16</sup> Poverty is one of the main obstacles to young people's health and development; the 'juvenilization' of poverty is well-documented.<sup>17</sup> Internationally, the lack of opportunities associated with poverty contributes to the 'disaffection' of young people, creating problems associated with substance abuse, petty crimes, violence and unsafe work.<sup>18</sup> These problems have repercussions in continued poverty and disaffection throughout the next generations.

Furthermore, there is evidence of a **high desire for emigration among Arab young people**, as noted in a survey conducted for the Arab Human Development Report (2002), which appropriately stresses the key contribution that this age group can make to the future of Arab societies.<sup>19</sup> As access to education is relatively high and in many cases increasing, lack of corresponding employment opportunities will exacerbate all these problems, and the continued emigration of young people will cause countries to lose the benefits of the investment in their education.

## Inadequate Public Response to Young People's Needs

**The rights to health, survival and development of young people are not adequately respected, protected, or fulfilled due to inadequate understanding of their specific needs, compounded by a lack of political will among State decision makers.**

According to WHO, the major health threats in adolescence stem from "accidents and injuries, early pregnancy and sexually transmitted infections."<sup>20</sup> The political controversies that may be stimulated by sexual and reproductive health education and services to protect young people's health may explain the lack of political will, but do not justify failure to act. Furthermore, choices made and habits formed in adolescence threaten young people's health in the future and pose high disease burdens on a country's health system. "Lifestyle diseases that are caused by smoking, risky sexual behavior, alcohol and drug abuse have their roots in adolescence, and are responsible for high morbidity and mortality rates globally."<sup>21</sup>

**This lack of political will entails a woefully insufficient supply of YPSRH services and education for young people. This inadequate public response on the part of the Arab States and Iran threatens the survival, development, and health of large numbers of young people, and thus future generations.**

The political will that made possible the region's notable progress in increasing educational opportunities for young people falters when confronted with culturally sensitive issues, particularly those that are steeped in long-standing custom, such as early marriage and FGM/C. Many young people are politically and socially disenfranchised and have great difficulty gaining access to the resources they need — for health, education and employment — without adult support. Adults are the 'gatekeepers' for any interventions that benefit young people still living at home, and for access to services of any kind. Due to opposition from these gatekeepers, both at the policy level and within families, young people face multiple barriers to the information, education, support and services they may need to protect themselves from STIs, including HIV/AIDS, and unwanted pregnancies. Young married girls are especially vulnerable to both maternal mortality and morbidity, to denial of educational advancement, and to domestic violence. The lack of access to contraception for young unmarried women results in unwanted pregnancies. Because abortion is illegal in most countries, this lack of SRH service access translates into maternal mortality and morbidity due to unsafe abortions.

In most settings, because sexual relations among unmarried young people are not socially accepted, particularly for young women, young people are typically afraid to go to health clinics and are more likely to seek over-the-counter medicines or contraception at pharmacies or other commercial outlets.<sup>22</sup> However, even at these outlets, young people often encounter hostile or judgmental treatment.

In most countries in the Arab States, the public social sector has not been willing to collect the data that would reveal the prevalence of health risks faced by young people and the factors that contribute to negative health outcomes. This reticence persists despite emerging evidence of a significant increase in such risks. Collecting this data must be a high-priority task, and must be done in a supportive, non-judgmental and non-stigmatizing way. The data is needed both for advocacy on young people's behalf, and to target resources where they are most needed in evidence-informed programming.

## **A Generation Gap Puts Young People at Risk**

**In a region where the family is traditionally close-knit, there is a growing generation gap due to increased educational levels of young people, access to global culture, and urbanization. Many young people find themselves isolated and unconnected to supportive adults. This missing connection deprives young people of a key protective factor, and its loss has significant implications for the sexual and reproductive health of many young people.**

Urbanization and modernization break down extended family systems and traditional cul-

tures, especially for young people who migrate from rural areas for employment or educational opportunities. According to several regional experts, the rise in female employment and long working hours for both parents may also deprive many young people of adequate adult support and supervision. These trends, combined with rising levels of secondary and higher education for both young men and women, create barriers of geographical distance and educational disparities between young people and their adult relatives. This isolation from their families exposes more young people than ever before to the risks of substance abuse, violence, unwanted pregnancies, complications from pregnancy, abortion, childbirth, and STIs including HIV/AIDS. Any interventions that would strengthen connections with families and with supportive adults outside the family would help protect young people's health.

