Breaking the Silence and Saving Lives:

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

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This review 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.

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ASRH	Adolescent Sexual and Reproductive Health
AIDSCAP	AIDS Control and Prevention Project
CEDPA	Centre for Development and Population Activities
CSW	Commercial Sex Workers
CRC	Convention on the Rights of the Child
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CESCR	Covenant on Economic, Social and Cultural Rights
DHS	Demographic Health Surveys
EMRO	Eastern Mediterranean Regional Office of the World Health Organization
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ICECSR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
IFRC	International Federation of the Red Cross and Red Crescent
IPPF	International Planned Parenthood Federation
IDU	Intravenous Drug Users
LFPA	Lebanese Family Planning Association
LSE	Life Skills Health Education
MENA	Middle East and North Africa
MENARO	Middle East and North Africa Regional Office for UNICEF
MEXFAM	The IPPF affiliate in Mexico
MDGs	Millennium Development Goals

MTC	Mother to child transmission
MSM	Men who have sex with men
NCCW	National Council for Child Welfare
NGO	Non-governmental Organization
ONFP	The Office Nationale de la Famille et la Population
PAPFAM	Pan Arab Family Health Survey
PFPA	Palestine Family Planning Association
PFHS	Population and Family Health Survey
PLWHA	People living with HIV/AIDS
RTIs	Reproductive Tract Infections
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
UAE	United Arab Emirates
UK	United Kingdom
UNAIDS	Joint United Nations Programme on HIV/AIDS
UN	United Nations
UNICEF	United Nations Children's Fund
UNGASS	United Nations General Assembly Special Session
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
UDHR	Universal Declaration of Human Rights
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization
WFFC	World Fit For Children – consensus agreement from UNGASS on Children 2002
YPSRH	Young people's sexual and reproductive health rights

Acknowledgements

The authors owe an immeasurable debt of gratitude to George Ionita, the Regional HIV/AIDS Advisor and Golda El-Khoury, the Regional Youth Advisor from the UNICEF MENA Regional Office, as the supervisors of this study. George Ionita took the lead, providing cheerful support, guidance, and flexibility that helped keep the study on track and surmounted various hurdles in the complicated process of producing the different aspects of this study. His talent for networking put us in touch with a diverse and numerous group of colleagues in the region, and ensured that we received relevant studies as they became available. Golda El-Khoury's close involvement with the study from the very beginning, and her detailed and perceptive comments on the first draft provided important guidance to the authors. This study would not exist without their efforts and input. Naheed Aziz, former Deputy Director of the UNICEF MENA Regional Office, was a remarkable peer reviewer and editor who commented on both the overall structure and the details of an initial draft. Sofia Gruskin, Director of the International Health and Human Rights Program at the François-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health, served as the second peer reviewer, and provided invaluable comments on the final draft of this report. Rana Taher of the UNICEF MENA Regional Office has provided invaluable administrative support. We are indebted to April Paffrath for the excellent and thorough final editing for the final publication, and to Margot Grisar, who did the design.

Julieta LeMaitre conducted the research on the legal frameworks and country comments of the human rights system. We are particularly grateful to research assistants Iman Mortagy (based in Egypt but who also travelled to Tunisia) and Rana Jawad (based in Lebanon but who also travelled to Jordan) for their immense contribution to this study. They both contacted relevant organizations and individuals knowledgeable about the sexual and reproductive health of young people in these countries, conducted interviews with them and collected valuable material. Rana also painstakingly compiled the statistics given in the Synoptic Table from diverse sources. Their insights along the way have been most appreciated.

Many people reviewing the document provided invaluable comments and corrections. Any remaining errors in the sections they reviewed are the sole responsibility of the authors. Reviewers included:

- Participants in the Second Inter-Agency Regional Meeting on HIV/AIDS in Cairo in June 2005
- Participants in the UNICEF MENA Adolescent Network meeting in Cairo in June 2004
- Participants in the UNFPA regional meeting on youth-friendly services in Tunis, July 2004.
- Participants at a consultative meeting at UNICEF-Amman, 10 July 2003

List of those interviewed is in annex I.

Executive Summary

This review[1] of young people's sexual and reproductive health (YPSRH) and gender issues affecting young people ages 10–24 in 19 Arab States[2] and the Islamic Republic of Iran (hereafter referred to as 'Iran'), was undertaken to: 1) strengthen the knowledge base on YPSRH, including gender issues, and on the regional programme and policy context; 2) provide recommendations for national YPSRH and gender policies and programmes based on evidence from international programmes and regional data; and 3) identify gaps in the knowledge base on YPSRH and gender issues in the region and recommend research priorities.

The authors and three research assistants conducted: 1) a YPSRH literature review globally and from the 20 specified countries; 2) policy analyses related to the countries' compliance with international human rights treaties and agreements on issues related to YPSRH and gender; 3) interviews with international and regional experts; 4) interviews with and email surveys of national programme professionals.

The Regional Context for Young People's Sexual and Reproductive Health and Rights

Overview

Regional economic, cultural and political contexts exert a major influence on the sexual and reproductive health (SRH) of young people of the Arab States and Iran. Poverty and affluence co-exist in all of these states, and the last 20 years have seen economic decline across the region, including the Gulf area, with resulting decreasing demand for migrant labour. Politically, the region has been plagued by civil and military conflicts that disrupt young people's programmes and health services, and undermine protective factors for young people's SRH. Weak mechanisms for citizen activism and political representation are key factors that prevent adequate participation of young people in decisions on policies that affect their well-being. In some countries, gender discrimination within personal status codes[3] and labour legislation, social and penal sanctions for sexual relations outside of marriage, and a socially conservative environment make it particularly difficult to address young people's SRH needs.

The situation analysis revealed an urgent need for investment in young people's programmes and for increased attention to this age group (10–24), which now comprises over one third of the total population of the region. Across the region, age at marriage has been rising for both sexes, for a number of social and economic reasons. Educational

levels have also risen rapidly, which, together with globalization and access to mass media, has increased generational differences. This trend results in young people's diminished access to trusted adults in matters related to reproductive and sexual health. Youth unemployment is the highest of any region, creating widespread frustration.
Media characterization of youth from the Arab countries and Iran as somehow 'politically dangerous' has obscured the need for positive attention to their needs, perspectives and aspirations. Researcher El Tawila calls for a development approach that recognises young people's strengths and potential.[4]

Protective and Risk Factors

Culturally and socially, there are both protective and risk factors affecting young people's SRH. The rising age of marriage is a protective factor against early childbearing. Increased levels of education for both sexes in most countries are protective as well. Other protective factors include the integrity of the family unit, a strong sense of social solidarity and cultural identity, the wider availability of Internet-based information in Arabic on SRH issues, and religious values that in many regards reduce SRH risks.

Risk factors for SRH for young women and girls include wide and persistent gender disparities in education in a few countries, and in employment and access to opportunities across the region. The region is characterised by a strong stratification of households by gender and age. In some cases this stratification is associated with low autonomy and mobility for young women and in extreme cases, gender-based violence. Later marriage has been shown to benefit young girls by preventing the health risks of early childbearing and providing them more options for employment and education.

However, the benefits of later marriage need to be complemented by availability of health services and education for young people of all ages and marital status. While the regional evidence is not conclusive, most experts believe that young people's sexual activity before marriage has increased and that there has been a resurgence of forms of non-conventional marriage. Therefore, the widespread inadequate attention to adolescent health education, and insufficient access to health services, including contraceptive and HIV prevention resources, put young people in this region at great risk of unwanted pregnancies, sexually transmitted infections (STI) and other SRH problems.

There are highly vulnerable young people with high-risk behaviours associated with pockets of relatively high rates of HIV infection and other health and development risks. Increases in intravenous drug use (IDU) in some countries are linked with high rates of infection among users. The prevalent patterns of young people's migration without families – for employment for males, and for education for both sexes – contribute to SRH risks. Anecdotal evidence suggests that young labour migrants from within and outside

the region often find themselves isolated and vulnerable, and that young women involved in domestic service – especially those from South Asia – may be subject to sexual harassment. In a few countries, national and intra-regional tourist and commercial sex trades have also created risks for the young people involved, including men who have sex with men (MSM). Children living or working on the streets, prisoners, refugees, orphans, and adolescents in conflict zones suffer multiple risks of involvement in violence, deprivation of opportunities for development, and SRH risks, including HIV infection.

International Human Rights Law and Country Policy Overview

The right to health is defined in the International Convention on Economic, Social and Cultural Rights (ICESCR)[5] as the right to the enjoyment of the highest attainable standard of physical and mental health. This right pertains to all aspects of adolescents' reproductive and sexual health. Article 24 of the Convention on the Rights of the Child (CRC) addresses adolescents'[6] right to health and health services in general, and Article 17 pertains specifically to their right to adequate information and education on health. The Committees for these Conventions have issued General Comments[7] that help to further clarify the obligations of governments for adolescent sexual and reproductive health.

Several General Comments of the Committee on the Elimination of Discrimination against Women (CEDAW) also underscore the right to be free from violence, female genital mutilation/cutting (FGM/C)[8]; and discrimination against women in the prevention and control of HIV/AIDS.

All countries in this study are parties to the Convention on the Rights of the Child, and all but five are parties to ICESCR and the Convention on the Elimination of All Forms of Discrimination against Women.[9] Most countries have agreed to be bound by these treaties with qualifying declarations and reservations.[10] Most of these declarations or reservations indicate that Shari'a law, national laws, or customs take precedence over the particular treaty obligations, particularly for articles that enshrine equality of men and women in general or in the family.

In the reporting process to these UN treaty monitoring bodies, governments provide information about their degree of compliance with their obligations under the treaties. This process also provides important opportunities at a national level for governments to collect and analyze information on the status of adolescent sexual and reproductive health and gender issues within their countries. Governments also receive suggestions from the treaty bodies about priorities in moving forward. Although there is significant country variation, the CRC Committee's comments related to YPSRH and gender equity focus on a core list of issues. These include but are not limited to: the lack of data on and

attention to adolescent health, the need for increased access to secondary education, discrimination against girls in secondary education, early and forced marriage, rape laws, FGM/C, 'honour crimes', and other instances of discrimination or violence against women and girls.

International Evidence and Recommendations on YPSRH Programme Design and Strategies

Overarching principles

Several overarching principles in the current frameworks for both young people's development and CRC-based human rights form the basis for the programme design recommendations in this review.

1. All frameworks mandate **young people's participation** in the design, implementation and evaluation of programmes that affect their lives, as well as the development of policies concerning young people.
2. A **'positive youth development'**[11] **framework** focuses on building young people's assets for adulthood and strengthening protective factors for health. This framework does not focus narrowly on specific problems, but rather employs two main approaches: comprehensive multisectoral programme designs and community and parent involvement.
3. **Certain principles of rights-based programming** based on the CRC are very relevant to young people's sexual and reproductive health. The implications of these principles are explained fully in chapter three. These principles would lead policies and programmes to:
    a) Make the best interests of the child a primary consideration. (CRC Article 3)
    b) Fulfil young people's right to life, survival and development. (CRC Article 6)
    c) Ensure non-discrimination in all of their policy and programmatic work. (CRC article 2)
    d) Take into consideration the views of the child. (CRC Article 12)

Another important component of rights-based programming is **attention to the law and policy context.** Advocacy is important to change laws and policies that may pose barriers to young people's access to the education and services that they need to protect their survival, health, and development.

4. **'Evidence-informed' programming** is a key element of programme design. This element includes:

    a) **Evidence from the context:** Disaggregated data on the diverse population of young people by individual factors such as sex, age, schooling and marital status, as well as contextual factors related to socio-cultural, legal, and policy issues.

    b) **Evidence from research in the YPSRH field:** Tested theories of behaviour change, current knowledge on contextual risk and protective factors for YPSRH, as well as current evidence on effective programme strategies.

    c) **Evidence from the programme itself:** Rigorous programme evaluation, particularly quality analysis of programme implementation and impact assessment, to determine whether the appropriate theory and methods are being used.

International Evidence on Key YPSRH Programme Strategies

Decentralised programme strategies have the following three advantages:

1. They facilitate community, parental and young people's participation;
2. They facilitate multisectoral cooperation, which is always easier at local levels;
3. They help programmes to weather controversies.

Much international evidence has accumulated on how to make **sexual and reproductive health and life skills education** effective in promoting YPSRH. This education is highly recommended as the main prevention intervention for the general population of young people, in organizations where they congregate in large numbers, such as schools, faith-based organizations, and the military. Evidence is now definitive that these programmes do not 'encourage promiscuity' as opponents claim. Rather, through increasing knowledge about reproduction, sexuality and building life skills, these programmes help youth to make responsible decisions, delay sexual initiation and prevent unwanted pregnancies and STIs (including HIV/AIDS). **Programmes that are most effective in protecting young people's health encourage and enable abstinence before marriage and faithfulness during marriage, but also promote safer sex for young people whose sexual activity puts them at risk.**

Additional evidence points to the effectiveness, for both health and development outcomes, of **incorporating YPSRH components into youth development efforts** outside the education sector, such as employment/livelihoods, literacy, sports programmes, and religious settings and programmes.

The international evidence on a variety of additional programme models is discussed in chapter three. Brief highlights follow:

- Confidential counselling venues such as telephone hotlines are highly recommended with adequate investment in marketing and infrastructure.
- Peer education programmes are recommended when it is possible to invest adequately in ongoing training, supervision and incentives.
- Youth-friendly services, through private, confidential means, are essential, but access for unmarried young people is difficult. Most young people prefer pharmacies and private doctors as venues, not health clinics.
- Properly researched mass media campaigns, and partnerships with media outlets with youthful audiences can break the silence and transmit key messages.
- Entertainment education is an important strategy to address socio-cultural barriers to YPSRH, transmitting key messages and encouraging dialogue at the local level.
- Multi-service youth centres – with recreational, educational and health services – rarely serve sufficient numbers of young people of both sexes to justify their cost. These centres often end up catering mainly to older male youth. However, there have been some experiments in the region with variations on the model, which need to be evaluated because they seem to have addressed these drawbacks.

Situation Analysis of YPSRH in the Arab States and Iran

Sexual and Reproductive Health Issues

The following are brief summaries of the main findings on specific issues. There is insufficient data to allow evidence-informed programming on almost all YPSRH issues in the region; hence, the full recommendations for research are extensive. Particularly, the multi-disciplinary research is lacking that links SRH problems with protective and risk factors, and that examines socio-cultural factors and norms.

Marriage: There is intra-regional diversity in marriage patterns, including non-conventional forms of marriage such as temporary and 'urfi' marriage. Nevertheless, certain general recent trends characterise the whole region, all of which all have clear relevance for YPSRH. These include:

> A rising age at marriage for both males and females
> Early marriage that is still a problem in pockets of all societies
> A high incidence of consanguineous marriages
> Persistence, but decline, in polygamy in some countries
> Increasing numbers of single women

Maternal mortality: The Arab States account for only 3 per cent of maternal deaths worldwide, but many of these deaths are concentrated in a few countries – particularly Yemen, Djibouti, Morocco, Egypt and Sudan. Anaemia in pregnancy is high across the region, and early marriage and childbirth, combined with poor nutrition, account for many adolescent maternal deaths in the low-income countries in the region.

Unwanted pregnancy and abortion: There is limited evidence to suggest that unwanted pregnancy is high among young women, who lack both knowledge and access to SRH services. Young people who marry early often lack knowledge about and access to contraception. They face enormous pressures to begin childbearing, so their first access to SRH services is usually during their first pregnancy. Unmarried young women are also unlikely to avail themselves of SRH services. They fear stigma in using family planning, in some cases resulting in unwanted pregnancies and clandestine, unsafe abortions.

Tunisia allows legal abortion on request, and due to the passage of a new law in 2005, Iran allows abortion in the first four months with the consent of both the husband and the wife. Seven countries allow abortion only to save a woman's life; three allow it to preserve her physical health, and three for reasons due to her mental health. In most countries, abortion remains very much a taboo topic, although Islamic teachings accept abortion before 'ensoulment', with diverse views on when during gestation it occurs. There is no reliable data available in the region on the relation between unsafe abortions and maternal mortality or morbidity, but worldwide, it is estimated that one in eight maternal deaths are due to unsafe induced abortion.

Reproductive morbidity: There have been few population-based studies conducted at the national level to assess overall levels of reproductive morbidity in the region, although some excellent micro-level data on reproductive tract infections (RTI) exist (e.g., the Egypt Giza study). These studies suggest that both obstetric and gynaecological morbidity is high among young women, and serious problems of vesico-vaginal fistulae and prolapse have been reported but not studied in low-income countries such as Yemen and Sudan.

Sexually transmitted infections: National-level data is also scarce concerning STIs because of stigma, poor reporting and lack of research. The few studies done suggest

that STIs are disproportionately high among young people. Experts suggest that young people suspecting such conditions would self-treat or resort first to pharmacies for advice and treatment, and perhaps then consult the private sector.

The role of RTIs and STIs in **infertility** needs to be publicised and addressed. Because of the high valuation of childbearing, infertility is particularly stigmatised in the region. When young women marry older and more sexually experienced men, there is a higher risk of contracting STIs and subsequent infertility. Therefore, infertility prevention should focus on publicizing these risks, and providing voluntary and confidential testing and treatment to cure RTIs and STIs before and during marriage.

HIV/AIDS: The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that there are 540,000 adults, of whom 250,000 are women, living with HIV/AIDS in the region. The estimated adult prevalence rate in the region is 0.3 per cent. AIDS killed an estimated 28,000 people in the region in 2004. Region-wide data are not available but it is estimated that 50 per cent of new infections are among young people. The main means of transmission are heterosexual sex and intravenous drug use (IDU). There are pockets of medium-level prevalence in some countries, mainly among highly vulnerable populations such as commercial sex workers (CSW), IDUs and prisoners, many of whom are young people. Only Sudan and Djibouti have generalised HIV/AIDS epidemics. Given the relatively low HIV/AIDS prevalence rate in all but these two countries, the region faces a critical window of opportunity now to prevent a generalised HIV/AIDS epidemic.

The cost of ignoring this window is high. Yet response to date has been slow due to the inter-related problems arising from the widespread public policy denial of the potential of an HIV/AIDS epidemic in the region. Strong and positive statements about HIV/AIDS prevention by political leaders in Djibouti, Sudan and Iran in particular have set a precedent for other countries in the region to follow. Another promising development was the signature of the Cairo Declaration on HIV/AIDS by 90 Muslim and Christian religious leaders in December 2004. The Declaration recognised the threat posed by the HIV/AIDS epidemic and the responsibility to undertake urgent action to prevent infection and to end stigmatization and isolation of those with HIV/AIDS.

Nevertheless, despite documentation of increasing premarital sexuality in the region and the known vulnerability of young people internationally to the HIV/AIDS epidemic, there is strikingly little information on the HIV/AIDS-related knowledge and behaviour of the 10–24 age group in the region. Furthermore, young people's access to voluntary counselling and testing for HIV/AIDS, or for any other STIs, and to antiretroviral therapies is very limited in the region.

Substance abuse:[12] It is known that both the cultivation and transit of illicit drugs occurs in the region, but data on harmful and/or dependence-causing substance use are scarce. This study did not unearth any regional or country-level assessments, except in Iran. Iran has reported a significant problem of intravenous drug use, particularly among the young, and is the only country in the region to have initiated harm-reduction programmes. In Libya, intravenous drug use is known to be the main route of HIV/AIDS transmission.

Female genital mutilation/cutting (FGM/C): FGM/C is practised in four countries of the region – Egypt, Sudan, Yemen and Djibouti – although, in Yemen, it is confined to certain regions of the country. Campaigns against the practice have been ongoing for several decades in Sudan, Egypt and Yemen particularly, although they have recently gained greater momentum with government commitment to its eradication.

Violence against women: Population-based data on the prevalence of domestic violence and other forms of violence against children and women is lacking in the region, but some studies on attitudes have shown high levels of acceptance of such violence among young people and adults of both sexes. Increasingly non-governmental organizations (NGO) are taking up this cause. They have documented instances of abuse, neglect, incest and violence across the region, and established confidential counselling hotlines or 'centres d'écoute.' 'Honour killings' are a particular form of violence, consisting of the murder by family members of girls and women who are suspected of transgressing sexual norms. These murders have been documented unevenly across the region, and codes in some countries explicitly eliminate or reduce criminal penalties for the perpetrator(s). To date, however, few governments have addressed this sensitive issue or developed programmes to address it.

Do Services Address Young People's SRH needs?

The major challenge in the region is the lack of willingness among government leaders to address YPSRH issues. For that reason, the region is characterised by a scattering of isolated YPSRH programmes, most of which have been initiated by NGOs, but no mainstream and scaled-up programmes, with the exception of Tunisia's government programme and Iran's premarital counselling programme.

Most schools in the region lack counselling or SRH/life skills education programmes. SRH education curricula are rare and where they do exist, relevant sections of the curriculum are often neither taught nor assessed by teachers unprepared or embarrassed to teach them.

Public sector health services neither respond to the particular needs of this age group nor create a climate in which young people, and especially unmarried young people, are

welcome. Private health services and pharmacies are therefore often the first recourse, although only for those who can afford them and are prepared to face the risk of judgmental attitudes from providers.

Most of the few YPSRH programmes that exist have not been extensively evaluated, so it is impossible to tell whether they are effective in helping young people protect their health.

Policy recommendations to governments

Increase investment in the health and development of young people

Policies and programmes should address the different needs of married and unmarried young people holistically by strengthening protective factors, that is, by integrating health and development interventions. Such holistic programmes would provide full access to health information and services, integrated with quality education, training for livelihoods, opportunities for civic participation, freedom from violence, and connections to supportive adults. Such initiatives are congruent with the current recommendations of human rights treaty bodies.

These integrated investments in young people's health and development should be a central element in medium- and long-term strategies to achieving the Millennium Development Goals (MDGs): 1) eradicating extreme poverty and hunger, 2) achieving universal primary education, 3) promoting gender equality with the target of reducing gender inequalities in education, 5) improving maternal health, and 6) combating HIV/AIDS.

Review human rights treaties and laws

Review status of country's ratification of and reservations to major human rights treaties: CRC, CEDAW, ICESCR and the International Convention on Civil and Political Rights (ICCPR) for implications on young people's health and development.

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

> Use the CEDAW and CRC Committees' country reporting documents to identify key human rights issues for young people. See the comments by country from treaty bodies in annex III in this report.
  > **Enforce minimum legal age at marriage** for boys and girls, and mobilise support to establish a minimum of 18 years for both.

- Introduce measures to ban and **eradicate FGM/C** in the four countries where it is practised.
- Reform laws on **violence against girls and women** as well as **child sexual and physical abuse** to provide better protection for victims.

Expand access to education, employment, and SRH services.
In accordance with Millennium Development Goals:

- Provide **free education** through secondary school and reduce all gender discrimination relating to education (with special attention to married and pregnant young girls). (MDGs 2 and 3)
- Provide both **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)
  - **Review age-of-consent laws** to ensure that young people have access to confidential SRH services.
- **Provide accessible and anonymous voluntary counselling and testing for all STIs and RTIs, including HIV/AIDS,** as well as **treatment,** through confidential services in primary and secondary care health facilities. Involve young people living with HIV in these programmes.

Prevent unwanted pregnancies and abortions, reducing abortion-related morbidity and mortality.