For these reasons, **the involvement of parents and religious leaders, when possible, in YPSRH programmes is of utmost importance.** Using the formal educational structures to involve and educate parents could help them address SRH issues with their sons and daughters, and may be a particularly fruitful approach in the region. This has been illustrated in Iran, where significant strides have been made to address sensitive issues of young people's sexual and reproductive health in a manner consistent with religious values. Given the widespread influence of religious leaders in the region, and their key involvement in presiding over the signing of marriage contracts, involving parents and leaders in providing information and counselling on sexual and reproductive health issues would provide invaluable adult support for many young people.

## **A Critical Window of Opportunity to Prevent HIV/AIDS**

**Given the current, relatively low HIV/AIDS prevalence in this region, the Arab Countries and Iran have a critical window of opportunity to prevent the expansion of the HIV/AIDS epidemic. Investment in SRH and development programmes for young people must be part of this prevention.**

The cost of ignoring this window of opportunity is high. A recent joint World Bank/WHO/UNAIDS report on HIV/AIDS in the region<sup>23</sup> notes that, in addition to the known humanitarian and social cost of ignoring the epidemic, the economic cost to GDP could be devastating. It estimates, based upon data from nine countries, that the average growth rate of potential GDP could be reduced by 0.2–1.5 per cent per year for the period 2002–2025. By 2015, annual expenditures to treat all AIDS patients may have increased by 1.2 per cent of GDP, even with only limited use of antiretroviral drugs. Even conservative estimates predict that “future losses of potential output and consumption [from 2002–2025] could be equivalent to 35 percent of today's GDP.” **Well-known prevention measures can generate enormous savings.**

According to this study, “increasing condom use and expanding access to safe needles for IDUs (intravenous drug users) can generate savings equivalent to 20 percent of today’s GDP.” Iran’s harm-reduction programmes for IDUs in prisons are an example in the region of the kind of prevention that is called for to halt or slow the spread of the epidemic.

To date, the slow regional response to these statistics is due in part to the interrelated problems of widespread public policy denial of the potential of the epidemic, public beliefs that the region is somehow immune from the global epidemic, and a dearth of evidence on the risks for vulnerable populations – given the sensitivities of collecting data on this issue. This task entails conducting socio-behavioural research on sexual knowledge, attitudes and behaviour – not just among adults, but very importantly, among young people.

Such policy complacency is not warranted, because all of the known risk factors for rapid transmission of HIV/AIDS exist in the region, such as poverty, political conflict and mobility. A commercial sex industry has been documented across the region, although it is often clandestine and therefore difficult to research and to address. Other highly vulnerable populations whose risky behaviours take place clandestinely due to social stigma include men who have sex with men (MSM) and IDUs. Programmes to serve the needs of these populations must not follow repressive strategies, which have proven to be counter-productive, and must fully respect the human rights of these populations.<sup>24</sup>

Pointing to several country experiences, most international experts agree that even **at the very early stages of the epidemic, where high rates of infection are concentrated in identifiable sub-populations, rights-based strategies that address their needs must be complemented by generalised prevention programmes.**

- > **Prevention efforts among the general population of young people have been shown to be key to halting the spread of the HIV/AIDS epidemic** in most countries, where approximately half of the new infections are among youth aged 15–24. Young people are still at the stage of experimentation and can learn easily to make their behaviour safer or to adopt safer practices from the start. There is clear evidence worldwide that young people are more responsive to HIV-prevention campaigns than adults.<sup>25</sup> Evidence has also shown that programmes encouraging and enabling **both** abstinence and safer sex (among the sexually active) are most effective in protecting young people’s health.
- > **A strong focus on research and programmes that meet the needs of the most vulnerable young people with rights-based approaches can prevent the epidemic from progressing from a**