- Review **reproductive health policies** and **abortion laws** to reflect current evidence on effective means of preventing unwanted pregnancies and abortions.[13]
  - The goal of making abortions as rare as possible, but safe when they occur under legal provisions, is feasible through universal access to SRH education and contraceptives, and through removing criminal penalties.
    - In particular, there is a need for increased availability of emergency contraception to young people in order to prevent unsafe abortions.
    - Worldwide evidence shows that criminal penalties do not prevent most abortions, but rather make them unsafe,

causing maternal mortality and morbidity.

- At a minimum, governments that have not already done so should legalise abortion to save the life and health of the mother, or in the case of foetal impairment. Cases of rape or incest should also be considered as eligible for legal abortion, given the potential emotional and psychological impact of continuing such a pregnancy.

Support participation mechanisms for young people.

> Invest more resources in **building the capacity of National AIDS Programmes and youth ministries** in multisectoral health and development programming that includes YPSRH, and in young people's participation mechanisms.

Programme Recommendations for Governments, Donor Agencies, and NGOs/Civil Society Organizations

Since there is much political and cultural resistance to implementing YPSRH programmes, **advocacy will play a central role** in getting any initiative off the ground. The focus of the programme in each setting should be determined by a **general health and development needs assessment** that involves young people and adult stakeholders and includes SRH and gender issues. Adequate evaluation designs should be set in place during programme design.

Priority populations

It is recommended that both public and NGO/civil society programmes serving young people create sustainable YPSRH interventions, giving high priority to:

> Young people in pockets of high poverty
> Marginalised young people, including: labour migrants, rural migrants to urban-based universities, refugees, orphans, children living and working on the streets, prisoners, sex workers, men who have sex with men, intravenous drug users and young people in conflict situations.
> All young people out of school, with special efforts to reach young women

Recommended Programme Strategies

- **SRH and gender equity 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, and training for teachers in participatory methods.
  - In mass media and entertainment education through sustainable partnerships with media outlets and producers.
- **Promoting gender equity** 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**
  - Counselling: Telephone hotlines, Internet-based chats with counsellors or experts, premarital counselling
  - Networks of youth-friendly private doctors and pharmacies for contraception, STI testing
  - Emergency contraception to avoid unwanted pregnancies and abortions among young people, whose sexual activity is often unplanned.
  - Additional measures to make condoms more widely available for HIV prevention
- **Peer education programmes** when assessments indicate that this strategy is preferred by the young people to be served.
  - Preferences may differ by gender and level of vulnerability, and may depend on the topic or on the programme component (information, counselling, life skills, contraceptive provision, etc)

Recommendations on Specific SRH Issues

Strengthen efforts to prevent **early marriage** through opportunities for education and livelihoods for girls, media campaigns, premarital counselling (based on the Iranian model), and changes in laws and regulations. Limit the harm caused by early marriage through premarital counselling and access to opportunities.

Raise community awareness about danger signs of **maternal mortality** and improve access to essential obstetric care. Prevent the malnutrition-related risk factors for maternal mortality (e.g., anaemia and stunting in early childhood).

Prevent **unwanted pregnancy and abortion** by making family planning universally available to young people with private, confidential treatment, counselling and records.

> Ensure provision of humane care when treating complications from unsafe abortions in hospitals, including counselling about and provision of contraceptive methods.

Reduce **reproductive morbidity,** improve access to obstetric care; increase access to testing and treatment for RTIs, improve screening for RTIs prior to intrauterine device (IUD) insertion and train family planning providers about risks of RTIs; raise awareness about genital and menstrual hygiene starting at puberty; and educate the general public about the risk of infertility from RTIs.

For HIV/AIDS and STIs, in addition to the recommendations above, educate against all forms of sexual violence and harassment, making special efforts to educate sexually active young men.

> Provide protection, information and services to highly vulnerable young people, ensuring that they have access to condoms and to accessible and confidential treatment of STIs in primary care facilities, not in specialised clinics.
> Strengthen efforts to involve young people living with HIV in prevention and services and to reduce stigma associated with HIV/AIDS
> Impress upon policy makers that measures to prevent RTIs and STIs such as widespread hygiene education and promotion of condom use are the most effective means of preventing **infertility.**

Substance abuse: Expand harm reduction programmes (as in Iran) and make efforts to destigmatise drug use in order to reach drug users with services. Expand youth development programmes to decrease demand.

To eliminate FGM/C, implement a three-pronged approach:

> Make all forms of FGM/C illegal, with enforcement mechanisms
> Finance media campaigns that reach rural areas and all linguistic groups practicing FGM/C
> Support community-based programmes to mobilise communities to develop their own strategies for eradicating the practice

To reduce violence against women:

- Focus strongly on prevention through information and education programmes with both sexes in all venues named above
- Bring country policies into accordance with international law recommendations on violence against children and women
- Train police, judges, social services and healthcare workers so that they take appropriate action

Research Recommendations for Governments, Donor Agencies and Research Institutions:

Improve the research environment by strengthening political and institutional support for SRH researchers. Improve dissemination of this research in the respective national languages – Arabic, Farsi and French – and through publication in international literature.

All agencies implementing YPSRH programmes are encouraged to support more **rigorous process and impact evaluations** of current programme models in the region.

Where possible, donors collaborating with national governments and regional bodies should **expand the range of issues** addressed in nationally representative health and development **surveys on young people.**

Legitimise and support inter-disciplinary research on SRH issues and young people that triangulates quantitative and qualitative methods, particularly on social protective and risk factors, and SRH-related knowledge, social norms and behaviour.

- Encourage **disaggregation by age and sex** and other relevant dimensions, both in primary research on SRH topics as well as in secondary analysis of existing data-sets that include young people.
- Conduct advocacy so that all data already collected on YPSRH are released.
- **Support inter-disciplinary research to fill specific knowledge gaps.** These gaps include young people's perceptions of SRH service needs and quality, as well as issues related to marriage trends, STIs and HIV, maternal mortality, obstetric and gynaecological morbidity, FGM/C, and violence against women. (See chapter four on Recommendations for full list.)

1 The review was 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, at the request of UNICEF 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).

2 Algeria, Bahrain, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Occupied Palestinian Territories, Oman, Qatar, Saudi Arabia, Sudan, Syria, Tunisia, United Arab Emirates, Yemen.

3 Personal status codes concern women's rights in marriage/divorce, right to inheritance, etc.

4 El Tawila 2002

5 International Convention on Economic, Social and Cultural Rights

6 '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.

7 "The right to the highest attainable standard of health." E/C.12/2000/4, CESCR General Comment 14 (April–May 2000); "HIV/AIDS and the Rights of the Child" CRC General Comment 3 (2003) CRC/GC/2003/1; "Adolescent health and development in the context of the Convention on the Rights of the Child." CRC General Comment 4 (2003), CRC/GC/2003/4.

8 Female genital mutilation is also referred to as "female genital cutting" (FGC) and "female circumcision," although there is general agreement that the latter term is misleading.

9 Iran, Oman, Qatar, Sudan, and United Arab Emirates are not parties to CEDAW, and Bahrain, Oman, Qatar, Saudi Arabia, and UAE are not parties to ICESCR. The Occupied Palestinian Territories do not have country status in the UN system, and cannot officially sign any international treaties.

10 Bahrain, Lebanon, Libya, Sudan, and Yemen made no declarations of reservations to the CRC, and Djibouti and Yemen made none for CEDAW.

11 This is the phrase most often used in the literature in this field, although this report refers to the wider age range of 10–24, and thus the phrase 'young people' is used whenever possible.

12 Physically or mentally harmful and/or dependence-causing substance use.

13 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.

CHAPTER ONE: INTRODUCTION

This review of young people's sexual and reproductive health (YPSRH) and gender issues affecting young people ages 10–24 in 19 Arab States[1] and Iran, was undertaken to fill information gaps on the subject and facilitate planning of supportive action by governments, donors and all agencies working with young people in the region. The review was conducted by Bonnie L. Shepard, of the International Health and Human Rights Program at the François-Xavier Bagnoud Center for Health and Human Rights at Harvard School of Public Health; and Jocelyn L. DeJong of the Institute for Development Policy and Management, University of Manchester and the American University of Beirut. The review was supported by a grant from UNICEF's Middle East and North Africa (MENA) Regional Office against funds made available to it by the Joint United Nations Programme on HIV/AIDS (UNAIDS) for HIV/AIDS-focused activities. The study was conducted in partnership with the regional offices of UNAIDS, United Nations Population Fund (UNFPA), and the International Federation of Red Cross and Red Crescent Societies (IFRC).

This study's main objectives were to: 1) strengthen the knowledge base on YPSRH (including gender issues) and on the regional programme and policy context, 2) provide recommendations and arguments for national YPSRH and gender policies and programmes based on evidence from international programmes and data from the Arab States and Iran, and 3) identify gaps in the knowledge base on YPSRH and gender issues in the region and recommend research priorities.

The authors and three research assistants conducted: 1) YPSRH literature reviews globally and from the 20 specified countries, 2) policy analysis related to the countries' compliance with international treaties and agreements related to YPSRH, 3) interviews with international and regional experts, and 4) interviews and email surveys with national programme professionals.

The study is divided into the following chapters[2]:

Chapter 1: **Introduction**

Chapter 2: **Situation Analysis:** Overviews of YPSRH statistics, research, programmes and policies in the social, cultural, religious and political context of the region. The analysis includes trends in marriage, unwanted pregnancies and abortion, maternal mortality and reproductive morbidity, HIV/AIDS and STIs, substance abuse, violence against women, and female genital mutilation. Some examples of YPSRH programmes in the region addressing these issues

are provided, as well as a Synoptic Table with the main relevant statistical indicators.

Chapter 3: **International Evidence on YPSRH Programmes.** Explanation of the principles of programme design suggested by international evidence and recommendations of effective practices for the most common YPSRH programme strategies.

Chapter 4: **Recommendations**. Suggestions for YPSRH policy, programmes and research initiatives for national governments and donors.

Annex I: **List of People Interviewed**

Annex II: **Synoptic Table of Statistics on YPSRH from the Region**

Annex III: **Policy Frameworks and Country Reference Tables** Brief discussion of international human rights frameworks, followed by reference tools and tables on ratifications and reservations on major human rights treaties, supporting language from UN conference agreements, and observations on each country by international treaty bodies, mainly the CRC and CEDAW committees.

Annex IV: **Bibliography.** References drawing upon international, regional and national sources.

This review focuses on the UN-defined demographic of 'young people', namely individuals ranging in age from 10–24. Depending on the literature sources referred to, the review also employs the terms 'adolescents' (ages 10–19) and 'youth' (ages 15–24). As age at puberty decreases worldwide due to better nutrition, and as educational levels increase, the 10–24 age range encompasses the earliest ages at puberty up to the average age of marriage in many countries.[3] As these trends delay the assumption of adult responsibilities, 'adolescence' becomes a socially recognised distinct stage in the life cycle. During this period in the life cycle, new issues related to sexual and reproductive behaviour and health accompany the important benefits from increased levels of education and delayed marriage. In many settings, young people increasingly engage in premarital sexual activity – even in very socially conservative cultures. In some contexts, harmful and/or dependence-causing substance use (hereafter called 'substance abuse') among young people increases, mostly among young men, particularly when employment opportunities do not match aspirations and outlets for positive self-expression are low.

This introduction will describe the theoretical and programmatic frameworks that guide this study and our recommendations, and ends with a 'basic bookshelf' of references that would be useful to YPSRH programme designers.

The Positive Youth Development Approach

This study advocates a comprehensive and positive approach to promoting and protecting young people's health. This approach addresses the multiple factors that reinforce each other to promote health and a safe and successful passage to adulthood. The main 'protective factors' for health correspond closely to human rights established in the Convention on the Rights of the Child; the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW); the International Covenant on Economic, Social and Cultural Rights (ICESCR); and the International Covenant on Civil and Political Rights (ICCPR) This comprehensive approach enhances these important protective factors, including:

- an adequate standard of living
- access to education
- access to opportunities for livelihoods
- safe and supportive environments that are free from violence and discrimination
- close relationships with adults in the family and/or the community
- opportunities for young people to participate in the governance and contribute to the welfare of the communities and institutions affecting their lives
- access to health information, education, counselling and services

Young people are invaluable assets, not problems; they are participants and not victims or beneficiaries. Young people should be the main protagonists in protecting their own health. Their inside knowledge of the opportunities and barriers facing them uniquely positions them to suggest appropriate interventions. Therefore, to ensure maximum effectiveness, YPSRH programmes should actively seek meaningful youth participation.

The human rights system and the youth development field have experienced similar shifts beginning in the 1980s. The youth development field has recognised that a negative focus on problems is not sufficient, and that effective programmes have a positive focus on building strengths and assets. Likewise, the human rights system recognises that governments have both 'negative obligations' (i.e., avoiding violations of rights) and 'positive obligations' (i.e., what government should do to protect and fulfil rights). Regarding the right to health, for example, a government should avoid the rights violations of withholding health treatment or allowing harmful treatments, and fulfil their obligation by providing access to health education and services for those who need them. The field of youth development has complemented its earliest focus on what we **do not want** for young people (e.g., disease, drug use, delinquency, unwanted pregnancy) with a focus on what we **do want** for them, and they want for themselves. This shift in focus has arisen from

the acknowledgement that "being problem-free does not necessarily mean that one is prepared for adulthood."[4] The consequent emphasis on developing young people's skills and assets is often called 'positive youth development', or an 'assets-building approach'.[5]

1. The first principle of positive youth development is that a society has to have a positive vision to guide its young people. Generally, this vision has to do with **helping young people attain the important assets for citizenship** and adulthood, such as education and training, employment, life skills, health, ethical values, social networks, critical thinking and decision-making skills, self-esteem and pride in one's heritage and culture.
2. The second principle emphasises **capacity building at the community level** as an integral aspect of the overall social and political framework that must support positive youth development for the programme to have a sustainable impact.
3. The third principle of **youth participation** holds that youth themselves, in partnership with adults, have critical roles to play as stakeholders in all efforts to promote their health and development. In these programmes, youth are not 'targets', but rather protagonists. The tasks for this stage in life cannot be limited to preparation for future adulthood; youth need to participate actively in shaping their future. Young people's participation in their communities, and in health and development programmes designed for their benefit, is a developmental need, a protective factor for health, and a basic human right.[6]

Young People's Sexual and Reproductive Health[7]

The most effective programmes to promote young people's sexual and reproductive health (YPSRH) have incorporated the principles of the youth development field, based on recognition that "problems have common roots, and that … strengthening these common [protective] factors addresses multiple behaviours at the same time and is more likely to have a deeper lasting impact."[8]

During the 1980s, evidence mounted that narrowly focused family planning or sex education programmes for young people were neither sustainable nor effective. Programmes often stimulated community and political resistance, so they either fell apart when external donors halted support or they stayed on a small scale with low coverage. Furthermore, many programmes were successful in increasing knowledge and health-protective attitudes, but did not produce the expected reduction in risky behaviours. As a result, beginning in the 1990s, YPSRH programmes began to apply positive youth development approaches, with increasing attention to gender-based issues such as violence against women and discrimination against girls and women in education and employment.
At the same time, sexual and reproductive health (SRH) programmes and policies began

to incorporate greater attention to human rights and gender equity, a trend that was accelerated by the framework of the 1994 International Conference on Population and Development (ICPD) Programme of Action, which emphasised: comprehensive approaches to sexual and reproductive health, empowerment of women, and attention to human rights, specifically reproductive rights. In a parallel process, the child health and development field – and in particular UNICEF – adopted the human rights framework of the Convention for the Rights of the Child (CRC)and the emphasis on women's and girls' rights as stated in the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW).

The ICPD Programme of Action (7.41–7.47) and the Committee on the Rights of the Child have recognised that States have a positive obligation to protect young people from health risks, including those that result from sexual activity. This positive obligation arises from universally recognised human rights such as the rights to survival, development, health, access to information that promotes health and access to health services.[9] These health risks have become increasingly severe as the HIV/AIDS epidemic expands, because young people are especially vulnerable. "According to UNAIDS – the Joint UN Programme on HIV/AIDS – the most recent trends are alarming: in most parts of the world the majority of new infections are in young people between the ages of 15 and 24, sometimes younger."[10]

General Comments from the Committee on the Rights of the Child regarding States' obligation to protect YPSRH

21. "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."

General Comment 4 (2003) "Adolescent health and development in the context of the Convention on the Rights of the Child." CRC/GC/2003/4.

17. The Committee is concerned that health services are generally still insufficiently responsive to the needs of human beings below 18 years old, in particular adolescents. … In the context of HIV/AIDS and taking into account the evolving capacities of the child, States parties are encouraged to ensure that health services employ trained personnel who fully respect the rights of children to privacy (article 16) and non-discrimination in offering them access to HIV related information, voluntary counseling and testing, knowledge of their HIV status, confidential sexual and reproductive health services, free or low cost contraception, condoms and services, as well as HIV-related care and treatment if and when needed … .

General Comment 3 (2003) "HIV/AIDS and the Rights of the Child." CRC/GC/2003/1.

The vulnerability of young people in the face of the HIV/AIDS epidemic catalyzed youth development programmes and reproductive health/family planning programmes to expand their focus to include sexuality. Researchers in the HIV/AIDS field have analyzed the multiple factors influencing sexuality and, consequently, effective prevention programmes address gender issues and other political, economic and social factors in young people's environment that affect their risk of infection. Girls are especially vulnerable due to the interaction of biological factors (the fragility of young women's vaginal tissue), social factors (girls' and young women's inability to negotiate the terms of sexual relationships), and political factors (such as discriminatory laws, policies, and practices). Conversely, young men are put at risk of STIs by gender-based norms of risk taking and social norms that condone multiple sexual partners – behaviours that in turn put their future partners at risk. Patterns of migration also increase these risks to men of all ages and their wives or partners when they return home.

The intense stigma and discrimination faced by people living with HIV/AIDS poses significant barriers to the effectiveness of HIV/AIDS prevention and care programmes, and has been the impetus for heightened attention to the protection of human rights within these programmes. At the same time, the predominance of young people among those newly infected has caused a productive cross-fertilization between the lessons learned in HIV/AIDS prevention programmes and those learned in youth development and/or reproductive health programmes.
Through this historical process, the UN and international agencies working on young people's health and development have reached consensus on the main areas where country programmes and policies should support young people to ensure their survival and health, and to help them develop to their fullest potential. Despite this consensus among professionals in these agencies, **controversies have accompanied YPSRH programmes and policies, as arguments based in religious morality mistakenly equate protecting young people from ill health and death with approval or even promotion of the behaviours that put them at risk. This report argues that young people's rights to survival, health, and development need to be foremost when setting public policies.**

At the global level, one recent manifestation of these controversies took place at the United Nations General Assembly Special Session (UNGASS)[11] on Children in 2002, where delegates from some countries raised fierce objections to language recommending adolescents' access to confidential sexual and reproductive health services. At the community or national level, controversies result in the failure of many sex education programmes in schools to include scientifically accurate information on condom use and contraception, while other programmes that could protect sexually active unmarried young people from unwanted pregnancy and infection with HIV/AIDS fail to include access to sexual and reproductive health services.

These controversies have a negative impact on government action to support YPSRH programmes, further exacerbating the lack of necessary programmes and services both within specific communities and at the national level. Because YPSRH issues are controversial, advocacy is an essential component of programmes that protect young people's sexual and reproductive health. Advocates for YPSRH need to engage the support of government 'duty bearers',[12] such as public officials or legislators, as well as work to create an enabling environment among parents, local leaders, religious leaders and school directors.

Ideally, in a rights-based and positive youth development approach, programmes to promote the well-being of young people should adopt a comprehensive approach – promoting both health and development. To escape these controversies, and because of bureaucratic divisions in funding streams, youth development programmes often have concentrated only on life skills, education and employment – excluding sexual and reproductive health content. Likewise, sexual and reproductive health programmes have not included youth development components. Both types of programmes suffer as a result of this failure to adopt a comprehensive approach.

This review urges governments and institutions to organise their young people's policies and programmes in such a manner that they promote both health and development, and fulfil their positive obligation to protect the sexual and reproductive health of the young. Failure to do so can have dire consequences for the health, well-being and economic productivity of the young people, as well as that of communities and future generations. Attention to the health and development of the young is a nation's soundest investment in future economic progress, overall development and fulfilment of human rights.

Basic Bookshelf

Several excellent overviews of good practices and recommendations on programmes to protect young people's health have been produced in the last five years. Chapter three will briefly summarise the most important points from this literature, emphasizing some issues that are especially pertinent to the Arab States and Iran.

Basic Bookshelf for YPSRH Programme Planners*

Policy Documents

Committee on the Rights of the Child, 2003. "Adolescent health and development in the context of the Convention on the Rights of the Child," General Comment 4 (2003), CRC/GC/2003/4. Available from the website: http://www.unhchr.ch/html/menu2/6/crc/doc/comment/adohealth.doc

Committee on the Rights of the Child, 2003. "HIV/AIDS and the Rights of the Child." General Comment 3 (2003) CRC/GC/2003/1 Available from website: http://www.unhchr.ch/html/menu2/6/crc/doc/comment/hiv.pdf

Situation Analysis

UNFPA, 2003. *State of World Population 2003. Making One Billion Count: Investing in Adolescents' Health and Rights*. New York: United Nations Population Fund.

UNICEF, UNAIDS, WHO, 2002. *Young People and HIV/AIDS: Opportunity in Crisis*. New York and Geneva: UNICEF, UNAIDS and WHO.

YPSRH Programme Evidence and Guidance

FOCUS on Young Adults, 2001. *Advancing Young Adult Reproductive Health: Actions for the Next Decade*. Washington, DC: Pathfinder International, The Futures Group International, and Tulane University School of Health and Tropical Medicine.

International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR), 1999. "Review of Key Elements and Strategies for Improving the Sexual and Reproductive Health of Young People," #4 in the *Self-Assessment Module: Sexual and Reproductive Health Programs for Youth*. New York: IPPF/WHR.

Program for Appropriate Technology in Health (PATH), 2003. *Capacity-building Resources in Youth Sexual and Reproductive Health*. Washington, DC: PATH and NGO Networks for Health. The publication provides training tools in YPSRH programme design, behaviour change strategies, youth-friendly health services, and monitoring and evaluation.

Population Council, 2003. *Adolescent and Youth Sexual and Reproductive Health: Charting Directions for a Second Generation of Programming*. Both the report and the background document on a workshop of UNFPA in collaboration with the Population Council, 1–3 May 2002. New York: Population Council

Reproductive Health Outlook, 2003. *Adolescent Reproductive Health*. Website ©PATH. PDF file accessed at http://www.rho.org/html/adolescent.htm

UNICEF, 2002. *The State of the World's Children*, 2003. Focuses on children's and young people's participation.

WHO and UNICEF, 2001. "Programming for Adolescent Health and Development: What should we measure and how?" Report of the third meeting, Washington, DC, June 12–16, 2000. Geneva: WHO Child and Adolescent Health and Development, Family and Community Health.

* Additional helpful references will be listed under several topics in this section. This list is meant to point the programme manager to several general references to use when designing programmes.

1 Algeria, Bahrain, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Occupied Palestinian Territories, Oman, Qatar, Saudi Arabia, Sudan, Syria, Tunisia, United Arab Emirates, Yemen

2 Jocelyn DeJong wrote chapter two – the Situation Analysis – with assistance from Iman Mortagy and Rana Jawad in gathering the data. Bonnie Shepard wrote chapter three on International Program Evidence. Julieta LeMaitre gathered the data for annex III on International Human Rights Frameworks, and the country policy reports. The recommendations section and policy report were written jointly by the authors, as was the Executive Summary. Rana Jawad compiled annex II, the Synoptic Table.

3 In several MENA countries, due to rising levels of education and other socio-economic factors, the average age at marriage is higher than 24. See Situation Analysis.

4 Pittman et al, 2000.

5 The following section is based on Inca Mohamed's Program Officer Memo, Ford Foundation, Youth Development Strategy (2000), on Pittman, Irby and Ferber, 2000, and on UNICEF 2003a. This section appeared in a longer form in Shepard et al 2001.

6 Convention on the Rights of the Child, article 12, paragraph 1, "States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child." A section in chapter three develops the topic of young people's participation more fully.

7 Other terms commonly used are youth sexual and reproductive health (YSRH) and adolescent reproductive health (ARH).

8 UNICEF 2003a

9 See articles 3, 6, 17 and 24 of the Convention on the Rights of the Child. Committee on the Rights of the Child General Comment 4 (2003) "Adolescent health and development in the context of the Convention on the Rights of the Child." CRC/GC/2003/4.

10 Committee on the Rights of the Child, 2003. "HIV/AIDS and the Rights of the Child." General Comment 3 (2003) CRC/GC/2003/, Article 1.

11 United Nations General Assembly Special Session

12 In a human rights framework, the duty bearers are those in the social and political environment of the child who have a positive obligation to ensure that the child's human rights are recognised, respected, protected, and fulfilled.

CHAPTER TWO: SITUATIONAL ANALYSIS OF THE REPRODUCTIVE AND SEXUAL HEALTH OF YOUNG PEOPLE IN THE ARAB STATES AND IRAN[1]

This situational analysis addresses the background and main issues pertaining to the reproductive and sexual health of young people in 19 Arab states[2] and Iran.

Note: The boundaries and the names shown and the designations used on these maps do not imply official endorsement or acceptance by the United Nations.

As noted in the introduction, the analysis is based on a desk-based review of both published and unpublished literature on the topic, interviews by telephone with experts knowledgeable about the subject in these countries, and responses to an email survey of relevant agencies in the field. In addition, two research assistants based in Egypt and Lebanon collected data and interviewed key experts in person in Egypt, Lebanon, Jordan and Tunisia. (See appendix I for a list of the names and institutional affiliations of those interviewed for the study.) All interviews were open-ended but guided by a set of standard questions concerning interviewees' perceptions of the main challenges facing youth; key sexual and reproductive health issues; perceived risk and protective factors; strategies for overcoming challenges; existing programmes serving youth (whether governmental or not) and the evidence needed to support programmes. Overall, 51 interviews were conducted with experts on young people's health, including nine with people working at regional or international levels, and the remainder with people in Morocco, Tunisia, Egypt, Lebanon, the West Bank and Gaza, Jordan, Yemen, Sudan, Oman, Bahrain, Djibouti, Syria and Iran. The Synoptic Table (see annex II) accompanying this review consolidates data for a number of indicators concerning the reproductive and sexual health of this age group in the region for which region-wide data is available, albeit from disparate sources.

On the basis of this research, the situational analysis first covers the economic, political and social context of young people's reproductive and sexual health in the region before

moving on to an analysis of specific reproductive and sexual health trends and problems in the second section. The third section identifies some research gaps, and the fourth and final section addresses the extent to which health, education and youth services are helping to fill the gaps identified.

It is recognised that each country covered in the review has its own particular context of sexual and reproductive health, calling for nationally tailored approaches. Nevertheless, states within the region share many characteristics, such as the predominance of Islam, which lays the foundation of religious values that have a positive influence on sexual and reproductive health. Moreover, with the exception of Iran, the countries share a linguistic and cultural heritage, making it possible to learn from culturally sensitive programme approaches in this field across the region. Increasing access to electronic media in recent years – particularly for youth – facilitates such intra-regional communication.

The region is economically diverse, with seven countries in the high-income category, nine in the middle-income category and four in the low-income group. Although some countries in the region have large proportions of their population in absolute poverty, inequality and relative poverty are particularly important as these are linked both to exposure to consumerism and rising expectations. There are strong economic connections within the region, however. The oil-rich nature of the Gulf States has attracted labour migration from across the region, as well as from other regions (predominantly South Asia), and migration for education is a common pattern in the region. These trends have clear implications for the sexual and reproductive health of young people both in sending and receiving countries.

Politically, the region also exhibits a range of governance arrangements. Ten countries are republics, eight are governed by monarchies, one is an Islamic theocracy and one has yet to receive independent statehood.

As will be discussed further below, there are few national government programmes addressing young people's sexual and reproductive health, and many innovative programme models are initiated by NGOs, although many of these programmes are small scale and, where evaluations are lacking, their effectiveness is difficult to measure. Governments across the region are showing increasing interest and awareness about the problems confronting youth and some are initiating policy in this area. The Arab League has recently initiated youth health and development survey modules in a number of countries. This review aims, therefore, to take advantage of this timeliness.

Why Focus on the Sexual and Reproductive Health of Young People in the Middle East and North Africa?

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 of 362 million; this proportion is as high as 36 per cent in Syria and Iran, and 38 per cent in Kuwait. Across the region, and particularly in North Africa, the average age at marriage has been rising for both sexes for a number of social and economic reasons. In Tunisia, the average age at marriage is the highest in the region, at 29 for women and 33 for men. This trend of later age at marriage, combined with a global trend in earlier age of puberty onset, has exposed young people to greater health risks associated with increasing premarital sexual activity and rising sexually transmitted infection (STI) rates, including HIV, in the region. This risk is heightened by young people's lack of information about their sexual and reproductive health, and lack of access to services. Educational levels have also risen rapidly, which, together with greater exposure to the norms of global culture, often create rifts between generations, particularly as social networks become more fragmented with greater urbanization and rapid social change. This generation gap deprives young people of the counselling and support they need from adults to help them face these risks and stay healthy. At the same time, young people's unemployment in this region is the highest in the world: 25.6 per cent of young people ages 15–24 are actively searching for work[3] owing to the 'youth bulge' in the population because of past fertility rates. This situation stifles opportunities to improve standards of living for the broadening cohorts of educated young people and creates widespread frustration, resulting in multiple negative consequences both for young people themselves and for their societies.

Despite these trends and considerable evidence of unmet needs among youth, both the literature reviewed for this document and the views of experts interviewed confirm that that there has been a lack of sufficient policy attention to the needs of this group in the region. This policy silence is, in turn, reflected in inadequate services and lack of information for married and unmarried young people alike. Across the region, young people report that they have insufficient access to information about their own development, including their sexual and reproductive health (SRH), whether from parents, teachers or health services. Parents often feel ill equipped to address the information needs of their sons and daughters, even though there is some evidence that they may be young people's preferred source of information.[4] Health and life skills education curricula that include SRH topics are rare and, where they do exist, relevant sections of the curriculum are frequently skipped over by teachers unprepared or embarrassed to teach them and are rarely assessed. Government health services create neither appropriate channels for addressing the special needs of this age group nor a climate in which young people, and particularly unmarried young people, are welcome. Private health services and pharmacies are often

therefore the place of first recourse, although only for those who can afford them and are prepared to face the risk of stigma.

This lack of policy commitment to protect the reproductive and sexual health of young people exists despite the fact that the Arab countries and Iran are parties to the Convention on the Rights of the Child, which enshrined State obligation to provide information and services that young people need to be healthy. However, singling out sexual and reproductive health for attention by no means ignores the imperative of addressing the needs of young people in their entirety; like people of any other age, young people 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 started. Media characterization of youth from 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. Egyptian social scientist Sahar El Tawila distinguishes between the 'deviant' paradigm of youth prevalent in the region, with its negative expectations of youth, and the new development approach recognizing young people's strengths and potential.[5]

The Arab Human Development Report of 2002 appropriately stresses the key potential contribution of this age group to the future of Arab societies, and consequently notes the loss represented by not dealing with their needs more explicitly. For example, it cites findings from a survey of youth conducted for that report that there is a high desire for emigration among youth. Although the sample for this survey was small, and further in-depth research is needed, it is clear that both economic and social reasons underlie this trend.

This report therefore aims to underline the positive potential of young people as participants in policies affecting the development of their societies. Addressing young people's needs with regard to sexual and reproductive health is vital, but it is only one of the many elements necessary for developing this potential. Moreover, there are many positive aspects of the region's social, religious and cultural values that promote the well-being of this age group, including the social and cultural solidarity across the region, the strength of the family unit, high educational aspirations and, increasingly, widening access to education and communication technologies. Increasing information, improving education and building skills 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.

Contextual Parameters

Economic Context and Poverty: Implications for the Sexual and Reproductive Health of Young People.

A defining feature of the Middle East and North Africa region is the co-existence of affluence with poverty.[6] The region as a whole is also in economic decline. The proportion of those living on less than $2 a day increased from 21 per cent in 1990 to 23 per cent today, amounting to 68 million people.[7] Estimates for the Millennium Development Goals (MDG) also indicate that the percentage of the population of Northern Africa and Western Asia living on less than $1 a day increased from 2.2 per cent of the population in 1990 to 2.7 per cent in 2000. The oil-rich Gulf States have attracted migrant labour from across the region and elsewhere, including male migrants predominantly from Yemen and Pakistan, female migrants predominantly from Sri Lanka and the Philippines, and some family migration from Egypt and Palestine[8] with under-researched implications for sexual and reproductive health in both the sending and receiving countries.

The poor are particularly disadvantaged in terms of sexual and reproductive health, although there is relatively little research exploring these relationships in the region. One study from the 1980s, which investigated the onset of puberty in Tunisia by social class, found that social class (and nutrition) made a substantial difference to age of menarche,[9] with the highest social class (I) having the lowest age, as the following table illustrates:

TABLE 2.1

Age at menarche by social class in Tunisia

Socio-Economic Class	I	II	III	IV
Average Age at Menarche (yrs)	12.30	12.75	13.02	14.12

Source: Nagati et al, 1988

Social class also crosscuts gender disparities in access to education. In Egypt, for example, a national survey of adolescents found that during the 1996–1997 school year, only 76 girls for every 100 boys in the low socio-economic category enrolled, whereas the female-male differential was 94 to 100 in the higher socio-economic groups.[10]

There is also evidence that the poorer, less-educated segments of society are more likely to marry early, have higher fertility, and be forced or pressured into behaviours that are risky in terms of the transmission of sexually transmitted infections, such as commercial

sex work. In some countries, economic decline has adversely affected government expenditure on health and education in the region, even as military expenditure is protected. The prevalent pattern of male-only migration to the Gulf countries and Europe (from Mashreq and Maghreb respectively) has clear implications for young people, including the prolonged absence of male role models, the rise in female-headed households and the increased risk of sexually transmitted infections for men who migrate and for their partners when they return. Economic decline, male migration and increasing educational levels among women have also contributed to a rising labour-force participation of women, increasingly in the public sector in many countries. These and other social trends imply positive changes for women, in terms of greater mobility and access to opportunities, but they also challenge traditional gender norms. They form the backdrop against which young people are reaching maturity.

The Wider Political Context: Implications for Sexual and Reproductive Health.

An analysis of the sexual and reproductive health needs of young people in the Arab countries and Iran cannot fail to address the particular historical and political circumstances of the region. Over the last 25 years, the region has experienced major conflicts and political upheavals, from the Islamic revolution in Iran (1978), the Iran-Iraq war of 1980–1988, Gulf crises and wars in both 1990 and 2003, civil war in Sudan since 1983, civil war in Lebanon (1975–1990), political unrest in both Egypt and Algeria, to the present continuing unrest and lack of political resolution in Palestine and in Iraq. For many years, sanctions with strong socio-economic implications have also been imposed on both Libya and Iraq.

Widespread conflict has resulted in untold numbers of casualties and people with disabilities, as well as broken families and orphans. In Iran, for example, in 1990, after the 8-year war with Iraq, orphans accounted for 7 per cent of all children aged 0–14, amounting to nearly 2 million children who are now young people. This figure is comparable to some of the countries in sub-Saharan Africa ravaged by HIV/AIDS.[11] Destabilisation and disruption of the provision of health and education services is not the only outcome of prolonged conflict. Such conditions often lead to a breakdown in social networks and solidarity, thus undermining some of the main mechanisms that protect young people's health and development, including their sexual and reproductive health. Moreover, the mobility associated with conflict is itself a risk factor for the transmission of sexually transmitted infections including HIV/AIDS. In Sudan, for example, the HIV/AIDS epidemic has largely been driven by civil war in that country. The war-torn south of the country is on one of the main HIV-belts of sub-Saharan Africa, and both widespread poverty and conflict have led to the emergence of a commercial sex industry there. The

persistence of conflict weakens and disrupts government and public health surveillance capacity. Thus, the transmission of infection to soldiers from the north of the country and ultimately their wives remains unchecked.

Sexual violence often increases in the context of armed conflict. After the fall of the Ba'athist regime in Iraq, Human Rights Watch has documented a sharp rise in the incidence of sexual violence against women and young girls in Baghdad, for which the legal system, health services and other services are singularly unprepared. To date, there has been little international assistance to address these concerns.[12]

The effects of conflict or civil unrest on the sexual and reproductive health of young people may be more subtle and difficult to discern. One demographic study in Palestine, for example, found that there was a rise in adolescent fertility at the time of the first *intifada* (or uprising against Israeli occupation) from 1987–1990, a trend associated with a declining age at marriage for girls during that period.[13] While further qualitative research is needed to investigate the reasons for this trend, and implications of the current unrest, the uncertainty and anxiety produced by political conflict may be one factor motivating parents to have their children married early. Palestinian interviewees for this report repeatedly state that the threat of violence, disruption to education and health services, inability to move from place to place, and other consequences of the ongoing conflict there are some of the main impediments to developing programmes to serve youth.

Both the United Nations Development Programme (UNDP) Arab Human Development Report[14] and the more recent World Bank report on governance in the Middle East and North Africa (MENA) region[15] point to the poor quality of institutions, political accountability and governance in the MENA region as a main feature holding back development. The World Bank report goes so far as to suggest that the region loses on average 1 per cent on average GDP growth annually for these reasons. Despite evident demands for greater political participation, citizens of the region remain, to varying degrees, subject to under-representation within political systems that have been slow to reform. This situation applies equally to young people, most of whom do not have channels to participate in policy formation affecting their lives. In most Arab countries the legal voting age is 18, although young people must wait until they are 20 to vote in Tunisia and until 21 in Kuwait, Lebanon, Morocco, Oman and Saudi Arabia.[16] Oman has recently lowered the voting age for women from 30 to 21.[17] Of the three countries in the world that deny both men and women the right to vote, two are in the region (Saudi Arabia and the United Arab Emirates); Bahrain only gave women the vote in 2001 and Kuwait is the most recent country to give women the vote, in 2005.[18]

The demographer Philippe Fargues, in an analysis of the relationship between Arab demographic trends and political trends, has argued that the roots of political violence

in the region relate to the combination of persistent paternalism with both increasing differences in education between generations and greater longevity; the younger generation has the advantage in terms of education, but the older generation still commands greatest authority and is living longer.[19] The ensuing generation gap deprives young people of 'connectedness' to supportive adults – a key protective factor for their health and development.

Social policy in the region remains a contested area given this political context and the competing views over the appropriate role of religion in social policy. In particular, these tensions apply to the field of sexual and reproductive health, given its association with deeply held religious and cultural values. The sexual and reproductive rights of young people and women are of utmost sensitivity. The challenge for the region is to find solutions that are authentic to the region's social and cultural identity, particularly for social problems related to sexual and reproductive health.

The political parameters above also translate into a generalised weakness of civil society across the region that applies particularly to the sexual and reproductive health field for the above reasons. Although a reproductive health movement has evolved since the early 1990s, partly spurred by the hosting of the International Conference on Population and Development in Cairo in 1994, organizations addressing the more controversial and stigmatised issues within this field – such as HIV/AIDS – face numerous constraints. Those brave organizations that do act in this area often do so at some risk and on a very limited scale.

Cultural and Social Context: Risk and Protective Factors for Youth

As the attached Synoptic Table demonstrates (see annex II), the population of the Arab States and Iran is overwhelmingly urban. With the exception of a few states where the proportion of their general population living in urban areas remains under 50 per cent, most countries are more than 50 per cent urban. Much of this urban concentration is a relatively recent phenomenon, however, indicating the rapid pace of social change occurring in the region. Although data is not available to support this hypothesis, it is thought that an even greater proportion of the youth population is likely to be concentrated in urban areas, where educational and employment opportunities are concentrated. Two key problems for young people, as cited in surveys for this report, are the often-crowded living conditions – particularly in slum, shantytown or squatter areas – and the constrained recreational space for young people. In some cases, such as Palestine, these problems are compounded by politically motivated sanctions that limit mobility and gatherings in public spaces. Educational facilities therefore provide a key venue for youth to meet, gather and to conduct activities, yet, as will be discussed below (see section education) these have become

overcrowded with the rapid expansion of educational opportunities and the 'youth bulge' described above over the last several decades.

The Arab States and Iran demonstrate considerable gender disparities in access to education, social opportunities and political participation. Indeed the region ranks next to last (behind sub-Saharan Africa) on UNDP's gender empowerment measure.[20] More than half of Arab women are illiterate. The region also has the lowest rate of female labour-force participation (26 per cent) of any region in the world.[21] Such statistics, however, underestimate the extent of women's participation in the informal sector and do not capture the rapid increase in both education and women's labour-force participation in recent years. For example, in Iran, literacy rates among young girls and women ages 10–24 have doubled from 48 per cent to 92 per cent over the last two decades, owing to the expansion of education generally, but particularly in rural areas.[22]

The increased presence of women both in the work force and in education, particularly in urban areas, has strained traditional gender norms where women's roles were largely confined to the domestic sphere. This frequently prompts defensive reaction on the part of conservative forces to tighten restrictions on women's mobility. These restrictions apply particularly to the case of girls and young women, both married and unmarried, and in turn translate into lack of opportunities to develop; to protect their health; to access education, programmes, services, recreation; and, indeed, to participate in public life.

With urbanization and social change, the structure of households in the region is also in a state of flux. The traditionally dominant extended family form is increasingly giving way to nuclearization, especially in urban areas.[23] Within both extended and nuclear households, however, the region is characterised by strong stratification of roles and authority along the lines of both gender and age. Within extended families, the mother-in-law often plays a key role in household decision-making and, typically, her daughter-in-law is weakest in power until childbearing proceeds and her age advances.[24] Brothers are also disproportionately powerful within the household, and are socialised to see it as their responsibility to defend family honour, especially as it pertains to the social and sexual behaviour of their unmarried sisters.[25]

Interviewees contacted for this study observed that family life in the region is changing because of migration, busy lives and changes in lifestyle brought by the mass media and consumerism. They expressed concern that families are therefore not playing the traditional protective and information-providing roles they once did, and that, as a consequence, young people lack adult role models. While studies reveal that young people would prefer obtaining information about puberty and their health from their parents, parents are often reluctant to provide it. Interestingly, a nationally representative survey of young people and their parents in Egypt found that although 42 per cent of fathers

with adolescent sons aged 10–19 indicate they talked to their sons about pubertal changes, only 7 per cent of boys who reported knowing something about puberty changes learned from their fathers.[26]

Within the public domain, the cultural discourse of shame and honour has key implications for policy and programmes pertaining to the sexual and reproductive health of women and youth. In a context where notions of honour and shame are deeply ingrained, an overt recognition within policy that youth have sexual needs and desires, may be sexually active before marriage, and that married couples experience sexual and reproductive health problems is deeply problematic. While one would hope to look to the public health community to address these difficult issues, as one interviewee articulated it, some public health authorities in the region "subvert public health directives to the arguments of culture." The danger of this tendency is the result of "saving face but not saving lives."[27]

Despite these numerous political and social constraints on the realization of sexual and reproductive health policies and programmes for youth in the region, however, there is nevertheless evidence of considerable ingenuity on the part of young people to communicate, forge relationships and even address some of these controversial topics.[28] In many respects, young people have capitalised the most on globalization and the communications revolution, and are forming new social networks through mobile telephones and the Internet. According to a former minister of information technology in Egypt, most of the Internet users are young.[29] In Egypt, new sites are becoming accessible to young people that allow them to have access to information on issues relating to sexual and reproductive health such as HIV/AIDS and contraception. The establishment of an Arabic language internet site on emergency contraception, for example, has been found to be in significant demand by Internet users, even in countries where emergency contraception is not yet available.[30] Nevertheless, the freedom of information that is actually available in some States of the region is variable, and there are reports of Internet surveillance by the State leading to loss of confidentiality in some settings.[31]

Less emphasised in discussions of the sexual and reproductive health situation of youth in the region are the many **protective elements** intrinsic to the current social context in the region. First and foremost, the strong emphasis on the integrity and strength of the family unit prevailing within social and religious discourses in the region is favourable for the sexual and reproductive health of young people. In particular, a positive relationship with parents has been shown by WHO in an overview of YPSRH studies as very important in protecting young people from SRH risks and other risks such as drug abuse. Similarly, a strong sense of social solidarity in many communities across the region provides young people with a sense of self-worth and identity that is key to protecting their sexual and reproductive health. Moreover, there is some evidence that youth in the region do not suffer from some of the problems reported among young people in other

regions. For example, a nationally representative study of adolescents in Egypt found that only 12.4 per cent of adolescents (12.8 per cent for girls and 12.1 per cent for boys) reported having a negative body image for any reason.[32]

Some aspects of gender roles, while in a state of flux, function positively for young women. For example, the increasingly widespread phenomenon of veiling has attracted both positive and negative attention. Veiling may allow women to have greater access to education and to navigate in previously male-dominated worlds of public employment by reducing familial and social opposition to their studying or working outside the home. Similarly, the predominant model in the region of single-sex schools, particularly at secondary level, has been a facilitating factor for greater access to education for girls.

Having spiritual beliefs and regular religious attendance has been identified by WHO as a protective factor for young people's health and development.[33] Religious values in the region also protect young people's sexual and reproductive health by connecting them with a supportive multi-generational community and by discouraging behaviour that would put them at risk. Islam in particular, as a number of authors have argued, plays a positive role in sexual health in its recognition of the importance of sexual fulfilment for both men and women, independent of procreation.[34] There is a diversity of interpretation of religion across the region, however, and as anthropologist Makhlouf-Obermeyer has argued using case studies of reproductive choice in Iran and Tunisia "Like other religious doctrines, Islam has been used to legitimate conflicting positions on gender and reproductive choice."[35]

Sexual and Reproductive Health Issues

This study covered some of the most relevant factors affecting young people's sexual and reproductive health in the Arab States and Iran, but cannot pretend to be exhaustive. Beginning with a discussion of marriage patterns, this section then discusses maternal mortality, unwanted pregnancy and abortion, reproductive morbidity and infertility, sexually transmitted infections (STI) with an extended discussion of literature and programmes addressing HIV/AIDS, and a brief discussion of substance abuse as it relates to the HIV/AIDS epidemic. The section ends with a discussion of harmful practices and violence against girls and young women.

As mentioned earlier, the knowledge gaps on many issues are notable. For example, there is little data on maternal mortality or reproductive morbidity that disaggregates by the relevant age categories for young people. The brevity of some sections does not signal their lesser importance, but rather lack of information.