**‘contained’ to a generalised stage.** In the Arab States and Iran, vulnerable populations of young people find themselves in situations that increase their risk of HIV infection, such as children who live and work on the street, refugees, migrants, prisoners, and university students. Worldwide experience also indicates that young women who marry more sexually experienced older men may be particularly at risk for STIs and HIV infection.<sup>26</sup> Other highly vulnerable populations suffer from discrimination and include large numbers of young people, such as intravenous drug users, commercial sex workers, and men who have sex with men. Research and outreach involving these discriminated groups encounter numerous barriers, requiring adequate political will and investments to overcome these barriers.

In this region, young people may be particularly at risk of HIV/AIDS. For example, in Morocco, 40 per cent of all STIs are among 15- to 29-year-olds. In Tunisia, 21 per cent of those with HIV are between 15 and 24 years, and 93 per cent of these are single. Youth organizations in the region have noted the practice of anal sex to preserve virginity. Yet, despite documentation in the region of increasing premarital sexuality and the known vulnerability of young people internationally to the HIV/AIDS epidemic, there is strikingly little information available publicly on the HIV/AIDS-related knowledge, attitudes and behaviour of the 10–24 age groups in the region. This information is crucial in order to design effective prevention, care and treatment programmes.

**Effective prevention focuses on reducing vulnerability, risks, discrimination and stigma.** The HIV/AIDS field has moved beyond a focus on ‘high-risk groups’, to recognise the underlying determinants of high-risk behaviours that make some people more vulnerable to infection. The field also recognises the importance of reducing the very high vulnerability to infection of people such as intravenous drug users and prisoners, and the importance of focusing resources on these populations as part of a prevention strategy. However, the vulnerability to infection of all young people is heightened when they lack access to the information, education and services that they need to avoid HIV infection.

In some countries in the MENA region, there are pockets of HIV infection among commercial sex workers (CSWs) of both sexes. However, even in countries where both general and CSW prevalence rates are low, CSWs are at high risk of infection and generally lack access to confidential and voluntary access to HIV counselling and testing. Throughout the region, the commercial sex industry is mainly clandestine and informal, making both CSWs and their clients extremely difficult to reach with HIV research and prevention programmes. Male CSWs and their clients are even more clandestine and harder to reach. Concerted efforts should begin immediately to work with CSWs – with full respect for their rights – to provide them and their clients with the information and

services that they need to reduce the risk of infection. When the men who are clients of CSWs are not convinced of the importance of using condoms, many refuse to use them, putting the CSWs, themselves, and their future or current spouses at risk. As stated above, prevention programmes throughout the general population, and especially among young people, are a necessary complement to programmes that work with these most vulnerable sectors.

Furthermore, research has shown that **reducing stigma and discrimination related to HIV is not only necessary to protect human rights, it is also essential to prevention.** The greater the stigma, the less people will want to know their status, seek testing or change their behaviours if infected. In addition to a greater likelihood of mortality, besides their own risk of illness and death, these individuals are more likely to infect spouses and other sexual partners. Widespread education and communication about HIV need to involve people living with HIV, thereby helping the general population understand that someone who looks respectable and healthy could be infected with HIV. As a result, individuals are encouraged to have a more realistic view of their level of personal risk. **Greater involvement of people living with HIV in policies and programmes, and their greater visibility in public fora, is key to effective prevention and stigma reduction.**

**Religious leaders in the region support HIV/AIDS prevention and anti-discrimination efforts.** In December 2004, 90 Muslim and Christian religious leaders signed the Cairo Declaration on HIV/AIDS, which recognises the threat posed by the HIV/AIDS epidemic and the responsibility to undertake urgent action. Significantly, the declaration affirms the need to abolish “all forms of discrimination, isolation, marginalization and stigmatisation of people living with HIV/AIDS.”<sup>27</sup>

Given the high levels of stigma and discrimination in the region, the limited availability of antiretroviral therapies, and the lack of well-institutionalised systems of voluntary counselling and testing for HIV, both the motivation and the means for young people to seek testing voluntarily are low. This situation endangers large numbers of young people in the region.