Marriage Patterns

When, how and whom young people marry in the region is central to any discussion of the sexual and reproductive health of young people. The universal valuation of marriage compounded by religious and social sanctions against premarital and extramarital sexuality places significant pressure on young people, particularly women, to marry early and start families immediately. A premium is placed on virginity before marriage, particularly that of girls, which is reflected in the traditionally widespread but now waning practice of producing the 'blood-stained' sheet on the wedding night, and in the more modern (but under-researched) practices of medical virginity tests and hymen repair operations.[36] In most countries of the region, it is unusual and frowned upon for women to live alone without a family. Religion plays an important role in the choice of partner for Muslims and Christians alike, both for social and religious reasons and due to legal sanctions against inter-faith marriages. Divorce is generally stigmatised, although this has been abating somewhat in recent years. Contrary to popular perception, divorce rates have been declining in recent years, according to survey data.[37]

While, there is tremendous diversity in marriage patterns in the region (although these remain relatively under-researched), certain general recent trends characterise the whole region. These include:

> A rising age at marriage for both males and females
> Early marriage that is still a problem in pockets of all societies
> A high incidence of consanguineous marriages
> Persistence, but decline, in polygamy in some countries
> Increasing numbers of single women
> A resurgence of forms of non-conventional marriage

The rising age of marriage in the region is a positive sign – particularly for women – in that it is protective against early childbirth and is associated with greater educational and employment opportunities; at the same time the greater period between onset of menarche and marriage is a risk factor for premarital and unprotected sexual activity. Without sufficient information or education, young unmarried people engaging in sexual relations are exposed to significant risks. Moreover, given prevailing social norms, a young single woman in the Arab States and Iran who becomes pregnant due to lack of information about or ability to negotiate use of contraception is placed in a highly difficult and marginalised position and, in extreme cases, may be subject to violence from male family members. Although the increased average age at marriage has been widely documented in population-based surveys across the region, there has been relatively little research on the reasons for this trend.[38] Interviewees and anecdotal evidence point to increased educational opportunities, economic deterioration and the rising cost of housing, as well as the

improved social status of women as possible explanations. In a nationally representative survey of adolescents aged 10–19 in Egypt, when parents were asked about the main problems facing youth, 59 per cent identified buying housing for marriage, 21 per cent replied that youth lacked money and 10 per cent identified problems in furnishing the marital home.[39] Certainly the rise in age at marriage for women is also closely linked to education; the chances of an uneducated woman in the region being married at ages 20–24 are approximately twice those of educated women of the same age.[40] Demographer Hoda Rashad argues that the contribution of changing marriage patterns to the fertility transition in Arab countries is a subject that has received little research attention in comparison to other factors such as contraceptive use.[41]

Statistics are not available to analyze the prevalence of so-called 'arranged marriage' in the region. In Turkey, however, sociologist Belgin Tekce has conducted research on pathways to marriage, and has argued that, in practice, many marriages have elements of both arranged and so-called 'love' marriages.[42] Moreover, within arranged marriage there is a wide continuum between merely facilitating social introductions at one extreme, to active coercion with no scope given for consent of the partners to be married on the other (much less frequent) extreme.

Research is needed on pathways to marriage and on reported (but highly sensitive) phenomena such as forced marriage or marital rape in the Arab States and Iran, and the SRH implications. To our knowledge, such research has not been conducted, although there may be some similarities to the Turkish context. Nevertheless, expectations that women – Muslim and Christian – will marry their first (parallel patrilineal) cousin remain ingrained in many parts of the region. Consanguinity in marriage ranges from a low of 18 per cent in Lebanon to a high of 56 per cent in Sudan,[43] and in seven countries of the region at least 30 per cent of ever-married women ages 15–49, are or were married to their first cousin.[44] As with other observed marriage patterns, research is needed to understand the sexual and reproductive health implications of this phenomenon. While consanguineous marriage is known to be a risk factor for children's health, some observers suggest that in some respects, it may be protective of SRH problems such as domestic violence, given the likelihood of the relatives on both sides of the marriage intervening to mediate any conflicts.

No studies on the SRH implications of polygamy in the region are known to the authors of this review, although most observers believe that it is a very limited and waning phenomenon. According to the information available in our review of CRC and CEDAW Committee country reports, the marriage of up to four wives remains legal in all countries except Tunisia, which outlawed the practice during the Bourguiba period.

A more recent and striking phenomenon is the growing cohort of young women who remain unmarried up until the 30–39 age group. In almost half of Arab countries,

more than 40 per cent of women ages 15–49 have never married and between 7–21 per cent of women in many Arab countries remain never-married by ages 30–39.[45] However, the research base is extremely weak on this trend and its underlying reasons,[46] and little attention has been paid to the health and economic well-being of unmarried women in the region.[47]

Early Marriage

Given the pressure prevailing in the region to initiate childbearing as soon as possible after marriage, early marriage translates into early childbearing, which poses documented health risks to women and their babies. Early marriage and consequent early childbearing is less common in the region than in South Asia or sub-Saharan Africa,[48] although there has been relatively little research in the region on the practice, despite its major implications for sexual and reproductive health. Early marriage is declining with the general trend towards increased age of marriage,[49] but there are still pockets of high prevalence of early marriage within all societies of the region. For example, the median age at marriage is 17.5 years in Oman, 19.5 years in Saudi Arabia and 18.6 years in the United Arab Emirates. It is estimated that across the region, about 1.6 million girls are married before the age of 20 and every year about 900,000 babies are born to teenage mothers (World Bank 2001). In Egypt, a nation-wide survey on adolescents ages 10–19 found a national prevalence of marriage of 11.7 per cent among this age group.[50] Given that marriage below the stipulated minimum age is illegal, however, there may be misreporting concerning this issue.

As Table 2.2 shows, the legal minimum age at marriage for girls in the Arab countries is as low as 15 years in Kuwait, the West Bank and Yemen, and 16 years in Egypt. In Iran, although there was a campaign by reformist parliamentarians to raise the minimum age at marriage to 15 for girls, it was blocked by the Guardian Council.[51] According to one interviewee, there is therefore no minimum age at marriage for girls in Iran. Although in practice the Islamic interpretation of nine years as a minimum age is widely used, under-age marriage is not recorded and no records are kept of the reproductive and sexual health of girls under 15.[52]

One of the few socio-cultural studies in the region of the reasons for early marriage,[53] although from fieldwork in the early 1990s, found that in two villages of Upper Egypt, 44 per cent of girls married before the legal marriage age of 16, 68 per cent before the age of 18 and 81 per cent before the age of 20. There the author found that: "It has been a common practice for a bride-to-be who is under-age (or her family) to declare that she has no birth certificate and present, instead, an age estimation by an accommodating physician."[54] She singled out girls' education as the most important factor in preventing early marriage.

While there are few reliable statistics from the region on links between early marriage and maternal risks, worldwide statistics suggest that these young brides are at very high risk. Early childbearing poses severe health risks to women in the form of maternal mortality, morbidity such as the problem of obstetric fistulae (known to be a problem in Yemen and Sudan particularly), as well as jeopardizing opportunities for education and involvement in community life. Pregnancy-related deaths are the leading cause of mortality for 15- to 19-year-old girls (married and unmarried) worldwide (UNICEF 2001). In a similarly culturally conservative context, recent research in Pakistan has shown that women in low-income areas of Karachi who marry early are at higher risk of reproductive morbidity, including uterine prolapse and pelvic inflammatory disease.[55]

TABLE 2.2

Legal minimum age for females to marry in Iran and the Arab Countries[i]

Puberty	Age 9	Age 15	Age 16	Age 17	Age 18	Age 20	Unlegislated
Iran	Gaza	Kuwait	Egypt	Syria[ii]	Algeria	Libya	Bahrain
Sudan		West Bank		Tunisia	Djibouti[iii]		Oman
		Yemen			Iraq[iv]		Qatar
					Jordan[v]		Saudi Arabia
					Lebanon[vi]		UAE
					Morocco		

i All data, unless otherwise noted, has been retrieved from the Women's Learning Partnership for Rights, Development, and Peace (WLP) website at http://www.learningpartnership.org/legislat/family_law.phtml with information compiled from the Emory Islamic Family Law Project, http://law.emory.edu/IFL/, Data accessed 29 April 2005

ii In Syria, women can be married at 13 with the permission of a judge.

iii UNFPA report on Djibouti acknowledges that the latest Djibouti Family Code legislates the female age of marriage at 18, see http://www.un.org.dj/UNFPA/CP%202003-2007%20DJIBOUTI.pdf, accessed on 15 May 2005

iv Women can get married in Iraq at 15 with parental consent.

v A temporary law in Jordan raised the age of marriage for both girls and boys to 18; this remains a temporary law until it is passed and endorsed by parliament.

vi Lebanon allows marriage at younger ages based on religious affiliation or sect. As described on the Emory Islamic Family Law project, "age of capacity is 18 years for males and 17 for females; scope for judicial discretion on basis of physical maturity and *wali*'s permission from 17 years for males and 9 for females; real puberty or 15/9 with judicial permission for Shi'a; 18/17 or 16/15 with judicial permission for Druze," from http://www.law.emory.edu/IFL/legal/lebanon.htm, accessed 15 May 2005

There have been few initiatives in the region addressing early marriage, and those that have been established are relatively small-scale. For example, the Women's Affairs Centre in Gaza initiated a programme of research and intervention with parents and local *mukhtars* (community leaders), who certify that girls are at the minimum age of marriage,

to educate them about the negative effects of early marriage. Similarly, a small-scale programme in the Moqattam district of Cairo among the families of *zabaleen* (garbage-collectors) has aimed to both raise the income-earning capacity of young girls and to help them to resist early marriage. The programme included rug-making, paper recycling and embroidery projects that provide an alternative to garbage sorting and enhance the skills and income of these girls. To encourage delayed and consensual marriage, a sum of 500 Egyptian pounds is offered to any girl who defers her marriage until age 18 and a Crisis Committee was established to counsel parents who attempt to have their daughters married under the age 18 against their will.[56] An interesting trend in the Gulf countries to encourage men to marry compatriot women is the establishment of marriage funds that help pay dowries and provide housing. Such funds exist in Saudi Arabia, Bahrain, Qatar and the United Arab Emirates.[57]

Diversity of Marriage Patterns

The diversity of marriage patterns in the region has been given some research attention, such as that of temporary marriage in Iran, but recent trends such as the resurgence of *'urfi* (or customary marriage) in Egypt have been scarcely studied and the sexual and reproductive health implications for young people are not known.

Temporary Marriage in Iran

Temporary marriage (or *mut'a*), which was one among several forms of marriage practised in pre-Islamic Arabia, was outlawed in the 7th century by the second caliph, 'Umar,[58] and is therefore forbidden among Sunnis. However, Shi'is continue to consider Umar's command religiously invalid, and that the practice is legitimated by the Qur'an. Iranian anthropologist Shahla Haeri describes the present form of this practice:

> *"Temporary marriage is a form of contract in which a man (married or unmarried) and an unmarried woman (virgin, divorced or widowed) agree, often privately and verbally, to marry each other for a limited period of time, varying anywhere from one hour to ninety-nine years. The couple also agrees on a specific amount of bride price to be given to the woman. Aside from paying the bride-price, a temporary husband is not obliged to provide financial support to his temporary wife…A Shi'i Muslim man is allowed to make several contracts of temporary marriage at the same time, in addition to the four permanent wives legally allowed Muslim men. Women, however, may not marry either temporary or permanently more than one man at a time."* [59]

The practice is most prevalent in Iran although it also occurs in Lebanon among the Shi'ite population there. In Iran, the Shah tacitly disapproved the practice, but some indi-

viduals within the leadership since the Islamic Revolution have actively encouraged it, stimulating widespread debate in Iran.[60] The Iranian President in 1990, for example, issued a number of statements arguing that temporary marriage was a particularly humane solution for young people given social attitudes towards their sexuality. He further endorsed measures to make registration of temporary marriages with mullahs easier:

> *"Nowadays in our society, young people mature at the age of 15, and sexual needs are awakened in them. Our college students are constantly exposed to the opposite sex in the schools, universities, parks, buses, bazaars and the work-place. They are continuously stimulated but have no resource. Who says this is right?"*[61]

However, currently temporary marriage is not condoned by the Iranian state in the form of registration nor by the majority of clergy.[62] Temporary marriage has been reinterpreted in the contemporary context of urbanization, high housing costs and social constraints to premarital sexuality. Experts on reproductive health in Iran report that it is an unusual channel through which young people can engage in sexual relationships but the reproductive health implications of the practice have not been extensively researched. Individuals within temporary marriages are probably at high risk for sexual and reproductive health problems, but because of the questionable legality of these marriages, they cannot benefit from public reproductive health programmes, including the mandatory premarital counselling programme.[63]

Customary ('*Urfi*) Marriage

Anecdotal and journalistic evidence has drawn attention to the resurgence of *'urfi* (or customary) marriage in Egypt. Drawing on the Islamic requirements of only two witnesses and that the betrothal become public knowledge, this practice has been transformed into one in which Egyptian youth are obtaining clandestine marriage certificates without announcing to their families their intentions to marry.[64] Elsewhere, however, it has not been recorded – particularly in countries that do not have large urban populations. In Jordan, there have been recent media reports that it is practised particularly among university students, and in Yemen it occurs very rarely and only if marriage to a non-Yemen is involved.[65] As in the case of temporary marriage in Iran, customary marriage represents a new response of young people to the economic and social impediments to conventional marriage. As Egyptian demographers Rashad and Osman state, it: "…may represent a coping strategy among youth as a compromise to the economic constraints to marriage and the cultural denial of extramarital relations."[66]

Like other forms of non-conventional marriage, much more research is needed to explore its sexual and reproductive health implications for young people.

'Summer Marriages'

A phenomenon with significant repercussions for the sexual and reproductive health of young people is the documented but under-researched pattern whereby Arab tourists from elsewhere in the region become engaged to and marry young Egyptian girls over the summer in return for a significant bride-price. In many cases, these unions end in divorce at summer's end. Thus, any children borne have, until recently, neither been entitled to Egyptian citizenship nor to the associated benefits of free government education and healthcare.[67] Further research is needed both on the prevalence of this practice and whether it is taking place in other countries of the region, such as Morocco and Tunisia, which have significant tourist industries.[68]

Revisions of marriage legislation

A number of countries have introduced revisions to marriage legislation – although these have always been controversial and subject to intense public debate – and their sexual and reproductive health implications have not been researched. Most recently in Morocco, for example, the King authorised a substantial reform of the personal status code in 2003, which was adopted in 2004 after decades of lobbying by women's groups in that country; its provisions include raising the minimum age of marriage to 18 and making it easier for women to obtain a divorce.[69] Similarly, in Jordan, a temporary law issued by Royal Decree (but yet to be ratified by parliament) has also raised the legal minimum age of marriage for both girls and boys to 18 (see Table 2.2 on page 25). There is public discussion about a similar reform in Egypt. Generally speaking, most of the campaigns to revise marriage legislation have as their objectives: 1) making explicit women's right to divorce within Islam, 2) increasing awareness of the options women have in contracts, and 3) raising public debate and awareness about the significance of marriage contracts for women's rights and well-being.[70]

Maternal Mortality

The region including the Arab States but excluding Iran accounts for only 3 per cent of maternal deaths worldwide, but represents 6 per cent of the total world's population. Many of the maternal deaths are concentrated in a few countries – particularly Yemen, Djibouti, Morocco, Egypt[71] and Sudan.[72] Measurement of maternal mortality remains a problem across the region. Only Tunisia and Egypt have conducted national confidential inquiries into maternal deaths, although other countries have addressed maternal mortality through national population-based surveys such as the Demographic and Health Surveys (DHS) and Pan Arab Project for Family Health (PAPFAM) surveys.

Few studies have explicitly explored the question of maternal deaths among young women. Although young women are known to be at higher risk of maternal mortality, they are not likely to account for the greatest proportion of maternal deaths in any given country simply because they are less likely to be married and get pregnant. The Egyptian 2000 study[73] found that, for example, maternal deaths in the 15–19 age group represented 5 per cent of maternal deaths (while that age group represents 11 per cent of the population); the comparable figures for the 20–24 age group were 19 per cent of maternal deaths and 32 per cent of the population.[74]

In Sudan and Yemen – countries with very high maternal mortality – there is evidence that early age at marriage and poor nutrition may be major risk factors for maternal mortality. Anaemia in pregnancy raises the risk of maternal mortality and is high across the region.[75] Results from the Giza study in Egypt illustrate that anaemia is particularly a problem for women under the age of 20: one in four young women in that age group were shown to have serious anaemia.[76] In Egypt overall, high levels of anaemia have been found across all socio-economic classes and among young girls; a nationally representative survey of adolescents found levels of 48 per cent among 10-year-old girls, 55 per cent among 14-year-olds and 33 per cent among 28-year-olds.[77]

The association between induced abortion and maternal mortality is known to be strong internationally, although no data is available to analyze this relationship for the Arab States and Iran.

Unwanted Pregnancy and Abortion

Lack of information about services, fear of side effects and social taboos all contribute to making family planning unavailable to young people.[78] Unmarried young people are unlikely to be able to avail themselves of services and risk stigma in using family planning. Equally, those who marry early often lack knowledge and access to services such as contraception. In Morocco, for example, among married young women ages 15–19, 15 per cent report having an unmet need for family planning.[79] In Oman, fewer than 1 per cent of women are reported to use contraception before their first child, given expectations they will give birth during the first year of marriage.[80] In the five countries where DHS surveys have been conducted (Egypt, Morocco, Yemen, Sudan and Jordan), ever-married women aged 15–19 and 20–24 have significantly lower rates of contraceptive use than all age groups of ever-married women. In Yemen, only 6 per cent of ever-married women aged 15–19 and 15.6 per cent of women aged 20–24 have ever used a modern method of contraception, compared to the figure of 37.7 per cent for all age groups of ever-married women.[81]

The Programme of Action of the International Conference on Population and Development, endorsed by 180 nations, recognises the health risk to women of unsafe induced abortion. Among the Arab countries, only Tunisia has legal abortion on request. Abortion is only legal to save a woman's life in Egypt, Lebanon, Libya, Oman, Syria, the United Arab Emirates and Yemen. It is only legal to preserve the physical health of the woman in Kuwait, Morocco and Saudi Arabia. It is legal for reasons due to the mental health of the woman in Algeria, Iraq and Jordan.[82] In Iran, although until 2005 it was only legal in order to save the mother's life, a recent proposed amendment has permitted abortion during the first four months of pregnancy with the consent of both the husband and the wife, if the life of the mother is in danger, if the baby risks being born with a physical or mental handicap, or if the lives of the parents might be harmed or become unduly difficult as a result of the birth.[83] A recent initiative to legalise abortion in Egypt has been overturned by the Shoura Council, or Upper House of Parliament.[84] Abortion remains a taboo topic in most countries despite the diversity of opinion among Islamic schools in the interpretation of when the ensoulment of the foetus occurs. In Islam, the foetus is considered living but not yet human prior to ensoulment, and therefore abortion is permissible before this stage.[85]

Because of the sensitivity of the topic, the prevalence of self-induced abortion among young people is unknown, with the exception of a few community-based studies. One exceptional community-based study in 1993 in a rural area of Egypt (Sharkiya governorate) found that out of a sample size of 623 respondents, 14 per cent of women had had at least one abortion during their lifetime; the proportion of women with unwanted pregnancies was much larger (40 per cent, but most of these were older women who had completed their child-bearing).[86] Among those women admitted to hospital for complications of abortion as reported in a nationally representative study of Egyptian public sector hospitals in 1996,[87] the mean age was 27.43 years, 4.6 per cent of post-abortion patients were 15–19 years of age, and 14.5 per cent were in the 20–24 age group.[88]

Availability of abortion is known to vary by class, whereby the upper classes have greater recourse to safe medical procedures. Given the prevailing sanctions against premarital sexuality, it would not be surprising to see higher rates of abortion among the unmarried, but there is little evidence to confirm this. At a regional IPPF conference on unsafe abortion in the Arab World in 1992, it was reported that a survey of women who had committed suicide in Algeria (where abortion is only permitted to save the mother's life), found that 30 per cent of them were pregnant and unmarried.[89] In Iran, it is estimated that 100,000 young women resort to illegal induced abortion every year, although there is no valid data available.[90] Similar data is not available to our knowledge for other countries of the region.

Emergency contraception – that is, medication or devices that can prevent pregnancy after unprotected sexual intercourse has occurred – while widespread in other developing regions, has only become available in the Arab world since 2001, when it was registered in Tunisia.[91] It is currently licensed for use in Tunisia, Algeria, Lebanon, Libya, Egypt and Yemen.[92] This method may have significant potential for reducing unintended pregnancy among young people in the region.[93]

Reproductive Morbidity and Infertility

Reproductive Morbidity: Within the international public health field, a preoccupation with mortality has only recently been complemented by increased focus on morbidity and the quality of life. In the Arab States and Iran, some pioneering research on reproductive morbidity has been conducted under the auspices of the Regional Reproductive Health Working Group established in the late 1980s. Their 'Giza study' has raised significant awareness within the region and internationally of the heavy burden of reproductive illness that women bear, that they often suffer silently and that frequently remains undiagnosed. In a household sample of 508 low-income women in the Giza governorate in Egypt, they found that over 50 per cent suffered from a reproductive tract infection, 56 per cent suffered from some form of genital prolapse[94] and 63 per cent suffered from anaemia. Since many of these conditions were associated with parity, the prevalence of such problems was lower among the 14–19 and 20–24 age groups. Nevertheless, 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,[95] while the prevalence of genital prolapse was 24 per cent for 14- to 19-year-olds and 43 per cent for 20- to 24-year-olds.

Despite these excellent micro-level data, however, few population-based studies in the region have been conducted at the national level to assess overall levels of reproductive morbidity, including obstetric (pregnancy-related) and gynaecological morbidity. Although no national, population-based data is available, there is evidence that levels of often-debilitating and highly stigmatizing obstetric morbidity, such as genital prolapse, are high in some countries in the region. In a study conducted by the Egyptian Fertility Care Society in Menoufiaya governorate of Egypt in 1995, sampling 7,000 households, 11.3 per cent of women reported genital prolapse, 6.2 per cent reported vesico-vaginal fistulae,[96] and another 1.3 per cent reported recto-vaginal fistulae. Problems such as vesico-vaginal fistulae and prolapse are reported to be particularly significant in poor, high-fertility countries such as Yemen[97] and Sudan. In both Yemen and Sudan, early marriage and poor nutrition are known to be major risk factors for women developing obstetric fistulae.

Gynaecological morbidity can be divided into three categories: 1) sexually transmitted infections, 2) endogenous infections, and 3) iatrogenic infections (where the infection is produced through the healthcare system).[98] Certainly, the Giza study pointed to the

absence or inadequacy of menstrual and genital hygiene as one of the root causes of contamination and infection. These problems are common in low-income settings, where water is scarce. This and other studies have also shown, however, that contaminated medical instruments (in vaginal exams or deliveries) are other risk factors. Inadequate screening of women for RTI infections before providing contraception, especially IUDs (category 3 above) also puts women at risk. These sources of risk need further research given the likelihood that there are high rates of infection in low-income settings in the region.

Infertility: Addressing reproductive morbidity is important to relieve physical suffering and potential mortality, but also to prevent infertility, since some RTIs lead to pelvic inflammatory disease. Given the strong cultural valuation of child-bearing in the region, couples – and particularly women – who are beset by problems of infertility face enormous stigma and suffering. The research base on infertility in the region is relatively low and is confined to epidemiological and medical publications with the exception of a detailed ethnography conducted by the researcher Marcia Inhorn in Alexandria, Egypt and forthcoming work on infertility in Lebanon.[99] Inhorn has shown that women often resort to multiple and costly treatments, with sometimes limited effect, even before men have been fully tested.[100] In a case-control study of 100 infertile women with 90 fertile women sampled from a population of patients consulting Shatby Hospital in Alexandria, 41 per cent of the infertile cases were 20- to 29-years-old and 2 per cent were under 19 years.[101]

Currently, recourse to *in vitro* fertilization is rapidly expanding in certain countries of the region, largely in the private sector. However, few programmes have focused on preventing infertility by addressing RTIs – including STIs – and other risk factors for infertility. While there is no evidence concerning infertility among young married people specifically, the strong emphasis on childbearing soon after marriage means that many young women are likely to be encouraged to seek care for infertility early on. This is another research gap.

Sexually Transmitted Infections (STI)

National-level data is also scarce concerning sexually transmitted infections.[102] Across the region, utilization of STI clinics is extremely stigmatised, particularly for women. Many people suspecting such conditions would self-treat or resort first to pharmacies for advice and treatment, and perhaps then the private sector. Although STIs are reportable conditions in most Arab countries and in Iran, reporting is low. Few studies have been conducted to analyze the incidence of sexually transmitted infections among youth. In Morocco, however, one study found that 40 per cent of STIs recorded were among

young adults between 15 and 29 years old.[103] According to WHO, efforts to strengthen STI surveillance and case management there have resulted in estimates of 600,000 STI infections per year.[104] This would mean that there are approximately 240,000 infections annually among the 15–29 age group in the country. In Djibouti, there are an estimated 25,000 cases of STIs yearly.[105] WHO has given a rough estimate of 10 million people infected by sexually transmitted infections in the region, although it is noted that under-reporting of STIs makes precise measurement difficult. Without correcting for underreporting, for the year 2002, WHO's Eastern Mediterranean Regional Office received reports of 73,000 STIs from five out of the 23 countries it covers, although the breakdown by age is not known.[106]

Relatively few studies have explored the extent of young people's knowledge about STIs, although there is some evidence to suggest that it is very low. For example, in a nationally representative study of adolescents ages 10–19 in Egypt, among 16- to 19-year-olds, 30 per cent of girls and 19.7 per cent of boys did not know any STIs (even HIV/AIDS). For those without schooling, these figures were as high as 37.7 per cent for girls and 31 per cent for boys.[107]

HIV/AIDS

The Arab countries and Iran constitute the region in the world where perhaps the least is known about the dynamics of the HIV/AIDS epidemic. This situation is due to the interrelated problems of widespread public policy denial of the region's epidemic potential, public belief in the region's immunity from the global epidemic, and the sensitivities involved in conducting socio-behavioural research on sexual patterns. Although, overall, the region is currently classed as low prevalence by UNAIDS (at an estimated 0.3 per cent adult prevalence rate or approximately 540,000 adults living with HIV),[108] there are pockets of worryingly high prevalence and fast growth, particularly in Sudan, Djibouti and Libya. UNAIDS estimates that AIDS killed an estimated 28,000 people in the region in 2004, and it seems likely that the proportion of new infections in the 10–24 age group is around 50 per cent, given worldwide patterns of transmission.[109] Clearly, the region faces a critical opportunity now to stem the growth of the epidemic, and the urgency of acting during this limited window of opportunity cannot be underscored more strongly. Experiences of other previously low-prevalence countries, such as Indonesia and India, illustrate that the epidemic can rise very rapidly and unexpectedly.

A 2002 joint World Bank/WHO/UNAIDS publication on HIV/AIDS in the region 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 on data from nine Eastern Mediterranean countries, that the average growth rate of potential GDP

could be reduced by 0.2 to 1.5 per cent per year for the period 2002–2015. 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. Expected costs over the next 25 years could be in the order of 35 per cent of current GDP, even under conservative assumptions.[110] Well-known prevention measures can generate enormous savings. According to a 2003 World Bank study in the MENA Region, "increasing condom use and expanding access to safe needles for IDUs (intravenous drug users) can generate savings equivalent to 20 per cent of today's GDP.[111]

Moreover, we live in an increasingly globally integrated world and, as one interviewee pointed out, if we have one region denying the virus it will have major global implications for prevention efforts internationally, as well as for the development of the HIV/AIDS vaccine. The region is closely integrated and shares a common cultural and religious heritage. National AIDS programme managers recognise the need to work regionally and inter-regionally on issues such as cross-border movements related to conflict, economic migration, sex tourism and trafficking – despite the many political and social sensitivities to addressing these concerns. In their 2004 report on the regional epidemic, UNAIDS notes that there is significant cross-border movement of people living with HIV/AIDS.

Although the region as a whole is considered low-prevalence, the dynamics of the epidemic vary considerably across countries. Some countries, particularly those in complex political emergencies, have generalised epidemics (e.g., Sudan and Djibouti). Others have epidemics mainly related to injecting drug use (e.g., Iran and Libya), affecting mostly males. According to WHO, heterosexual transmission, however, remains the dominant mode of transmission, accounting for 81 per cent of cumulative AIDS cases by 2002.[112] The epidemic is increasingly affecting women, with a little less than half of those living with HIV/AIDS – 250,000 – estimated to be women.

Despite the known vulnerability of young people internationally to the HIV/AIDS epidemic, there is strikingly little information on the HIV/AIDS-related knowledge and behaviour of the group aged 10–24 years in the region (see Synoptic Table on page 163). In some countries, however, there is overwhelming evidence that youth are highly at risk. In Djibouti, for example, the country with the highest AIDS prevalence in the region, among recorded AIDS cases, 3.8 per cent are found among those 15- to 19-years-old, and 43.6 per cent among those 20- to 29-years-old.[113] In a study of 200 male and female young people in and out of school, 71 per cent of those between 15 and 19 years old admitted having sexual relations, and only 39 per cent reported having used a condom (the data is not gender disaggregated, however).[114]

The few studies of sexual behaviour in the region show wide variations in the sexual behaviour of young people. At the low end of the range, in Jordan, a 1994 study showed

that seven per cent of college students admitted to non-marital sex and, in a national study among the general population between ages 15 and 30 in 1999, four per cent admitted the same.[115] In Egypt, in 1996 in a survey among four universities, 26 per cent of the males and three per cent of the females reported having sexual intercourse at least once.[116] Moreover, 52.6 per cent of men sampled in Lebanon were found to be sexually active before the age of 20.[117] Syrian organizations cited another sexual practice that is a major risk factor for STIs and HIV – engaging in anal sex to preserve virginity. All studies on sexual behaviour, however, are likely to be characterised by under-reporting because of the sensitivity of the subject and the difficulty of addressing sexual behaviour through population-based surveys.

Evidence from different countries of the region shows that whereas young people have heard of HIV/AIDS, they do not always have specific knowledge regarding prevention. They may also be unaware that healthy-looking people can be HIV-positive. For example, in a nationally representative survey of adolescents in Egypt, among 16- to 19-year-olds, 65.8 per cent of girls and 76 per cent of boys had heard about HIV/AIDS, but this knowledge was not matched by knowledge of condoms; only 5.1 per cent of girls and 14.3 per cent of boys reported knowledge of condoms. The authors of this survey, however, note that the association between condom use and illicit sexual relationships may lead to under-reporting on this question, particularly by girls.[118] Similarly in Sudan, UNFPA reports that only 12 per cent of young women ages 15–24 are aware that consistent condom use prevents HIV/AIDS.[119]

Relatively little is known about the vulnerability of women in the region to HIV/AIDS due to the lack of studies on this issue and the likelihood of under-reporting of HIV/AIDS cases among women. Based on reported cases made available to WHO for the Eastern Mediterranean region, men continue to be more affected than women; however, women tend to develop AIDS at a younger age (25–29 years) than men (35–39 years), indicating that young women are at a greater risk of HIV compared to men of the same age.[120] Certainly younger women who marry older men (a frequent occurrence in the region)[121] are more at risk. This increased risk is equally true of women who are married to men who are involved in civil conflict (such as in Sudan) or to men who migrate without their families.

Existing surveillance systems in most countries of the region have a number of limitations, including the fact that they rarely reach the most vulnerable people adequately and are less likely to include women and young people (except for those countries where antenatal clinics are included). Because Saudi Arabia and the Gulf countries demand that all foreign workers entering the country take HIV tests, most countries have information on mainly male migrants to the Gulf. As noted earlier, information from STI clinics is likely to be biased toward men and non-youth. Of all the channels for surveillance of

HIV/AIDS, only those for antenatal care users directly reach young women; however, this mode is likely to reach almost exclusively married women. Testing of military recruits is one surveillance channel that reaches youth, but this information is typically not publicly available in the region.

Given the high level of stigma attached to HIV 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 of and the means for young people to seek testing voluntarily are low. According to one interviewee, for example, only one clinic in Yemen offers confidential testing and counselling.[122] This situation endangers large numbers of young people in the region.

Such policy complacency is not warranted, for all of the known risk factors for rapid transmission of HIV/AIDS are known to exist in the region, such as poverty, political conflict and mobility, already discussed above. A commercial sex industry has been documented across the region, although it is often clandestine and therefore difficult to research and intervene in with programmes. Morocco has recently extended its official surveillance programme to include commercial sex workers (CSW) and prisoners; there, a 2.27 per cent HIV prevalence rate was reported among commercial sex workers and 0.8 per cent among prisoners in 2003.[123] Commercial sex – whether formal or informal – is known to involve both men and women in the region. Even in conservative countries such as Yemen, for example, a 2002 Situation Analysis of HIV/AIDS by WHO and UNDP found that increasingly young boys, particularly from poor backgrounds, are reported to be lured into sex with older men by offers of gifts, money or Qat.[124] The same situation analysis, however, revealed scope for intervention among commercial sex workers. After a programme of HIV testing and education of female CSWs in Aden, increased condom use was reported. Elsewhere, in Tunisia, in a study of 300 men aged 20–69, 12.1 per cent reported that their first sexual relations were with another male. Overall 30.9 per cent of the men in the study reported having had male-to-male sexual experiences, more in rural than urban areas, with such relationships beginning in adolescence and being generally transient.[125] Studies such as these on sensitive issues are rare in the region and it is therefore difficult to know how representative they are.

In the more urbanised countries of the region, youth and children who live and work on the street are also particularly at risk. One estimate for Sudan, for example, is that there are 32,000 children living and working on the streets in Khartoum alone.[126] Throughout the region, but particularly in large urban centres with large populations living in poverty, such as Cairo and Tehran, children who live and work on the streets are likely to be extremely vulnerable to sexual abuse, much of which would remain undetected.

Intravenous drug use, although not widespread, is rising and is a concern particularly in both Libya and Iran, which have seen major outbreaks among drug users (mainly young) and prisoners (see the section on substance abuse below). Some countries, such as Egypt, have had problems concerning commercial blood donations that are inadequately screened, as well as some transmission of HIV/AIDS through the healthcare system.

Above all, there is little information about the sexual behaviour of highly vulnerable people, including the young. As the 2002 joint agency report on HIV/AIDS mentioned above states, although there are many socio-behavioural researchers in the region, they often lack sufficient institutional and political support to conduct relevant studies. In some cases, dissemination of findings from the research is restricted for political reasons. In most countries of the region, it is politically difficult if not impossible to conduct research among such socially marginalised people as men who have sex with men, drug addicts or commercial sex workers. Given that homosexuality, illicit drug use and commercial sex work are all illegal across the region, conducting research about these issues risks causing harm to these populations. Thus the knowledge base about risks, behaviours and perceptions among these populations is minimal.

For all the above reasons, there is considerable cause for concern regarding enormous stigma and a high potential for human rights violations surrounding the HIV/AIDS epidemic in the region, particularly for youth and vulnerable populations mentioned above. Deportation of foreigners found to be HIV-positive is a norm across the region. Recent reports from Saudi Arabia reveal that an HIV/AIDS patient was expelled from a private hospital in Jeddah.[127] In Yemen, a survey of healthcare workers found that the majority of respondents believed that AIDS patients should be isolated.[128] A qualitative study of young people's attitudes about HIV/AIDS in Cairo and Qena, Egypt, found that the majority interviewed believed that people with HIV/AIDS should be isolated or imprisoned. Despite its pervasiveness, such stigma has received little research attention and relatively few programmes address stigma and discrimination. One exception is a programme of the International Federation of Red Cross and Red Crescent Societies to address and reduce stigma in Jordan.[129] Increasingly, also, the region has seen the formation of groups of people living with HIV. Sudan has led the way in this trend (see below), and new organizations of the same nature are being formed in Libya[130] and elsewhere in the region. Until now, the exclusion of people living with HIV in the formulation of HIV/AIDS policy in the region has been a considerable deficiency. Worldwide, such inclusion provides substantial benefits in the design, implementation, and oversight of appropriate programmes and policies for HIV/AIDS prevention, voluntary counselling and testing, care, and development of the political will to reduce stigma and discrimination.

The Sudanese Association for Care of People Living with HIV/AIDS

Sudan is exemplary in the region for the creation of a number of associations representing people living with HIV/AIDS (PLWHA). For example, in July 2003 the Sudanese Association for Care of People Living with AIDS was officially registered with the Sudanese government. Its members number 150, of whom 35 are infected with HIV/AIDS (25 are men and 10 women). There are also 130 orphaned children included among its membership. The organization currently has branches in Juba and Al-Obeid, although future branches are planned in Gedarif, Port Sudan, the White Nile and Southern Darfur. The main objectives of the organization are to help PLWHA to cope with their disease, to provide care and support to them and their families, as well as to seek broader change at the level of Sudanese society in terms of attitudes towards PLWHA. To reach these objectives, the Association has carried out public lectures, delivered speeches on State Radio and in prisons, sports clubs and other venues where young and vulnerable populations are concentrated. Its members have participated in numerous workshops and have organised social activities for PLWHA and their families

Source: Personal communication from Hind Hassan, UNDP-Sudan with Iman Mortagy

Generally, across the region, public policy has been slow to respond to the HIV/AIDS epidemic, but there have been laudable efforts on the part of National AIDS Programs to develop innovative programmes in this area, which are effective in reaching young people (see, for example, the sidebar about hotlines below). These are often constrained, however, by denial at higher levels of government and the lack of sustained funding. Nonetheless, certain countries in the region stand out for having the exceptional foresight during early stages of the epidemic to recognise HIV/AIDS as a problem affecting their populations, and galvanizing activity. The Djibouti government was one of the first in the region to acknowledge the HIV/AIDS risk faced by the country, and in May 2003 the President called for active interventions with an inter-sectoral response and created an Executive Secretariat to tackle the epidemic.[131] Similarly, the Sudanese President has described HIV/AIDS as a national priority. In Iran, the President expressed the government's commitment to addressing HIV/AIDS on the World AIDS Day December 2002 and, as shown below, Iran has been one of the most open countries in the region in initiating harm-reduction programmes. In Tunisia, government openness to address questions of reproductive health, including youth reproductive health, has created an environment in which both government bodies and NGOs could take a proactive approach to the epidemic.

Another promising development was the signature of the Cairo Declaration on HIV/AIDS by 90 Muslim and Christian religious leaders in December 2004. The Declaration recognised the threat posed by the HIV/AIDS epidemic and the responsibility to undertake urgent action. Significantly, the declaration affirmed the need to abolish

"all forms of discrimination, isolation, marginalisation and stigmatisation of people living with HIV/AIDS."[132]

Until recently, there were relatively few NGOs active in HIV/AIDS in the region and, in many cases, these were afraid or not willing to work with particularly vulnerable people. Few have worked with men who have sex with men (MSM), for example. One notable early exception is the Association de Lutte Contre le Sida in Morocco, which in 1984 initiated an outreach project with male commercial sex workers in the public parks of Casablanca. Programmes that work with out-of-school youth and children who live and work on the streets who may be vulnerable to sexual exploitation are also rare.

Examples of SRH Hotlines Reaching Youth in the Middle East/North Africa Region

In a cultural context where face-to-face discussion of matters related to sexuality are so sensitive, confidential telephone hotline counselling and information services have shown to be a highly effective and demanded intervention in the Middle East/North Africa region. Given the stigma associated with premarital sexuality, they have also been a key method of reaching young people, as the following examples illustrate.

Egyptian Ministry of Health AIDS Hotline

In 1996, the National AIDS Program of the Egyptian Ministry of Health opened a telephone AIDS Hotline entitled 'Ask About Aids' (funded by the Ford Foundation). The service is staffed by male and female HIV/AIDS counsellors who are employees of the Ministry of Health and who undertook training in confidential HIV/AIDS counselling. It is advertised in public buses, in metro stations and in newspapers, and the service has received calls from every governorate of Egypt, and even Egyptians living in the Gulf states and Europe. Within a year of its inception, the hotline was receiving an average of 1,000 calls per month, although by 2001 this figure had dropped to 5,169 calls for the year. Most of the callers to the hotline are young and unmarried and they are able to raise questions concerning premarital sex, condom use, homosexuality or drug use as well as basic questions pertaining to sex education. In 2001, 64 per cent of the callers were single, 32 per cent married (with data being unavailable concerning the remaining 4 per cent), and 72 per cent were between the ages of 13 and 25. Calls from women initially represented only 20 per cent on average of calls, but rose to 25 per cent by 2001. Staff at the hotline report, however, that at times they can hear a mother's voice prompting her son to pose certain questions. Callers can choose to speak to a man or a woman. Counsellors' responses to questions are monitored by a counselling trainer to ensure that they are factually correct, non-judgmental and provide full information. There are plans to extend the hotline to other areas of Egypt. The service is completely confidential and anonymous and provides both information and counselling. Respondents request permission to ask the caller basic information about their sex, age and level of education to monitor the demand on the hotline.

Source: Dr. Nasr Mohamed, Egyptian Ministry of Health and Population, personal communication; Gawhary 1998; UNAIDS 2000; Ministry of Health and Population Report on Hotline for 1 January 2001 to 31 December 2001.

continued

(Examples of SRH Hotlines, continued)

Palestinian Family Planning Association (PFPA) Hotline

Perceiving the enormous need for information about sexual and reproductive health among Palestinian young people, the PFPA began a hotline in both Gaza and the West Bank in 1999 (funded by the Ford Foundation). Telephone communication is particularly important in Palestine because of political restrictions on mobility. The hotline aims to reduce the level of anxiety and distress among young people in relation to their SRH through providing appropriate, credible and timely advice. Counsellors are given training to handle a range of SRH problems and to provide appropriate referral for specialised care where necessary. The service is operated on a 6-day-a-week basis from 8:30AM to 5:30PM. It has become increasingly widely known through newspaper advertising and word of mouth, and has attracted calls from all over Gaza and even from Arabs within Israel. For the period January–June 2003, the service received over 800 calls. Staff of the PFPA report that a variety of needs are met by the service. The service has received messages of gratitude from young men and men who had called before marriage for help regarding the first night. The PFPA has learned that this form of counselling is socially acceptable and communities have encouraged them to continue this initiative.

Source: Dr. Izzat Ayoub, Palestinian Family Planning Association, interview July 2003.

Lebanese Family Planning Association (LFPA) Hotline

The Lebanese Family Planning Association (with funding from the European Union) initiated a hotline to provide confidential counselling regarding sexual and reproductive health (SRH), because of recent studies in Lebanon that showed that people are either too inhibited or lack the funds to visit a SRH specialist. The hotline guarantees anonymity. The callers can be called back only at their request. People are given advice and information and may be referred to an SRH centre. In 2001, the hotline received 375 calls but the number dropped in 2002 to 225 callers (mainly attributed to the lack of a dedicated line and the fact that the hotline was a cellular number and therefore expensive to telephone; the LFPA has now established a dedicated landline and expects the numbers to rise). The hotline was announced in major Lebanese newspapers. According to staff at the LFPA, most of the callers have questions about AIDS, STIs, sex education and contraceptive use, and they often demonstrate lack of information on the most basic issues of SRH (including the menstrual cycle). Ninety per cent of the calls concerning HIV/AIDS are made by young people ages 18–28 – most aged 19–28 – and the rest being women in their 30s and 40s. Sixty per cent of the calls are about AIDS with testing being a main question of concern. The service was able to persuade many people who were in need of treatment to consult a health service. The LFPA will soon open two voluntary counselling and testing centres for youth, including a resource centre for awareness-raising. They expect to be able to refer callers to this service.

Source: Panorama 1997:4; Lebanese Family Planning Association, (personal communication with Rana Jawad)

continued

(Examples of SRH Hotlines, continued)

Other countries in the region are experimenting with hot-lines on sexual and reproductive health. The Ministry of Health in Jordan, in collaboration with Family Health International in Jordan, for example, has started an AIDS Hotline, although to date the number of callers has been relatively low. A similar initiative is underway in Oman in collaboration with UNICEF. The relatively low number of callers to the hotlines in Jordan and Lebanon suggests the need to invest heavily in marketing, particularly at the start-up stage, in order to generate enough demand to justify the investment and to reassure potential callers of the confidentiality of the service. Experience with hotlines also points to the need to ensure sufficient infrastructure capacity so that callers are not discouraged by busy signals. In all cases, special efforts need to be made to reach potential female callers who also face strong social stigma in using such services and to ensure that there are female counsellors available.

Substance Abuse

Research on substance abuse in the region is particularly difficult given current legal, religious and social prohibitions. It is known that both the cultivation and transit of illicit drugs occurs in the region.[133] According to the United Nations Office for Drug Control and Crime Prevention (UNODC), however, data on utilization of drugs in the region are scarce and there have been no regional assessments. UNODC produces region 'Rapid Assessments' focusing on each country, and they have completed three assessments to date (Egypt, Lebanon and Jordan). Further assessments currently planned are for Syria, Libya and Algeria. Some information on drug use is available in relation to the HIV/AIDS epidemic. It is known, for example, that in Libya, intravenous drug use (IDU) is the main transmission route for HIV/AIDS.[134] The percent of all HIV infections represented by IDUs ranges from 60 per cent in Bahrain, to 5 per cent in Oman.[135] In Egypt, drug abuse is considered as a grave social policy issue affecting particularly young people.[136]

The frequency of substance abuse among young people is also unknown in most countries except Iran, which is one of few countries to initiate harm-reduction programmes, including methadone, needle exchange, and bleach. Proximity to the drug-producing countries of Afghanistan and Pakistan, drug trafficking across borders and intravenous drug use have posed particular problems in Iran. There it is estimated that there are 1.2–1.6 million drug users, of whom 12–16 per cent are intravenous drug users (IDU), and 10 per cent start before they are 15-years-old.[137] According to the Head of the Youth National Organization Mir Bakri, 2.5 per cent of youth are addicted.[138] Moreover, many of the prisoners in Iran are serving sentences for drug use and many are young; Iran Prisons Institutions report that of the 170,000 prisoners in Iran, most are imprisoned for drug dealing or use and most are under 30.[139] The government, however, has taken a proactive and exemplary approach to the problem by initiating some innovative IDU harm-reduction programmes in prisons.

Harmful Practices and Violence Against Women/Young People

Female Genital Mutilation/Cutting

Female Genital Mutilation (FGM/C) is also called female circumcision (rather misleadingly given the false association with much more minor male circumcision), or – a term favoured more in recent years – female genital cutting (FGC). This refers to several different traditional practices that involve the cutting or mutilation of female genitals.[140] Although several justifications are put forward for the maintenance of the practice, it is linked primarily to implicit or explicit efforts to control women's sexuality, linking women's marriageability to their reduced sexual desire and, in the most extreme forms of the practice, to their ability to be penetrated vaginally. The UN treaty bodies and the entire UN system now consider FGC a 'harmful traditional practice' that is a violation of girls' human rights. A joint WHO/UNICEF/UNFPA (1997) statement estimated that, globally, roughly two million girls are at risk of being subjected to FGM/C annually, and that 130 million girls and women have been cut or mutilated.