## **Reproductive Tract Infections (RTI), Sexually Transmitted Infections and Infertility**

**In recognition of young people’s vulnerability to STIs and RTIs, public health officials should concentrate resources on measures that reduce the risk of these types of infections. In the long term, interventions of this kind have the potential to reduce HIV and future infertility incidence while improving health and well-being.**

Most data on RTIs are not disaggregated by age, so the incidence among young women is not known. One study from Egypt showed very high RTI rates among adolescent women, and it is to be expected that rates are high in areas where homes have little access to clean water. The consequences of RTIs are long-term and far-reaching. Prevention, diagnosis and treatment during adolescence carries benefits through the life cycle.

For women, some common RTIs result not only from sexual activity, but also from contaminated medical instruments (in vaginal exams or deliveries), inadequate menstrual hygiene, or lack of genital hygiene (resulting in contamination with faecal bacteria). The latter two are common in low-income settings, where water is scarce. Washing the genital area also increases risks where water is contaminated, necessitating multisectoral involvement in solutions to this problem. In one of the few household prevalence studies in the region, in Giza, Egypt, the prevalence of reproductive tract infections was 45 per cent among 14- to 19-year-olds, and 55 per cent among 20- to 24-year-olds. If untreated, these RTIs can lead to severe reproductive morbidity, including pelvic inflammation and infertility, and are a risk factor for HIV infection.

As marriage age increases above a certain level, men in particular are more apt to be sexually active before marriage, and more at risk to contract an STI. Some of these, such as Chlamydia, are asymptomatic in both men and women, and commonly go untreated, leading to later infertility of the couple.

Prevention of RTIs and STIs is a more resource-efficient approach to address infertility than infection treatment, which is costly for families and health systems, since many remedies rely on high levels of technology.

## Recommendations for Policies, Programmes and Research to Protect Young People's Sexual and Reproductive Health (YPSRH)

The recommendations in this section are based on the principles of international human rights documents, on international evidence about the most effective ways to promote young people's health and development, and on a 20-country literature review on young people's sexual and reproductive health in the Arab States and Iran.<sup>28</sup>

Governments are urged to **increase their investment in the health and development of young people**, formulating policies that address the different needs of married and unmarried young people holistically. As mentioned earlier, these investments and the following recommendations are in line with the current recommendations of the Committees for the Convention for the Rights of the Child (CRC) and Convention

on the Elimination of All Forms of Discrimination Against Women (CEDAW), especially the CRC Committee's General Comments 3 (on HIV and the Rights of the Child) and 4 (on Adolescent Health and Development).

Worldwide evidence shows that effective health and development programmes for young people are based on a 'positive youth development' framework, which focuses on the young person in his or her social context. It also focuses on building strengths holistically in the young person while reducing risks arising from the context. This approach reinforces protective factors such as education, skills-building, access to livelihoods, freedom from violence and abuse, non-discrimination, and close connections with supportive adults.

The implications of using this framework to design YPSRH programmes and policies are: **increased multisectoral cooperation; promotion of community and parent involvement**, which necessitates some degree of decentralization of authority to local levels; and **young people's participation** in design, implementation and evaluation of programmes and policies that affect them.

The following are the highest priority recommendations selected from regional YPSRH study on which this document is based:

## **National and international law**

### **Review country's ratification and reservations status of major human rights treaties: CRC, CEDAW, ICESCR, ICCPR**

- > Mobilise support among government leaders and officials for signature and ratification of unsigned treaties.
- > Review any reservations to CRC and others for implications concerning young people's health and development.
- > Improve reporting on YPSRH issues to treaty bodies, and use recommendations as guidelines for reform.

### **Review existing civil and customary law from human rights and gender equity perspectives.**

- > Use the CEDAW and CRC country reporting documents to identify key human rights issues for young people.<sup>29</sup>
  - > Establish legal mechanism and set aside resources for **young**

**people's participation** in policy discussions, education and programmes designed to serve them.

- > Enforce **minimum legal age at marriage** for boys and girls, and mobilise support to establish a minimum of 18 years for both, per CRC recommendations.
- > Introduce measures to ban and **eradicate female genital mutilation/cutting** in the four countries where it is practiced.
- > Reform laws on **violence against girls and women**, as well as on **child sexual and physical abuse**, to better protect the rights of victims.
- > Review **age-of-consent laws** to ensure that young people have access to confidential sexual and reproductive health services.
- > Review **reproductive health policies and abortion laws** to reflect current evidence on effective means of preventing unwanted pregnancies and abortions.<sup>30</sup>
  - National policy makers are urged to reduce the abortion rate through universal access to SRH education and contraception – in order to prevent unwanted pregnancies and unsafe abortions – rather than through criminal penalties for the provision and receipt of services. The goal of making abortions as rare as possible, but safe when they occur, is feasible.
  - Worldwide evidence shows that penalties do not prevent most abortions, but rather make them unsafe, causing maternal mortality and morbidity.
  - At a minimum, national policy makers are encouraged to work to legalise abortion to save the life and health of the mother, in cases of rape or incest, and in case of foetal impairment (if government has not already done so).

## Young People's Health and Development Policies and Programmes in Accordance with Millennium Development Goals

The authors recommend the creation of sustainable health and development interventions for both public and NGO/civil society programmes serving young people, including a SRH component. Such initiatives should give high priority to:

> **Populations**

- > Young people in pockets of high poverty
- > Marginalised vulnerable populations, including labour migrants, refugees, children who live and work on the street, prisoners, commercial sex workers, men who have sex with men, intravenous drug users.<sup>31</sup>

> **SRH education, skills-building and referrals**

- > Where young people are congregated in large numbers (especially in schools and religious organizations, and also in the military, youth organizations, etc.), including parallel education programmes for parents
- > In mass media and entertainment education

> **Promoting gender equality** in all programmes and policies

- > Special concern for young women out of school – married and unmarried
- > Education and advocacy to prevent gender-based violence

> **Decentralised YPSRH counselling and service networks**

- > Hotlines, Internet, premarital counselling
- > Private doctors and pharmacies

In addition, this review recommends that policy makers and civil society advocates mobilise support for the following policies and programmes:

- > Provision of **free education** through secondary school and ultimate elimination of all gender discrimination relating to education (with particular attention to married and pregnant young girls). (MDGs 2 and 3)
- > Provision of **access to livelihoods** through increased investment in vocational education and internships for both young men and women.
- > Provision of universal **HIV-prevention education and services, including access to condoms, and reproductive health education and services**, including a full range of contraceptives and emergency contraception, to young people to prevent HIV/AIDS and STIs, RTIs, unwanted pregnancies, maternal mortality, infertility and abortions. (MDGs 5 and 6)
  - > **Provision of accessible and anonymous voluntary counselling and testing for all STIs and RTIs**, including HIV/AIDS – and

**availability of treatment** – through confidential services in primary and secondary care health facilities and through ‘youth-friendly’ private channels.