Within the region reviewed here, FGM/C is practised in only four countries, namely Egypt, Sudan, Yemen and Djibouti (see Table 2.3 on page 43). Sudan has had the earliest nationally representative, population-based data (DHS 1990) on the practice where it is known to be generalised (as of 2000 over 89 per cent of ever-married women ages 15–49 were affected) and of a severe form. In Egypt, the DHS 1995 provided the first information on the national extent of the practice, which shows now over 97 per cent of women aged 15–49 affected (DHS 2000), although of a less severe form. In Egypt it is practised among both Muslims and Copts (Christians). In Yemen, the practice is regionally concentrated in the coastal areas of Hodeidah, Hadramout and Al-Mahara, although the national prevalence rate is 23 per cent. While in Egypt and Yemen the practice is mainly conducted pre-puberty, in Yemen it is frequently also performed on young infants. In Djibouti, there have been no national population-based studies, although hospital-based data reveal a prevalence rate of 97 per cent, with diversity in both prevalence and severity across ethnic groups.[141]

The four countries in the region where FGM/C is practised have all seen increased public debate and efforts to eradicate the practice in recent years. In Egypt, a small-scale campaign has been underway to eradicate the practice since the 1950s, most notably by the Cairo Family Planning Association. In the 1990s, largely prompted by the adverse publicity on the practice during the International Conference on Population and Development (ICPD) in Cairo in 1994 and the emergence of DHS data in 1995, a more broad-based NGO movement emerged to counter the practice. Most recently, the issue has been taken up strongly by the government (particularly by the National Council for Childhood and Motherhood). In Sudan, activities by NGOs and university-based insti-

tutions have been underway for several decades. At a conference held in Khartoum in 2003, the Minister of Health issued a statement committing the government to the eradication of the practice both through legal mechanisms and awareness programmes. In Yemen, the Ministry of Health has commissioned studies and actively engaged in the campaign against FGM/C.[142] A project in Yemen on FGM/C sponsored by the Pacific Institute of Women's Health has shown direct impact on the practice through partnerships with NGOs.[143]

TABLE 2.3

Prevalence of female circumcision among ever-married women in selected Arab Countries

Country	Egypt	Sudan	Yemen	Djibouti
Prevalence 15–49 women ever married (%)	97.3	89.2	22.6	97
Prevalence 15–19 (%)	99.1	86.8	19.3	
Prevalence 20–24 (%)	97.4	89.7	22.2	
Source:	DHS 2000	DHS 1990	DHS 1997	Maternity-based study reported by M.C. Mutanda interview 2003

Given this heightened public awareness about FGM/C and recent political commitment to eradicating the practice, it is particularly important to conduct rigorous evaluations of existing initiatives and programmes to expand the knowledge base about effective interventions in the regional and sub-regional context.

'Honour' Killings

So-called 'honour' killings are the murder by relatives of girls and women who are deemed to have transgressed deeply held sexual mores, and thus besmirched the 'honour' of the family. As family law expert Lama Abu Odeh has expressed: "A paradigmatic example of a crime of honour is the killing of a woman by her father or brother for engaging in, or being suspected of engaging in, sexual practices before or outside marriage."[144] Anecdotal evidence suggests that honour killings occur across the region, although the research base is weak on the practice, both because of the sensitivity of conducting

research and widespread under-reporting. Therefore, no figures are available on overall regional prevalence of this practice. Certain countries where efforts to document the practice have been rigorous have been given the most attention, although this is not to suggest that the prevalence of the phenomenon is highest there.[145]

Prevention efforts have by and large concentrated on raising awareness about the problem, challenging laws and judicial practices that implicitly legitimise or sanction these crimes, enforcing laws which mitigate honour killing as well as working with the police and units of the Ministries of Interior to sensitise their staff to this issue.[146] Cultural and political barriers to addressing this issue persist. In Jordan, one of the most active on this issue, a Family Protection Department has been established in the police force, but an amendment to the penal code that would increase the sentence for perpetrators has twice been rejected.

Other Forms of Violence

Violence Against Women

NGOs and women's groups have led the public discussion on violence against women in the region, starting a network of counselling centres in the Maghreb countries, the West Bank and Gaza and Jordan. In some cases, their advocacy has succeeded in encouraging governments to address the issue, such as in Morocco,[147] but in most cases activities are restricted to NGOs and are small-scale. Women's NGOs in the region have established centres for victims of violence (such as the Nadim Centre in Egypt), and telephone hot-lines such as that of the Women's Centre for Legal Aid and Counselling in Palestine and 'Centres d'écoute' in the Maghreb countries. These efforts have helped to document cases of violence, incest and sexual abuse against women, children and young people across the region. Yet, to date, no government policies to our knowledge have explicitly addressed this sensitive issue, other than through some revision of legal codes and practice. Therefore, efforts to prevent the practice have been largely small-scale.

Moreover, few population-based studies are available to assess the prevalence of violence. Official figures are constrained by under-reporting as well as debates over culturally acceptable definitions of violence. The absence of data makes it difficult to determine the frequency of violence against young people in the 10–24 age group.

One of the few sources of nationally representative population-based data on attitudes and the incidence of violence against women is the Egyptian Demographic and Health Survey published in 1995. It found that 86 per cent of ever married women reported agreeing that men are sometimes justified in beating their wives; agreement was somewhat higher among younger women ages 15–19 (at 92.3 per cent). Among that age

group, 69.9 per cent said violence was justified if the wife refuses sex, 76.4 per cent if the wife answers back and 64 per cent if the wife talks to other men. One out of three Egyptian ever-married women reported having been beaten once since marriage, mainly by their husband. This figure is slightly lower (at 28.7 per cent) for the 15–19 age group and is higher in rural areas. Higher education was found to be a main protective factor against violence against women in this survey.

Another nationally representative population-based survey from Egypt among young people aged 10–19 found that 21.5 per cent of adolescents reported having observed violence between their parents 'always or sometimes'.[148]

A critical need in this area is for more in-depth research investigating attitudes towards violence by both men and women, young and old. For example, two separate studies among Palestinian women (sample size of 550) and men (sample size of 600)[149] found that among women, slightly over half disapproved of violence against wives under any circumstances. However, 13–69 per cent of the same women agreed that wife beating is justified under certain instances, particularly where the wife has been sexually unfaithful. The proportion of men who disapproved of violence in general was lower at 41 per cent, but 71 per cent expressed some approval of violence against the wife when she has been unfaithful. Such studies reveal deep-seated contradictions in attitudes to violence, which merit further in-depth research. Future research on this topic should employ qualitative as well as quantitative methods and highlight the need to understand culturally specific notions of violence and violations to bodily integrity. Once these notions are understood, surveys using culturally appropriate frameworks could assess prevalence and identify risk factors.

Do Services and Programmes Address Young People's SRH Needs?

This study found a notable lack of information about the coverage, quality, and effectiveness of health services and SRH education available to young people. Among experts, the general consensus is that both health services and educational programmes are woefully inadequate in response to the level of need; however, hard data is lacking. Throughout this section, sidebars highlight programme examples that seem to be successful in this region and worthy of replication. However, in most cases the evaluation data was insufficient to comment on whether a model that seems promising is actually effective.

The section mainly discusses health services and SRH education, reflecting the programmes on which there is the most information. Information on youth centres and media YPSRH programmes is summarised briefly as well.

Health Services

Public health services are of varying quality but generally available and accessible in the region, with the exception of countries with poorer access due to mountainous topography or poverty (such as Morocco, Sudan, Djibouti and Yemen). Models of healthcare across the region tend to be highly medicalised, however; countries such as Iran that have put strong emphasis on developing community-based health outreach programmes are the exception. This situation is particularly the case for elements of reproductive healthcare such as childbirth. Unlike other regions, the Middle East and North Africa region has not seen an active women's health movement lobbying for changes in childbirth medical practices, for example, to make them more sensitive to women's needs and preferences.[150]

For young people with sexual and reproductive health concerns, public health services in the region provide few services and do not cater specifically to their needs. Where services are available, they may not always be conveniently located or staffed. Furthermore, there are significant cultural barriers to young women and men using them. Few government services are equipped to counsel and answer young people's questions pertaining to their sexual and reproductive health – despite the known stigma and psychological suffering associated with SRH problems – and there is often little scope for confidentiality. In some cases, unmarried young people report being distrustful of public services, such as in Morocco[151] and in Syria where it has been reported that health service providers are sometimes hostile or judgmental.[152] Interestingly, Iran has issued a directive to primary healthcare service delivery points not to enquire about the marital status of clients requesting contraceptive services, which has led to a 20 per cent increase in demand for condoms.[153]

Given the barriers young people often face accessing government health services, the private sector is often the first port of call and goes some way towards filling this gap, but is accessible only to those who can pay.[154] The private sector, however, tends to be poorly regulated, more concentrated in urban than rural areas and does little in terms of preventive health education. In many cases, NGOs have filled a significant gap, although their programmes are often of limited scale. In Palestine, for example, the Union of Palestinian Medical Relief Committees was one of the first institutions to begin a women's health programme catering to the specific problems of young married and unmarried women. And throughout the region, the network of Family Planning Associations linked to the International Planned Parenthood Federation has had a special focus on young people.

Premarital Counselling in Iran

The evolution of population policy since the Islamic Revolution of 1978 from explicit pro-natalism to an active policy that recognises the importance of reproductive health provides a fascinating case study on the flexibility of interpretation of reproductive choice within the context of Islam. As sociologist Homa Hoodfar has argued, "To the credit of the Islamic Republic, the population policy demonstrates a sophisticated understanding of the complex social, economic, and political variables that influence fertility behaviour in any society."[155] Moreover, while the population policy endorsed in Iran since the late 1980s was motivated by a perceived demographic imperative of reducing population growth, at the same time it recognises women's central role as decision makers. It has thus presented new opportunities for women activists to improve women's rights within the Islamic context.[156] Thus, Iran's integration of family planning within a broader approach to reproductive health and rights actually pre-dated the ICPD in 1994.

A central component of Iran's population policy is a programme of premarital counselling and training for all couples that intend to marry. Attendance at government-sponsored sessions for both members of the couple is compulsory and linked to the issuing of marriage licenses. This programme is consistent with a broader policy of encouraging male involvement in family planning; indeed, Iran operates the only condom factory in the Middle East.[157] The premarital training consists of a half-day course on sexual and reproductive health issues and, in addition, each couple must undergo medical tests for syphilis infection and drug use.[158] The Ministry of Health and Medical Education administers 500 counselling centres around the country, as well as many mobile teams in rural areas.[159] Because the limits on the age at marriage are low in Iran (see section on early marriage above), counsellors sometimes find themselves preparing girls and boys as young as 10–15 for marriage.

One of the materials used in the premarital counselling is a government-produced booklet entitled *The Message of Happiness for Young Couples*. As one source described it, this booklet "emphasizes love, caring and spiritual connection in the sexual relationship, and advises a young man to ensure the consent and readiness of the women before having sex. The text goes so far as to explain physiological responses to sexual arousal, and contains very explicit information on the enjoyment of each partner, sexual foreplay, hygiene, STI prevention and the reality that AIDS can happen to anyone…"[160]

The framing of premarital counselling within Islamic teachings in Iran makes it culturally acceptable. Indeed, this intervention is likely to be effective across the region, and an evaluation of the lessons learned in this programme would be invaluable. While some countries, such as Jordan, have developed a manual for similar premarital counselling; only Iran has generalised this practice and made it compulsory. Another Muslim country, Indonesia, has also made registration of marriage contingent upon the production of evidence that the marriage is neither forced nor polygamous, and on attendance at a session on reproductive health.[161]

Sources: Hoodfar 1996; Roudi-Fahimi 2002; Population Action International 2002

Educational Programmes

The Education Sector

Respondents to the survey conducted for this report frequently cited the inappropriateness of educational curricula and pedagogical methods to meet young people's needs in many areas. The emphasis on rote learning for exams rather than critical thinking – common throughout the region – often fails to prepare young people for difficult judgments and decision making or to instil 'life skills'.

Although educational opportunities have expanded rapidly over the last several decades, there is evidence of declining quality and overcrowding. In Egypt, for example, a study by the Population Council found that although the class size is limited officially to 36, only 20 per cent of schools nationally comply with this law. In an effort to reduce class size, 30 per cent of schools there have implemented double shifts, with adverse consequences for girls' education; the dropout rate was five to six times greater among girls who attend double-shift schools.[162] As a regional report by the UK Department for International Development found: "the quality of educational provision is low, despite a relatively high (but decreasing) level of funding, and there is an increasing mismatch between the output of education systems and labour market demand."[163] This deterioration in funding is not lost on youth. As one young person aptly stated to a team conducting a KAP survey in Djibouti:

> *"Les profs sont découragés par les arriérés de leurs salaires, alors comment voulez-vous qu'ils nous enseignent?". (The teachers are discouraged by the arrears in salary payments, so how do you expect them to teach us?)* [164]

On the other hand, in terms of performance there is evidence that girls are performing better than boys at high school level.[165] Moreover, as is shown in the Synoptic Table (see page 163), several countries (such as Bahrain, Kuwait, Libya, Qatar, Sudan and the UAE) have higher secondary enrolment ratios for girls than boys. Although reasons for these discrepancies need further research, particularly in the Gulf countries, in the poorer countries, the likelihood is that boys drop out more than girls to work in the formal sector.

Young People's Knowledge about SRH and SRH Educational Programmes

Both qualitative and population-based research in the region indicate that young people's knowledge about their own physiology and about sexuality and reproduction is highly limited. There is some comparative data (albeit from non-comparable age groups) from the existing youth and development surveys cited above, for example, about young peo-

ple's knowledge about puberty changes. It must be taken into account, however, that responses to questions about knowledge of sensitive issues relating to puberty – and particularly puberty changes of the opposite sex – are likely to be subject to reporting bias. This said, however, as Table 2.4 below shows, there is evidence that a significant proportion of young people in the region lack knowledge about puberty changes, particularly about the opposite sex. These data also confirm that young people have few legitimate sources of correct information about their own physiology, and mainly learned about puberty changes by themselves.

TABLE 2.4

Young people's knowledge about puberty changes as reported in population-based surveys

Country	Egypt	Jordan	Palestine	Syria	Algeria
Age group	10–19	10–24	12–19	15–24	15–24
% females who do not know about puberty changes	30%	In females: 11.6% In males: 17%	In females: 5.3% In males: 10.3%	In females: 9.7%	N/A
% males who do not know about puberty changes	55%	In females: 24.6% In males: 12.6%	In females: 28.9% In males: 14.1%	In males: 9.5%	N/A
% females who learned by self about puberty changes	60%	N/A	N/A	59.3%	73.3%
% males who learned by self about puberty changes	69%	N/A	N/A	76.8%	95%
Source (see below)	A	B	C	D	E

Source:

A. Tawila et al. 1999

B. Salem-Pickartz, Josi (2002) *Jordanian Youth: Their Lives and Views,* UNICEF, Jordan

C. PCBS 2004 *Palestinian Central Bureau of Statistics Youth Survey,* 2003, Main Findings

D. Arab League PAPFAM Youth Module

E. Arab League PAPFAM Youth Module

As noted earlier, there have been few formal attempts at introducing health education with SRH components in school curricula, and where these do exist there is some evidence that teachers skip the sensitive sections and thus some initiatives in the region have focused on training teachers.[166] Only Tunisia, Morocco, Algeria, Jordan and, more recently, Bahrain have a human reproduction/health education module in their national school curricula.[167] Iran has also introduced measures to develop an age-appropriate reproductive health education curriculum. In 1994, they created a Youth Office within the Family Health Department to work with schools, teachers, and parents on the medical and social consequences of youth sexuality.[168] In 2001, the Ministry of Education made reproductive health education part of the (assessed) school curriculum for senior high school students.[169] Books for parents, and married and unmarried youth are being tested in three different provinces.

Using the formal educational structures to help parents address SRH issues with their sons and daughters may be a particularly fruitful approach in the region. For example, with the support of UNFPA and the Family Planning Association of Iran, the education ministry is also developing and testing educational materials to help parents communicate with their children.[170] Youth surveys across the region have indicated reluctance among young people to seek such information from their parents, on the premise that this might lead their parents to assume they are engaged in illicit sexual activity. Interesting contradictions emerge in some studies; for example, in the nationally representative study of adolescents in Egypt[171] only 7 per cent of adolescent boys reported learning about pubertal changes from their fathers, while 42 per cent of the same fathers indicated that they had discussed such changes with their sons. Interviews with knowledgeable experts in both Yemen and Syria indicated that a perceived risk factor for YPSRH is the fact that parents are busy and have less time to spend with their sons and daughters.

Few programmes or interventions in the Arab States and Iran focus on out-of-school youth. In Egypt, a nationally representative study of adolescents found that of girls ages 10—19, 45.5 per cent had never attended school. Of those surveyed at the current age of 17, 11.7 per cent had dropped out before the age of 11, 21.1 per cent dropped out before the age of 14 and 38 per cent dropped out before the age of 17.[172] Nevertheless, the same survey reveals some improvement in dropout rates with younger cohorts.

The following sidebar provides the example of a programme in Egypt to develop the life skills of young girls who are out-of-school. In the programme, reproductive health issues are included within a broader programme of building the competencies and confidence of young girls.

'New Horizons': A Life Skills Programme for Out-of-School Girls

The Centre for Development and Population Activities (CEDPA) began a programme in 1997 targeting girls in the age group 12–20 years who are out of school and therefore have a higher likelihood of illiteracy. The programme was designed by curriculum specialists and local NGOs and consists of 100 carefully structured sessions to provide information about life skills to girls. The life skills component of the curriculum includes topics such as identity, family and community; girls' rights and duties; maternal health, nutrition and the environment. The reproductive health component addresses adolescence, violence, marriage, and pregnancy. Local facilitators use simple materials – posters, songs, and drama to convey ideas and generate discussion.

Nearly 60,000 girls have benefited from the programme, evaluations have shown that gender relations have begun to change in communities benefiting from the programme, and primary enrolment rates of girls have risen. Girls participating in the programme showed greater knowledge of reproductive health, from very poor knowledge at baseline (for example, less than 10 per cent could name three modes of HIV transmission). At the end of the programme, they also demonstrated increased self-awareness and confidence.

CEDPA subsequently started a New Visions Programme aiming to reach boys ages 12–20 in recognition of boys' need for information but also to engage males in promoting gender equality.

Sources: CEDPA draft documents evaluating the above programme provided at interview of CEDPA-Cairo staff with Iman Mortagy, Cairo, August 2003.

Respondents to the survey conducted for this review frequently cited university students as being particularly vulnerable in terms of sexual and reproductive health. For example, a doctor running an SRH clinic in Tunisia reports that young girls coming from rural areas to study at university in Tunis – where they are isolated from the social support of their families – are particularly at risk of unwanted pregnancy and sexually transmitted diseases if they form relationships with urban men.[173] Yet, other than in Tunisia, where an innovative project has started in female dormitories of Tunisian universities (see next page), few university programmes specifically addressing sexual and reproductive health issues exist in the region.

Youth Centres

In many countries of the region, ministries of youth have established youth centres, yet many of these are weak institutionally and lack sustained funding. There is also evidence from the region that they are often not located in geographic areas that are conducive to regular female attendance. As a result, their main beneficiaries tend to be young men rather than young women. These trends parallel the international evidence on the weaknesses of this programme model. Some youth centres in the Arab States and Iran have

ISHRAQ: An Intervention Research Project with Out-of-Schools Girls Aged 13–15

Building upon the curriculum developed by CEDPA (above) as well as a Caritas literacy-training tool entitled *Learn to be Free,* the Population Council and Save the Children-USA in Cairo initiated an intervention and impact study for out-of-schools girls aged 13–15 in Minya, Egypt, in 2001. The objectives of the programme, called *Ishraq* (or enlightenment) were to increase the mobility of girls within their community, provide expanded opportunities to them, and enhance their participation by building their skills and knowledge. In this part of Upper Egypt, adolescent girls are conspicuously absent from public spaces; recent research has indicated that these girls often have low self-esteem, considering themselves 'ignorant' and 'doing nothing' with their lives. As in other countries, being out of school is associated with many other disadvantages. As of April 2002, nearly 200 girls were enrolled in these Ishraq classes, which in the first stage include literacy, numeracy, life skills, and reproductive health information, drawing on the above curricula. The programme will also explore whether organised sports programmes, combined with community service activities, add to the impact of standard literacy and awareness-raising interventions. This programme stands out for its close work with other family and community members, including elder brothers, parents, and community leaders. While such involvement is now a standard recommendation, too few programmes follow it. A longitudinal study was designed to monitor changes in the girls' lives and in community norms. Qualitative and quantitative data is collected at each stage of the project. An endline survey conducted in February 2004 revealed that Ishraq had had significant impact on the participating girls in terms of academic and practical skills, delayed teenage marriages, increased influence over marriage decisions, lower incidence of female genital cutting and reduced desire to circumcise their own children, among other indicators. The Egyptian government has expressed a desire to replicate the intervention on a larger scale throughout Egypt and plans are underway among the participating institutions to do so.

Sources: Population Council (Cairo) 2001, 2002 and 2004; Draft Endline Report on Ishraq by Alyce Abdallah and Ray Langsten; Interview with Rania Salem and Barbara Ibrahim, Population Council (Cairo), July 2003.

instituted a variety of community outreach strategies to attract girls and young women, and to increase utilization. Moreover, the Ishraq programme described above found that their interventions – combining sport, life skills and literacy training for out-of-school girls – were most effective if provided through youth centres rather than schools. In all cases, careful analysis of what institutions are available and accessible that can serve young people is needed in each context.

Media Involvement in Young People's SRH

Throughout the region, the taboo surrounding discussion of sexuality has been described as an important obstacle to advocacy, and to implementation of programmes that would protect young people's sexual and reproductive health. The use of media is often one of the most effective strategies for addressing the stigma and sensitivity surrounding sexual and reproductive health concerns, and for promoting health-protective social norms and behaviour among young people. There have been a number of innovative programmes

The 'Double Protection' Project in Universities of Tunisia

The 'Double Protection' project is a rare example in the region of a sexual and reproductive health programme targeting university students. It aims to prevent unwanted pregnancy and sexually transmitted diseases among male and female university students in five regions of Tunisia (Ariana, Jendouba, Sousse, Kairouan and Sfax). Funded by the UNFPA and the IPPF, it has been implemented by the Tunisian Family Planning Association. In the first stage, the project aimed to impart to 6,000 young women in university the knowledge and competence to avoid these health problems. The project consisted of preparatory activities, sexual and reproductive health training of 'educational pairs' of volunteer university students or peers, a situation analysis of young students and an education strategy. The latter proceeded according to the following chronology: announcements about the project on local university radio stations, conferences with resource people (such as doctors and midwives), group sessions and individual interviews with students conducted by 'educational pairs'. Referrals to government centres can be made if necessary (according to Elizabeth Bennour, IPPF, interview July 2003).

A qualitative evaluation was conducted at the end of the project to assess the knowledge imparted to students, the degree of acceptability of this form of intervention and to assess students' needs with regard to sexual and reproductive health services. The evaluation found that there was a high level of interest in the programme and that this form of education (individually and in groups) provided both useful information and an opportunity for young people to discuss matters pertaining to sexuality in a non-threatening context. Information that was most retained concerned HIV/AIDS, unwanted pregnancy, the menstrual cycle and where adolescent health services are offered. Students expressed their appreciation that these sensitive issues were being addressed, but also recommended that the project be extended to other dormitories and involve their parents. The evaluation recommended that the project proceed to work with boys and to redefine the role of the 'educational pairs' in recognition that, as peers, they cannot act as experts or do more than facilitate discussion. It highlighted the importance of adequate support for peer educators if they are to conduct educational activities, and recommended that the project extend the topics covered to questions of violence and drug use. As a qualitative evaluation, it was not able to yield insights on service use.