- Involve young people living with HIV in these programmes.
- Ensure access to rights-based voluntary services for highly marginalised groups such as CSWs.
- > Explore all possibilities for **increasing access to confidential counselling** on SRH and gender issues.
  - Telephone hotlines and through the Internet.
  - Invest in universal premarital counselling programmes
    - with education on SRH and gender issues
    - access to testing and treatment for RTIs/STIs and to contraception
    - messages to prevent too-early childbearing and violence against women, and to promote bride’s access to education and employment
- > **Enabling multisectoral YPSRH, health and development programmes for young people with their participation**
  - > Investment in **building the capacity of National AIDS Programmes and youth ministries** in multisectoral youth development and health programming and young people’s participation.
- > **Enable evidence-informed YPSRH programming through the following measures to strengthen the knowledge base in the region:**
  - > Promote rigorous **evaluations** of current YPSRH models used in the region to identify effective strategies and to generate lessons learned from implementation. The review found a notable lack of reliable evaluation information in the region to guide programme design.
  - > Improve the knowledge base about prevalence and both social and medical risk factors for unwanted pregnancy; maternal mortality; reproductive morbidity, including RTIs, STIs; and HIV/AIDS among young people in the region.
  - > Expand research on STI and HIV prevalence, protective and risk factors, and health-related cultural norms among people at high risk of HIV infection, such as CSWs and IDUs.
  - > Improve the research environment by strengthening political and

institutional support for SRH researchers.

- Improve dissemination of this research in national languages – Arabic, Farsi and French.
- > Encourage disaggregated secondary analysis of existing data-sets that include young people, analyzed by sex, marital status, educational enrolment status, level of urbanization of primary dwelling, and other relevant factors depending on the country context.
- > Where possible, in collaboration with national governments and regional bodies, expand the range of SRH issues addressed in nationally representative health and development surveys of young people.
  - Arab Countries who have not done so<sup>32</sup> are urged to conduct national PAPFAM surveys that include the youth module.
- > Encourage qualitative research on young people's perceptions of service needs and quality, and gender and sexuality norms, including violence against children and women. Where possible, gain insight into the sexual behaviour of young people.

- 
- 1 The content of this policy report is based on Shepard, B.L. and DeJong, J.L. 2005, *Breaking the Silence and Saving Lives: Young People's Sexual and Reproductive Health in the Arab States and Iran* – a review supported by a grant from UNICEF's Middle East and North Africa Regional Office against funds made available to it by UNAIDS, for HIV/AIDS focused activities, on the request of the country offices. The study was conducted in partnership with the regional offices of UNAIDS, UNFPA, WHO and IFRC (the International Federation of the Red Cross and Red Crescent). This policy report is intended to be used and adapted by advocates for young people's sexual and reproductive health programmes and policies as a stand-alone briefing report when communicating with decision makers in the region.
  - 2 Note that information on the conventions and conferences to which the Arab countries and Iran are signatory pertaining to young people's sexual and reproductive health are given for individual countries in annex III in Shepard and DeJong, 2005, op. cit., available from the UNICEF MENA regional office.
  - 3 Physically or mentally harmful and/or dependence-causing substance use.
  - 4 Iran, Oman, Qatar, and Sudan. The Occupied Palestinian Territories do not have country status in the UN system, and cannot officially sign any international treaties.
  - 5 Bahrain, Oman, Qatar, Saudi Arabia, and UAE are countries that are not parties to either treaty. However, Bahrain is a party to the CRC and CEDAW without reservations --treaties that are based on principles in these two unsigned treaties.
  - 6 The Charter was adopted by the Council of the League of Arab States by its resolution 5437 (102nd regular session) on 15 September 1994.
  - 7 Bahrain, Djibouti, Syria, and Yemen made no declarations of reservations to the CRC, and Bahrain, Djibouti and Yemen made no reservations to the CEDAW.
  - 8 See annex III in the policy section of Shepard, B.L. and DeJong, J.L. 2005, op.cit. for summary of all reservations and declarations, by 19 Arab countries and Iran.
  - 9 'Adolescents' is the word used in most of the CRC General Comments, covering the age range from 10–19, while the UN definition of 'child' applies to individuals up to the age of 18.
  - 10 "The Right to the Highest Attainable Standard of Health." CESCR General Comment 14 (2000), E/C.12/2000/4.