Sources: Elizabeth Bennour, IPPF, personal communication; Dr. Ben Mansour, interview with Iman Mortagy, July 2003; TFPA, personal communication and Association Tunisienne du Planning Familial, Evaluation du Projet "La Double Protection pour les Jeunes" : Résultats d'une enquête qualitative, 2003).

across the region – whether television chat shows, such as in Lebanon[174]; entertainment or documentary films, such as in Palestine, Lebanon, the Maghreb and Egypt particularly; as well as a range of radio programmes addressing YPSRH.[175] Television spots have been produced in most countries of the region, addressing such issues as HIV/AIDS, family planning and maternal mortality.[176] With rare exceptions, however, many of these efforts have been one-off, either because of the difficulty of obtaining funding (given the high cost of producing media) or the resistance created by government reluctance to address controversial questions. Government control over the media remains the case in most countries of the region, and therefore it is often difficult for independent producers to obtain access to official media channels. In Egypt, for example, the government produces 90 per cent of what is shown on television. Consequently many high-quality videos addressing young people's SRH that have been produced have not been widely circulated.

Research Gaps

As is clear from the research shown, there remain major knowledge gaps in almost all areas pertaining to the sexual and reproductive health of young people in the Arab States and Iran. While epidemiological and medical research has been conducted on many reproductive health problems, this research has not always been complemented by interdisciplinary research combining both quantitative and qualitative methods. In particular, the perspectives of young people themselves on sexual and reproductive health problems are often lacking. Furthermore, evaluation data is weak in the region, thus limiting the knowledge base for new programmes or policies relating to sexual and reproductive health. Advocacy is needed with all parties involved – including donors – to initiate high-quality programme evaluations, which are an important step if programmes are to proceed from pilot-level to achieving greater scale and impact.

Although a wealth of population-based data exists on health and population issues in the region, the data have not been disaggregated sufficiently to analyze the situation of young people, and very few have addressed unmarried young people. In some cases, data availability to researchers is limited because of the need to obtain government clearance. Moreover, comparative research is hampered by the lack of standardization of these sources across the region. The Synoptic Table (see page 163) accompanying this review draws on these disparate sources, but, while compiling this table, it was found that consistent data were not available for even some of these basic indicators across the region. For some other indicators relevant to assessing the status of young people's sexual and reproductive health, such as those on sexual behaviour, no data is available at all for most countries.

In addition to nationally sponsored and executed population-based surveys, Demographic and Health Surveys have been regularly conducted in Egypt, Jordan, Morocco, Tunisia and Yemen, sponsored by USAID. Historically these have focused on demographic- and family planning–related questions, although in recent years have broadened to include the reproductive health of married women. The Gulf States have implemented the Gulf Family Health Surveys. In addition, the Arab League has supported PAPFAM Surveys in a number of countries with valuable population and health-related data. While these have followed the DHS in tending to sample only ever-married women, the Morocco survey included unmarried women. Of particular relevance to this review, PAPFAM has developed a youth module that covers a range of issues pertaining to the health and welfare of youth, including their sexual and reproductive health.[177] In the case of Tunisia and Algeria, the government permitted questions related to sexual behaviour to be asked. However, this module and the questions therein are optional, limiting the potential for comparative analyses of this data across countries. Moreover, as countries have different needs in relation to the youth population, the age groups sampled vary (e.g., 18–28 years

in Tunisia, 15–29 in Algeria, while other countries have sampled the 15–24 age group). Nevertheless, this youth module presents an important opportunity to provide nationally representative population-based data on youth in the region for the first time.

Some countries in the region also have conducted nationally representative surveys of young people, such as the national survey conducted by the Population Council and partners in Egypt of adolescents aged 10–19. These surveys provide a valuable source of information on which to base policy addressing young people.

The degree to which existing research is accessible varies across the region; it is important to distinguish between countries where data is available but not accessible for largely political reasons, and others where the relevant data has not been collected at all. If proper and comparative research is to be undertaken, greater advocacy is needed by all those with a stake in disseminating research –including researchers, NGOs and donors – to make collected data available.[178]

Despite the research gaps identified throughout this report, there is an evident paradox that, although reproductive health issues are highly sensitive within this cultural context, some pioneering research has been conducted in the region that has informed both reproductive health policy as well as international debates.[179] Improved dissemination of existing research is needed both to share results across the region through translation into Arabic, Farsi and French, and to increase its availability internationally through more extensive publication in the international literature.

Conclusion

This situation analysis has summarised the existing evidence concerning the reproductive and sexual health and rights of young people aged 10–24 in the Arab States and Iran. As noted in the introduction to this report, the categorization of young people within this age group is consistent with accepted international definitions. As one interviewee pointed out, however, it is critical that health professionals and others dealing with the sexual and reproductive health of young people treat adolescents according to their evolving capacities, and not according to an arbitrary age cut-off. For example, health professionals need to make a judgment whether the young person in question has the capacity to understand a treatment choice.[180]

Certainly much more research is needed in the region to understand culturally meaningful stages of transition from childhood to adulthood. As presented in this analysis, many young people bridge these stages abruptly, for example, through early marriage, childbearing or early employment, even when they do not have the psychological or physical

maturity to assume adult roles and responsibilities. But on the other end of the spectrum, many young people in the region are deferring marriage for social and economic reasons; they are increasingly educated but economically dependent on their families because of high rates of youth unemployment.

As the situation analysis has made clear, the evidence on the reproductive and sexual health of young people in the region is relatively weak compared to many other regions. Taboos against discussion of sexuality are a major impediment to further research on the topic. In other comparably conservative settings, such as India, for example, the HIV/AIDS epidemic has opened up possibilities for discussion and research on matters related to sexuality.[181] However, this is not the case in the Arab States and Iran, given widespread perceptions that HIV/AIDS is not yet a major problem.

Across the region, there have been some promising initiatives starting to address youth sexual and reproductive health, some of which are documented here, which need to be built upon, evaluated and, where appropriate, replicated. Tunisia and Iran stand out in this respect. Tunisia, with its government commitment to youth SRH, has attempted to scale up programmes for youth to a national level through the introduction of adolescent health clinics, the provision of information to young people whether married or unmarried, and supporting peer education interventions in Tunisian universities on SRH topics among other initiatives. The example of Iran has also shown that high-level political commitment to addressing young people's reproductive health – such as provision of premarital counselling programmes – can achieve nationwide impact. As noted in this report, Iran has shown exemplary openness in dealing with HIV/AIDS, offering harm reduction and recommending that health professionals do not require information from young people about their marital status. Across the region there have been many initiatives by women's groups and non-governmental organizations in this field, some of which have been mentioned and documented here. Generally, however, there also has not been sufficient opportunity to share within the region lessons emerging from these programme models, both among Arab countries, and between these countries and Iran. The innovative experience of Iran in addressing reproductive and sexual health issues in a manner that is consistent with the religious values of the region could be especially instructive for similar efforts in other countries.

Despite the political and social constraints to addressing the universally sensitive and controversial issues entailed in promoting the sexual and reproductive health of young people, the Arab States and Iran share many positive features that are protective of young people's health. Moreover, the recent past has seen much greater openness on the part of decision makers to address some of the more controversial issues, such as SRH education, HIV/AIDS and female genital mutilation/cutting.

As noted throughout this report, if programmes take a positive youth development approach, in which the reproductive and sexual health needs of young people are framed within a wider perspective of their needs, clear progress can be made. As researcher Shadia Wannous from Syria noted in an interview, this approach requires working with key gatekeepers: "Winning community support requires helping parents and leaders to understand health issues inherent in young adult's sexual behavior, to recognise the need for programme action, to agree on solutions, and to work with health professionals to carry them out." If such action is linked to the opportunity offered by growing access to education and electronic media, culturally sensitive SRH programmes for young people can help them to reach their full potential as active citizens of their societies.

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1 The author of this chapter is Jocelyn L. DeJong.

2 Algeria, Bahrain, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Occupied Palestinian Territories, Oman, Qatar, Saudi Arabia, Sudan, Syria, Tunisia, United Arab Emirates, Yemen.

3 ILO. 2004. *Global Employment Trends,* 2004. Geneva: ILO.

4 El Tawila et al. 1999 on Egypt; Johns Hopkins University and National Population Commission (Jordan) 2001

5 El Tawila 200

6 El-Ghonemy 1998

7 UK Department for International Development, Regional Assistance Plan 2003

8 Philippe Fargues, European University Institute, personal communication, March 2005)

9 By contrast, the Egyptian nationally representative survey of adolescents (El Tawila et al. 1999) found only minor differences between ages at menarche for girls in the low socio-economic status (13.87 years) as opposed to those with a high socio-economic status (13.47).

10 El Tawila et al. 1999

11 UNAIDS/UNICEF/USAID 2002

12 Human Rights Watch 2003

13 Khawaja 2000

14 UNDP 2002

15 World Bank 2003

16 See the Arab election law compendium website: www.arabelectionlaw

17 UNIFEM 2004

18 Guardian Weekly, 2003, and "Women in Kuwait get Vote" Associated Press, May 17, 2005 accessed online at www.iht.com, 22 May 2005

19 Fargues 1995

20 DFID 2003

21 DFID 2003

22 Population Action International 2002

23 Note, however, that Rashad and Osman (2003 p. 31) finds a decrease in the proportions of women setting up their own homes with their husband at marriage over time, which she suggests may be tied to the rising cost of housing.

24 See, for example, Doan and Bisharat's 1990 study on the extended family residential unit in Amman, Jordan.

25 This tendency is particularly pertinent to the so-called 'honour killings' discussed above.

26 El Tawila et al 1999

27 Robert Thomspon, UNFPA, July 2003 [quoted with permission]

28 A point made by Robert Thompson, formerly WHO and UNFPA in the region, interview July 2003.

29 BBC programme "Egyptians Tackle Taboos Through the Net" Tuesday, 2 September 2003, 09:22 GMT 10:22 UK, available on http://news.bbc.co.uk/go/em/fr/-/2/hi/technology/3199007.stm

30 See Foster et al. 2005

31 BBC programme "Egyptians Tackle Taboos Through the Net" Tuesday, 2 September, 2003, 09:22 GMT 10:22 UK, available on http://news.bbc.co.uk/go/em/fr/-/2/hi/technology/3199007.stm

32 El Tawila et al 1999
33 WHO 2003b, *Broadening the Horizon.*
34 For a historical analysis of Islam and sexuality, see Musallam 1983
35 Makhlouf Obermeyer 1994: 49
36 The latter topic has received little research attention. Exceptions are Foster (2002) on Tunisia and Cindoglu (in Ilkkaracan 2000) on Turkey.
37 Fargues 2003
38 Two exceptions are Singerman and Ibrahim 2003 and Amin and Al-Bassusi 2003.
39 Singerman and Ibrahim 2003
40 Rashad and Osman 2003
41 Rashad 2000
42 Tekce 2002
43 The figure for Sudan needs to take into account that most recent population-based surveys in Sudan have only been conducted in the northern part of the country because of the civil war in the South.
44 Rashad and Osman 2003; their analysis covers only 13 countries of the region, however.
45 Rashad 2000
46 Rashad and Osman 2003
47 Rashad 2000
48 UNICEF 2001
49 World Bank 2001
50 El Tawila et al. 1999
51 Population Action International 2002
52 S. Tremayne, interview, July 2003
53 Hamamsy 1994
54 Hamamsy 1994: 8
55 Sajan and Fikree 2002
56 Information on the Egyptian initiative is from UNICEF 2001, and is drawn from Assad, M. and Bruce, J. (1997) "Empowering the Next Generation: Girls of the Maqattam Garbage Settlement." *Seeds,* No. 19, New York. http://www.popcouncil.org/publications/seeds/seeds19.html#m

The publication does not show clear evaluation results, partly because the numbers involved were small, but there is no information, for example, on what percentage of those involved in the programme successfully delayed marriage. One interesting but discouraging finding was that many girls who successfully postponed marriage until age 18 found that once married, they faced strong family opposition to continuing their income-generation activities.
57 UNIFEM 2004
58 Haeri, in Ilkkaracan 2000
59 Haeri 2000: 349
60 Haeri 2000
61 Rafsanjani 1990 quoted in Zan-I Ruz, No. 1294: 55 (1990) cited by Haeri 2000: 344
62 Dr. Ali-Reza Vassigh, UNFPA-Iran, personal communication 2 March 2005
63 Dr. Ali-Reza Vassigh, UNFPA-Iran, personal communication 2 March 2005
64 Hardee et al. 2003
65 Ibid.
66 Rashad and Osman 2003: 39
67 In Egypt, until very recently it was not possible for a woman to convey citizenship to her child. This issue has been a main point for advocacy of the Arab feminist movement.
68 NOTE: A television programme on the Al Jazeera channel of October 13, 2003 featured discussion of three forms of non-conventional marriage: temporary marriage, 'urfi marriage and jawaz al misyar, or business-related marriage that was reported to be practised increasingly in the Gulf countries.
69 Guardian 13/10/03
70 See Singerman and Ibrahim 2003 regarding revisions to marriage legislation in Egypt
71 It should be noted, however, that Egypt has recorded a significant decline between the 1993 and 2000 surveys, from 174 in 1992-3 to 84 per 100,000 in 2000 (Egypt Ministry of Health 2001).

72 World Bank 2001
73 Egyptian Ministry of Health and Population 2000
74 Egypt Ministry of Health and Population 2001
75 World Bank 2001 –but note that information is provided only for the 15 –49 age group.
76 Khattab, Younis and Zurayk 1999
77 El Tawila et al 1999
78 World Bank 2001
79 World Bank 2001
80 Al Riyami et al. 2004
81 El-Zanaty and Way 2001; Azelmat et al. 1996; Central Statistical Organization Yemen 1998; Department of Statistics Yemen 1991; Department of Statistics Jordan 1993
82 Rahman et al. 1998
83 From BBC Wire service, Jomhuri-ye Islami (4/13/2005 p. 14) on the 12 April Majlis session, followed by Resalat column "On the Sidelines of the Majlis" p. 3.
84 S. Said, "Abortion issues in Egyptian spotlight," on www.arabnews.com accessed 20 March 2005
85 Musallam 1983; Huntingdon 1997
86 Ragab 1993
87 EFCS 1997
88 Huntington 1997
89 IPPF 1992
90 Population Action International 2002
91 Foster et al. 2005
92 Ibid.
93 Ibid.
94 Prolapse is defined as the significant descent of the uterus and vagina, which may descend partly or completely beyond the vulva. It causes disturbing symptoms such as pelvic fullness, back pain, urinary symptoms, vaginal discharge and bleeding (World Bank 2001).
95 There have been numerous articles published based on the Giza study, but the overall findings are summarised in Khattab, Younis and Zurayk 1999.
96 Vesico-vaginal fistulae (VVF) represent a health problem that occurs when a hole develops between the vagina and bladder of a pregnant woman during prolonged and obstructed labour. In some cases the fistulae develop between the rectum and the vagina causing recto-vaginal fistulae. Either type of fistulae leaves the woman incontinent and has devastating social consequences.
97 Personal communication, Dr. Nagiba Abdel Ghani, Reproductive Health, Yemen Ministry of Health, September 2003
98 See Germain, Holmes, Piot, Germain, Wasserheit et al. 1992
99 Inhorn 1994
100 The failure to test males clearly leads to ineffective treatment since, worldwide, estimates range in 40–50% of all cases regarding male infertility as a factor in infertility in couples. Male infertility was found in 36.8% of cases in a study of 250 couples in Iraq. [A.H. Razzak and S.A. Wais, "The infertile couple: a cohort study in Duhok, Iraq" In Eastern Mediterranean Health Journal, January 2002.]
101 Inhorn and Buss 1994
102 This section on sexually transmitted infections is separate from the broader question of reproductive morbidity; although strictly speaking sexually transmitted infections are reproductive tract infections, the singling out of STIs focuses on those RTIs which are known to be sexually transmitted as opposed to those related to poor menstrual hygiene or iatrogenic factors such as related to the insertion of IUDs.
103 World Bank/WHO/UNAIDS 2002
104 WHO-EMRO STI update 2002
105 Presentation by Jihane Al Tawilah, WHO-EMRO, December 2002
106 Jumana Hermez, WHO-EMRO, personal communication, September 2003
107 El Tawila et al. 1999
108 Information from www.unaids.org accessed online 22 August 2005
109 According to a personal communication from Neff Walker of UNICEF, 19 September 2004. The percentage of new infections

represented by youth not available in the MENA Region, except in the Sudan. This is yet another example of the need for disaggregated data.

110 World Bank/WHO/UNAIDS 2002

111 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.

112 Powerpoint presentation of Jihane Tawilah, WHO-EMRO, December 2002

113 World Bank 2001

114 World Bank/UNAIDS/WHO 2002

115 Ibid.

116 El Zanaty and Abdalla 1996

117 Information drawn from powerpoint presentation of Jihane Tawilah, WHO-EMRO, 2002 [year of study unknown].

118 El Tawila et al. 1999

119 UNFPA, "Indicators: Sudan" UNFPA, http://ww.unfpa.org,/profile/sudan.cfm (accessed 4 May 2005)

120 WHO Progress Report to the 50th Regional Committee: REF. WHO EM/RC50/INF.DOC.1 kindly supplied by Dr. Jumana Hermez, WHO-EMRO, February 2004.

121 In Egypt, for example, the Demographuic and Health Survey of 1995 found that Egyptian wives are 7.5 years younger than their husbands and over one quarter are married to men who are at least 10 years older than them.

122 Interview with Abdullah As-Sayari, ICD, Yemen, September 2003.

123 2004 Report on the Global AIDS Epidemic

124 The leaves of the shrub *Catha edulis,* which are chewed like tobacco or used to make tea. It has the effect of a euphoric stimulant. In Yemen, kat is widely used.

125 Troudi, H., R. Ridha and F. Haffani. Resultats de L'enquete sur la Sexualite Masculine en Tunisie. Powerpoint presentation, 2003 cited in Carol Jenkins Powerpoint presentation, The Middle East and North Africa: Vulnerability to the HIV/AIDS Epidemic, Bangkok International AIDS Conference, July 2004.

126 Samia El Nagger, interview July 2003

127 George Ionita, Regional HIV/AIDS Advisor, UNICEF-Amman personal communication

128 World Bank/UNAIDS/WHO 2002

129 10 July 2003 presentation at UNICEF-Amman.

130 Website of International Federation of Red Cross and Red Crescent Societies, accessed online September 2003

131 M-C. Mutanda, UNICEF-Djibouti, interview, September 2003

132 UNDP, Press release, "Arab religious leaders agree unanimously to respond to HIV/AIDS by signing the progressive Cairo Declaration" available on www.unaids.org accessed online 22 May 2005

133 Powerpoint presentation of Jihane Tawilah, WHO-EMRO, December 2002

134 WHO 2002

135 WHO 2002 Jihane Al Tawilah presentation

136 UNODCP 2001

137 Powerpoint presentation of Jihane Tawilah, WHO-EMRO, December 2002

138 Quoted in Al Hayat 5/27/03

139 Ibid.

140 WHO has classified the practice into four Types, ranging from Type I (clitoridectomy), to Type II (excision), to Type III (infibulations) and an unclassified category Type IV of pricking, piercing, stretching etc. female genitalia.

141 M.C.Mutanda, UNICEF-Djibouti, interview, September 2003

142 Dr. Naguiba Abdel Ghani, Reproductive Health, Ministry of Health-Yemen, personal communication, September 2003

143 Pacific Institute for Women's Health (2002)

144 Abu-Odeh in Ilkkarcan 2000: 363

145 A journalist for the Jordan Times, Rana Al Husseini, has documented every case of honour killing in Jordan since 1986. In recent years, estimates are that honour killings claim the lives of 25 women each year (Faqir 2001).

146 The British Council, for example, has supported such work in both Palestine and Jordan.

147 Amado 2004

148 Tawila et al 1999

149 Haj-Yahyia 1998a and 1998b

150 Emerging research, however, is suggesting that existing medical practices concerning childbirth in some countries may not respond to women's preferences, but also may contradict evidence-based practice and in some cases even be unsafe. See for example Khayat and Campbell's 2000 study which found that some prevailing medical practices surrounding childbirth in Lebanon were out-dated and even harmful, and Khalil et al's study of obstetric practices in an Egyptian public hospital where excessive and inappropriate oxytocin use was found.

151 World Bank/UNAIDS/WHO 2002

152 Shadia Wannous, Syria, interview, July 2003

153 According to UNFPA's Country Office report for Iran in 2004

154 As in Tunisia, for example (WHO 2002a)

155 Hoodfar 1996: 32

156 Ibid.

157 Roudi-Fahimi 2002

158 Population Action International 2002

159 Ibid.

160 Population Action International 2002: 28

161 UNICEF 2001: 15

162 Lloyd et al. 2001

163 DFID 2003: 8

164 Ministère de la Santé et al. (2001) République de Djibouti

165 See, for example, Bloom 2001 on Jordan.

166 In Jordan, for example, the Futures Group found that several sections of the curriculum were not being taught, so they are collaborating with the Institute of Higher Education there to train teachers on these aspects (Ed Abel, Futures Group, interview, June, 2003)

167 Beamish 2001

168 Population Action International 2002

169 Ibid.

170 Ibid.

171 El Tawila et al. 1999

172 El Tawila et al. 1999

173 Interview with Dr. Hedia Ghouayel, UNFPA-NY, July 2003, quoting Dr. Ben Mansour, M.D., Tunisia

174 Such as, for example, the talk show Shater Yihki produced by Janane Mallat on Future Television in Lebanon.

175 For example, a series produced by the BBC Arabic Service entitled Talking About Sex Frankly.

176 An interesting example of such spots was one produced by USAID in Egypt entitled "Sahithom fi ideekom" (Their Health is in Your Hands), which targeted men about the symptoms of high-risk deliveries so that they could recognise danger signals.

177 We are grateful to Dr. Ahmed Abdel Monem of the PAPFAM Surveys at the Arab League for supplying this information and survey documents at interviews both in July 2003 and September 2004.

178 In the case of the PAPFAM surveys, any researcher wishing to use PAPFAM data needs to provide a proposal, indicating which variables are needed and if the director of the survey in country gives permission, they can obtain access to the variables needed, although never the complete data-sets (interview with Dr. Ahmed Abdel Monem, PAPFAM, September 2004).

179 For example the above-cited Giza study – see Khattab, Younis and Zurak 1999 – has informed international debates on reproductive morbidity at the ICPD and afterward.

180 We are grateful to Rebecca Cook, University of Toronto, interviewed July 2003 for this point.

181 Shireen Jejeebhoy, Population Council-India, interview July 2003

CHAPTER THREE: INTERNATIONAL OVERVIEW OF EFFECTIVE PRACTICES IN PROGRAMMES THAT PROMOTE YOUNG PEOPLE'S SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS[1]

Introduction

UNICEF's Middle East North African Regional Office requested this review of the literature covering international evidence on effective rights-based practices in programmes that promote young people's sexual and reproductive health (YPSRH). This review complements the regional situation analysis, so that the programme, policy, and research recommendations in this report are grounded both in regional data and in evidence on programmes and policies worldwide.