- 11 "HIV/AIDS and the Rights of the Child." General Comment 3 (2003) CRC/GC/2003/1
- 12 "Adolescent health and development in the context of the Convention on the Rights of the Child," General Comment 4 (2003), CRC/GC/2003/4.
- 13 General Comment 4, paragraph 30.
- 14 Please see Shepard and DeJong, 2005, op. cit., annex III, for details on the range of concluding comments for all of the countries in the study.
- 15 Department for International Development (UK). 2003 *Regional Assistance Plan Middle East and North Africa*, Consultation Draft; and *Population Reference Bureau*, 2000. *The World's Youth* Washington, DC.
- 16 Yousef, Tarik M. 2003. "Youth in the Arab World: Demography, Employment and Conflict," in B. Ruble et al., eds., *Youth Explosion in Developing World Cities: Approaches to Reducing Poverty and Conflict in an Urban Age* (Princeton, NJ: Woodrow Wilson Center).
- 17 United Nations, Secretary General, 1999. "Implementation of the World Programme of Action for Youth to the Year 2000 and Beyond." <http://www.un.org/esa/socdev/unyin/library/5459.pdf>
- 18 DFID 2000
- 19 The survey sample was small, and further in-depth research is needed, but it is clear that both economic and social reasons underlie this trend.
- 20 WHO Department of Chile and Adolescent Health website, "Adolescent Health." Accessed August 2005: [http://www.wpro.who.int/health\\_topics/adolescent\\_health/](http://www.wpro.who.int/health_topics/adolescent_health/)
- 21 Ibid.
- 22 Rivers, Kim and Peter Aggleton. 1999. "Adolescent Sexuality, Gender and the HIV Epidemic." *HIV and Development Programme*, UNDP. [www.undp.org/hiv/publications/gender/adolesce.htm](http://www.undp.org/hiv/publications/gender/adolesce.htm)
- 23 Jenkins, Carol and David A. Robalino 2003, *HIV/AIDS in the Middle East and North Africa: The Costs of Inaction*. Washington, DC: The World Bank Executive Summary, p. xviii.
- 24 Program on International Health and Human Rights, François-Xavier Bagnoud Center for Health and Human Rights, and ICASO, 2004. *HIV/AIDS & Human Rights in a Nutshell*.
- 25 A list of these examples is in "Facts and Figures," 1999 World AIDS Campaign, UNAIDS.
- 26 The key role of infection of young women by older men in driving up HIV prevalence levels is suggested by many studies, including a recent 4-city study in West Africa, UNAIDS 2000 World AIDS Campaign "Men Make a Difference."
- 27 UNDP, Press release, "Arab religious leaders agree unanimously to respond to HIV/AIDS by signing the progressive Cairo Declaration" available on [www.unaids.org](http://www.unaids.org) accessed online May 22, 2005
- 28 For a full discussion of all these elements, please see Shepard and DeJong, 2005, op. cit.
- 29 See the comments by country from treaty bodies in annex III, Shepard and DeJong, 2005, op. cit.
- 30 Worldwide evidence clearly shows that legal prohibitions do not stop most girls and women of any age from having abortions; illegality only makes abortions unavailable from trained providers, and thus unsafe. Mortality and morbidity from unsafe, illegal abortions can best be addressed by universal access to contraception, elimination of criminal penalties and guaranteeing the safety of legal procedures.
- 31 This is not an exhaustive list, and conditions in a particular country would warrant a concentrated focus on fulfilling the needs for information and services of one or more of these groups. For example, in Libya, IDUs would probably warrant such a focus, and in the Sudan, refugees.
- 32 Tunis, Syria, Algeria and Djibouti have added the Youth module to the PAPFAM Core Questionnaire and Morocco and Lebanon have decided to do the same, according to an interview with Dr. Ahmed Abdel Monem of the PAPFAM Surveys, September, 2004. In Morocco the PAPFAM main survey, in collaboration with DHS, sampled unmarried as well as ever-married women.

**International Health and Human Rights Program  
François-Xavier Bagnoud Center for Health and Human Rights  
Harvard School of Public Health**