It is difficult in such overviews to avoid re-inventing the wheel and repeating widely accepted truisms. On the other hand, for the reader's convenience, it seems important to include basic points of consensus emphasised in numerous sources. This chapter aims to strike a balance by outlining important points, and then referring to resources in the literature. The chapter also highlights certain issues that are especially relevant to UNICEF programmes, and to the context of the Arab Countries and Iran.

The chapter is divided into two broad areas: 'Principles of Programme Design' and 'Evidence and Guidelines on YPSRH Programme Strategies.' The first area discusses cross-cutting principles to be applied to all types of YPSRH programmes and interventions. The second area analyzes the international evidence on particular YPSRH programme models such as youth centres, school-based 'family life' education, 'youth-friendly' health services, and peer education programmes. These models are the most prevalent in the region and the most considered when determining appropriate interventions. The author proposes certain YPSRH strategies as most appropriate for the region.

The audience for this chapter is two-fold: 1) any programme planner in NGOs, governments, or international agencies involved in decisions about the basic design of a YPSRH programme; and 2) programme-level decision makers seeking guidance on certain aspects of YPSRH programme implementation, such as young people's participation or incorporation of gender issues.

Principles of Programme Design

This area discusses the main principles that should guide all programming for young people. The description of these principles highlights issues related to sexual and reproductive health. The first two sections discuss overarching principles of programme design: evidence-informed programming and a human rights framework based on the Convention for the Rights of the Child for programming. The sections following those discuss other key principles: comprehensive and multisectoral programme design, gender equality and women's rights, young people's participation, community and parental involvement, and methods of scaling up proven YPSRH programmes. The chapter concludes with a checklist that incorporates all of the principles.

Evidence-Informed Programming for Young People

This review uses the term 'evidence-informed' as opposed to the more common term 'evidence-based', because the latter term can be used to discourage innovation, that is, to oppose initiatives that have not already been proven effective, but could prove to be effective when evaluated.[2] Programmes based on available international, regional and local evidence are more likely to be effective in improving health outcomes and to be appropriate for the local context. This review will discuss several elements of evidence-informed programming as they apply to YPSRH programmes. After this initial list of the main elements, more detailed discussions of each element follow.

> **Evidence from the context:** It is critical that the data collected on the diverse population of young people be disaggregated to the extent possible by gender, age, marital status, schooling status, location (urban or rural), socio-economic status and other factors relevant to the effective functioning of a programme. Analysis of health risks faced by each segment in the population of young people, including collection of data on their preferences and norms, as well as on the social context of that information, makes it possible to make evidence-informed decisions about which segments to prioritise. Data collection methods and dissemination should neither stigmatise them nor divulge information that could lead to repression or harm, with particular attention to ensuring respect for the rights of vulnerable populations such as intravenous drug users (IDU). Policy-related contextual evidence to be collected includes information on laws, regulations, and practices that pose obstacles to young people's access to SRH information and services.

> **Evidence from research in the YPSRH field:** Programme design should be based on tested theories of behaviour change in health

Key Resources on International Evidence on YPSRH Programmes

Bond, Kate. 2004. *Key Issues in the Implementation of Adolescent Sexual and Reproductive Health Programmes*. Geneva: WHO Department of Child and Adolescent Health and Development. WHO/FCH/CAH/04.3

FOCUS on Young Adults, 2001. *Advancing Young Adult Reproductive Health: Actions for the Next Decade*. Washington, DC: Pathfinder International, The Futures Group International, and Tulane University School of Health and Tropical Medicine.

Johnson, B., M. Carey, K. Marsh, K. Levin, L. Schott-Sheldon, "Interventions to Reduce Sexual Risk for the HIV Virus in Adolescents, 1985–2003." *Archives of Pediatric Adolescent Medicine,* Vol. 157, April 2003.

Population Council and FHI, 2003. "New Findings from Intervention Research: Youth Reproductive Health and HIV Prevention." Meeting Report. September 9, 2003. Washington, DC.

Population Council, 2003. *Adolescent and Youth Sexual and Reproductive Health: Charting Directions for a Second Generation of Programming*. Both the report and the background document on a workshop of UNFPA in collaboration with the Population Council, 1–3 May 2002. New York: Population Council. See especially chapter two: "Steps in Building Evidence-Based Programmes for Adolescents," by Judith Bruce.

Speizer, Ilene, Robert Magnani, Charlotte Colvin. 2003. "The Effectiveness of Adolescent Reproductive Health Interventions in Developing Countries: A Review of the Evidence," Journal of Adolescent Health 33(5): 324–348.

WHO 2002. *Growing in Confidence: Programming for Adolescent Health and Development*. WHO/FCH/CAH/02.13.

WHO, Department of Child and Adolescent Health and Development, 2003. "Broadening the Horizon: Balancing Protection and Risk for Adolescents." PDF file at website: http://www.who.int/child-adolescent-health

YouthNet publications on website: http://www.fhi.org/en/Youth/YouthNet/Publications/index.htm

promotion. Using a positive 'assets-based' approach mandates the use of current knowledge about risk and protective factors for YPSRH to set programme objectives and indicators. Finally, the choice of strategies and implementation plans should be based on current evidence of how best to implement different programme strategies.

> **Evidence from the programme itself:** Evaluating programmes as rigorously as possible is essential to avoid wasting scarce resources on ineffective approaches. All evaluations should collect evidence on quality of implementation, and all new programmes should collect evidence on impact. Involving young people in the evaluation is an important cross-cutting design principle.

The 'key resources' in the sidebar above include the current evidence on effective YPSRH practices around the world. Local contextual data on young people's sexual and reproductive health collected at the start, combined with the global evidence on how to design and implement YPSRH programmes, provide sufficient guidance for the design of

new programmes in the Arab States and Iran. With adequate evaluations of these programmes, managers can then determine whether and how the new programmes need to be adapted. Another important mechanism for cultural adaptation is the participation of young people and communities in programme design – a basic principle discussed in this chapter.

Unfortunately, the regional literature search found little evaluation evidence on YPSRH programmes in the Arab States and Iran. The authors urge new and existing programmes to invest in evaluation to add to the regional knowledge base on effective practices in YPSRH programmes in this region.

Time and resources spent gathering information for effective programme design and evaluation is necessary and well spent. Without a basis in these three sources of evidence, YPSRH resources can be wasted in programmes that follow intuitive and opportunistic approaches, using strategies based on rosy anecdotes from other programmes that have not been seriously evaluated for effectiveness. Opportunistic approaches are often linked to donor preferences or to opportunities, such as the sudden availability of a building. Investing in using these three sources of evidence leads to YPSRH programmes that are suited to local contexts and that effectively address young people's needs and risks.

Evidence from the Context: Baseline Information

Below is a list of types of information that create an appropriate contextual frame for programme design and evaluation. The first type of baseline information allows analysis of various factors in the population of young people that might affect their level of health risk. When this disaggregated baseline data is combined with SRH-related data, designers can identify those segments of the population of young people that are most at risk. The second type of information on young people's preferences, constraints, and needs enables programs to be 'youth-friendly' and to fashion programmes that are appropriate to the socio-cultural context. The third type of information, on the policy context, helps to identify relevant policy issues that need to be taken into account in program design, and included in YPSRH advocacy.

Analysis of the diversity among young people[3] in the programme's context (country, region or community) by disaggregating health and development data. The following list explains why each aspect is important:

> **Gender.** The needs, limitations and opportunities for girls and boys tend to differ dramatically, especially post-puberty. Cultural norms on sexuality are also very different for males and females.

- **Age.** Physical changes and social expectations change dramatically throughout the age span of 10–24 years. The age breakdowns are 10–14, 15–19, and 20–24 in most demographic surveys. However, in some contexts, different groupings make more sense, (e.g., if a key life event or ceremony usually happens at a certain age).
- **Marital status.** Cultural norms on sexuality are strictly related to marital status, especially for young women. Unmarried young people have less access to sexual and reproductive health information and services because of cultural (and sometimes legal) norms prohibiting premarital sexual relations. In addition, young married girls are among the most under-served and vulnerable populations of young people in many countries, while young unmarried men tend to be at high risk for sexual health problems.
- **In/out of school.** Health risks often rise for young people who are out of school; a close connection with school has been shown in the literature to be a protective factor. Young people who are no longer in school are much harder to reach with health programmes, and require community-based or workplace-based strategies. In many countries, most young women ages 15–19 are out of school.
- **Educational level.** SRH risks tend to decrease as educational levels rise, so that disaggregation can help identify young people most at risk. Educational level also determines the appropriate type of educational materials and strategies that can be used in YPSRH programmes.
- **Urban or rural location.** This information is an important factor in national- or state-level planning, since lack of infrastructure in rural areas can make it hard for rural young people to gain access to SRH education and services, thus increasing their risks.
- **Family structure.** For programme purposes, it is important to learn which members of the family are the 'gatekeepers' (determining young people's access to resources and opportunities), and then reach out to these family members. In conflict settings where many families are displaced or in cities with recent rural migration, the breakdown in extended family structure increases young people's vulnerability.
- **Socio-economic status.** Risks differ according to socio-economic status. Poverty is a risk factor for many threats to health, such as maternal mortality and reproductive tract infections. On the other hand, regional evidence suggests that middle-to-upper-class unmarried young people are vulnerable when they study far from home and do not have access to SRH information, education and services. For some

young men of higher socio-economic strata, access to cash may facilitate access to illegal drugs, alcohol or commercial sex, thus increasing their risks.

> **Employment status.** Access to income reduces poverty, and thus improves a young person's situation dramatically, if they have control over the funds. Furthermore, workplaces are often an excellent and cost-effective venue for health education and services.

> **Racial/ethnic group.** In many countries, certain ethnic groups suffer from discrimination and marginalisation, and are more vulnerable to health risks. Typically, gender and sexuality norms differ from those of the mainstream culture. Some young people may not be literate in the official language, needing tailored educational strategies and materials. Young people from these groups may distrust outsiders. Programme outreach and education need to take all these factors into account.

> **Religion.** When there is religious diversity in the programme's context, social norms on gender and sexuality may differ by religion, entailing the need for different educational strategies for young people depending on religion. Furthermore, religious leaders' support and involvement is a key entry point for reaching young people, as well as a factor in favour of a programme's sustainability.

Collecting information on young people's current views, norms, preferences, risks and behaviour, and on their social and cultural environment. The main tasks involved in collecting evidence from the context have been identified by WHO and others:[4]

> Successful programming in YPSRH is based on data that analyzes knowledge, attitudes and behaviour to understand which are protective and which pose risks.

> Finding out what young people do when they are concerned about their health turns a spotlight on gaps in existing services.

> Finding out about the environment in which young people live – the norms and practices of their families, schools, communities, peer groups, workplaces and mass media is the first step towards addressing risk factors and enhancing the protective factors that support healthy lifestyles.

> Surveying the views, norms and preferences of adolescents is the beginning of a journey to involve young people in programming.

- Surveying the attitudes and actions of parents of young people helps policy makers support families and can be used to guide programmes in involving families.
- Surveying teachers' attitudes and practices provides a better planning base to ensure that school health programmes have feasible strategies that address attitudes and practices that pose obstacles to YPSRH health promotion.

Collecting information on the policy environment affecting YPSRH.[5] Data on the policy environment includes information on laws, regulations, institutional policies and practices. The following have been found to be pertinent to YPSRH in many different settings.

- Issues that affect young people's access to confidential health services and counselling include age-of-consent laws for provision of health services without parental notification or consent, and access to contraception in primary healthcare facilities.
- Policy-related factors that negatively affect young people's health and development include barriers to education access, such as school fees and entrance exams, and policies or practices that inhibit young people's participation. It is important to analyse whether laws and policies discriminate against vulnerable sectors of young people, such as HIV-positive young people or young married women.
- Other key policy-related issues affecting YPSRH include: age-of-marriage laws; legal, political and administrative measures dealing with physical and sexual violence against children and women; policies on SRH in life skills education programmes; the legal status of abortion and prevalence of unsafe abortion; legality and availability in the health system of all methods of contraception; and budgetary policies that impinge on the availability of YPSRH education, programmes and services.

International Evidence from Research on Behaviour Change and YPSRH

This second category of evidence pertinent to programme design draws on the international literature about prevention and risk-reduction programmes for young people. This section discusses theories of behaviour change with the implications for programme design, the risk and protective factors for young people's sexual and reproductive health, and the importance of the dual goals of abstinence/delayed sexual initiation and protected sex.

Theories of behaviour change.

Theories of behaviour change have evolved; it is now understood that sustainable individual behaviour change is most effectively achieved when interventions with individuals are complemented by protective changes in the social, economic and political determinants of risky behaviour.[6]

> *"Research has proven numerous times that education alone is not sufficient to induce behavioural change among most individuals. Thus, second generation interventions were developed based on individual psychosocial and cognitive approaches that educate individuals in practical skills to reduce their risk for HIV infection (Kalichman, 1997). More recently, social researchers have come to realize that because complex health behaviours such as sex take place in context, socio-cultural factors surrounding the individual must be considered in designing prevention interventions. Finally, beyond the individual and his or her immediate social relationships lie the larger issues of structural and environmental determinants that also play a significant role in sexual behaviour" (Sweat, 1995).*[7]

Numerous theories of behaviour change have been developed to take some or all of these factors facilitating behaviour change into account. Many experts comment that when aiming for behaviour change among young people, it is important to follow a behaviour change theory consistently that takes socio-cultural and structural determinants into account. Based on Kirby's[8] analyses, researcher Kate Bond[9] comments that, "Given that almost all theoretical approaches utilised in carefully implemented interventions have, in one form or another, achieved successful outcomes … **having a theory about how behaviour is changed and implementing it through a well-designed intervention is more important than the particular theory selected."**[10] [emphasis added]

Key Resources for the Topic of Behaviour Change Theories & Logic Models

Breinbauer, Cecilia, Matilde Maddaleno. 2005. *Youth: Choices and Change.* Washington DC: Pan American Health Organization.

King, Rachel. 1999. *Sexual Behavioural Change for HIV: Where Have Theories Taken Us?* UNAIDS Best Practices Document. Geneva: UNAIDS.

Kirby, Douglas. 2002. BDI LOGIC MODELS: *A Useful Tool for Designing, Strengthening and Evaluating Programs to Reduce Adolescent Sexual Risk-Taking, Pregnancy, HIV and Other STDs.* ETR Associates: Version: June 15, 2002. PDF file available at http://www.etr.org/recapp/BDILogicModel062002.pdf

A YPSRH programme that uses behaviour change theory to design interventions has two principal characteristics: 1) it is informed by knowledge of the risks and benefits of behaviour as these relate to the social context as well as individual health, and 2) planners construct a **results framework** with explicit expected changes in YPSRH-related behaviours and norms.

Following is a list of common expected outcomes in several behaviour change theories. When constructing the results frameworks in YPSRH programmes and reviewing the content of a YPSRH educational curriculum, designers should note whether these elements are addressed:

> Interventions promote 'self-efficacy' in carrying out new behaviours (i.e., an individual must feel able to overcome barriers to the behaviour).

> Interventions create awareness of social influences through assessing how relationships with others influence behaviour. Individuals can then be more aware about how to manage negative social influences and seek social support toward positive change.

> Interventions promote awareness of and changes in values underlying behaviours that have negative consequences.

> Interventions promote change in group norms. Norms are the expected and appropriate rules of behaviour, linked to positive or negative sanctions, or costs and benefits, associated with following or violating those rules. Programmes can work with groups or social networks of peers to identify and modify norms that contribute to risk and promote norms that lead to positive, healthy behaviours.

> Interventions build social skills. Since sexual and reproductive behaviours are embedded in relationships with others, learning social skills such as negotiation, assertiveness, communication and respect for others can help to reduce an individual's risk and vulnerability.

The main benefit of using one of the established behaviour change theories is that it helps programmes to construct a 'programme theory',[11] or model, with clear hypotheses about the process of behaviour change. Many examples of tools to construct such programme theories are based on a 'logic model' that clearly specifies the expected impact outcome, the activities, the intermediate or 'process' objectives, indicators to measure intermediate and longer-term change, and means of verification of the indicators.[12]

YPSRH Goals for Behaviour Change: Political Conflicts

Many of the current political conflicts regarding YPSRH programmes centre on the appropriate behavioural goals for the programme. Some advocate teaching 'abstinence only' with the behavioural goal of delaying sexual initiation until marriage. Others promote both delay of sexual initiation and, for those young people who are already sexually active, use of safer sex practices, including contraception and condoms. The current international evidence shows that **to be effective, YPSRH programmes should have the dual goals of delaying first intercourse and encouraging protected intercourse.**[13] Evidence from YPSRH programmes clearly shows that these goals and messages are compatible and that both are important. SRH and life skills education should encourage abstinence, most effectively starting before the age when sexual activity starts in a specific social context, and also provide education about safer sex and contraception.

All programmes should provide scientifically valid information on safer sex and contraception to young people. Unfortunately, many 'abstinence-only' programmes tend to highlight so strongly the drawbacks of contraceptive methods (and in many cases distort the scientific evidence to do so) that sexually active young people exposed to these programmes are at greater risk of unwanted pregnancies and STIs.[14]

Evidence on YPSRH risk and protective factors

Much of the research on risk and protective factors for YPSRH has pointed to the close interdependence between adolescent health and development. Situations and factors that enhance development also protect health, while good health enables development. This quote contains most of the elements of the many definitions of adolescent development: "To become healthy and productive adults, youth must develop the attitudes, behaviors, competencies and skills that allow them to succeed as parents, citizens and workers. Youth who do not have opportunities to develop these attributes and test them in a supportive environment are at risk of a variety of negative behaviors and poor outcomes."[15] The Search Institute has developed a widely-used list of the most important developmental assets for adolescents.[16]

The most recent evidence collected by WHO, through literature review[17] and expert meetings from many continents, suggests key protective and risk factors for young people relevant to their ability to avoid unwanted pregnancies and STIs. Many additional factors are also listed in the following 'key resources', and it stands to reason that more explicit risk and protective factors would also pertain in each setting.

The research on risk and protective factors leads to the conclusion that programmes that promote positive social norms and relationships in the families, communities and peer

groups of young people should exercise a more powerful effect than programmes that just concentrate on individuals.

With regard to protective factors, YPSRH researcher Doug Kirby's[18] emphasis on the powerful combined impact on young people of 'connectedness' and social norms (of the groups young people are connected to) could pertain to multiple desired programme effects. For example, a young woman's close connections with a peer group that favours gender equitable norms or with a mother who models female empowerment should be a protective factor against being a victim of sexual or physical violence.

Key Resources for the Topic of Risk and Protective Factors

WHO, Department of Child and Adolescent Health and Development, 2003b. "Broadening the Horizon: Balancing Protection and Risk for Adolescents." PDF file at website: http://www.who.int/child-adolescent-health

WHO and UNICEF, 2001. "Programming for Adolescent Health and Development: 'What should we measure and how?'" Report of the third meeting, Washington, DC, 12–16 June 2000. Geneva: WHO Child and Adolescent Health and Development, Family and Community Health. See chart based on Douglas Kirby's research.

The following protective and risk factors collected by WHO-convened experts are related to early sexual initiation, depression and substance abuse – three important and interrelated health risks faced by adolescents worldwide.

Protective Factors (adapted from WHO 2003b)[19]

- A positive and supportive relationship with parents
- For protection against substance abuse,[20] parental structure and boundaries
- A positive school environment and relationships with teachers
- Spiritual beliefs and regular attendance of religious ceremonies
- Social norms among family and peers that promote health and development
- Opportunities for community service and civic participation
- Hope for the future, with linkages to opportunities for education and livelihoods

Risk Factors (adapted from WHO 2003b)

- Friends who are sexually active or who use substances
- (For sexual initiation) engagement in other risky behaviours (such as substance abuse)
- Conflicts or divorce within the family
- History of sexual abuse

This and other research indicates that high-risk youth behaviors grow from a common soil and are interrelated. Those young people practicing unsafe sex, for example, are often the same that perform poorly at school or are involved in substance abuse. The interdependence of health and development for young people leads to the recommendations in this review for comprehensive and multisectoral programme designs – issues that will be discussed later in this chapter.

Evidence from the Programme Itself: Monitoring for Implementation Quality and Evaluation of Impact

Creating evidence from the programme itself demands attention during the design stage. Monitoring and Evaluation (M&E) depend on the development of a clear programme theory with a framework of expected outcomes and measurable indicators such as a logic model, and on collection of adequate baseline information on all these measures before the programme begins. For some evaluation designs, control or comparison groups need to be identified.

Monitoring and Evaluation (M&E) is an immense topic, and some recent guides to M&E for YPSRH programmes are weighty tomes. This section is limited in scope; it presents the main arguments for investments in monitoring and evaluation of YPSRH programmes, points the reader to useful references, and posits a few evaluation guidelines that, if followed, would help to fill key gaps in the evidence on YPSRH programmes.

Why Evaluate?

Following current theories of behaviour change, YPSRH programmes need to be comprehensive and multisectoral. They need to aim for impact on protective and risk factors as well as on health outcomes, and on young people's development as well as health. Such programmes are complex undertakings. Therefore, learning how to coordinate and implement multiple components most efficiently is of the utmost importance.

Most YPSRH programmes to date mainly have monitoring information that can produce some information on implementation quality and some anecdotal evidence of impact. Some programmes have produced articles on 'lessons learned' (i.e., the 'how to' of implementing these programmes). All but a few suffer from weak evaluation designs that cannot attribute any impact on young people's health to the programme.[21] The evaluation evidence from large scaled-up programmes is especially lacking. As YPSRH researcher Ilene Speizer remarked in a recent literature review:

> *"The present review also highlights a number of significant holes in our current understanding of the efficacy of adolescent reproductive health intervention. First, only a small proportion of adolescent reproductive health interventions undertaken to date have been rigorously evaluated, and thus the relative merits of alternative intervention approaches remain unclear. Second, the majority of the programmes that have been rigorously evaluated have been small-scale in nature and implemented over relatively brief periods of time, and thus we lack information on larger scale, longer running programmes, including on how well successful small-scale interventions can be 'scaled-up'. Third, little evidence is available on long-term behavioural effects of interventions.*[22]

Key Resources for the Topic of Programme Evaluation

Bamburger, Michael, Jim Rugh, Mary Church, Lucia Fort, "Shoestring Evaluation: Designing Impact Evaluations under Budget, Time, and Data Constraints." *American Journal of Evaluation,* Vol. 25, No. 1, Spring 2004.

Barton, Tom, 2002. "Guidelines to Monitoring and Evaluation. How are we doing?" CARE - Uganda. PDF file available on website: http://www.kcentre.com/phls/CARE_Uganda_Guidelines_to_Monitoring_and_Evaluation.pdf

UNICEF Evaluation Office, 2002. "Children Participating in Research, Monitoring and Evaluation (M&E) - Ethics and Your Responsibilities as a Manager." Evaluation Technical Notes, No. 1

Weiss, Carol, 1998. *Evaluation*. Second edition. New Jersey: Prentice Hall.

WHO and UNICEF, 2001. "Programming for Adolescent Health and Development: 'What should we measure and how?'" Report of the third meeting, Washington DC, June 12–16, 2000. Geneva: WHO Child and Adolescent Health and Development, Family and Community Health.

Evaluation questions and guidelines

Given the complexity of the necessary strategies to promote young people's sexual and reproductive health and rights, the most important evaluation question for YPSRH programmes is: "What minimum set of interventions and programme strategies at what intensity is most effective in producing sustainable positive health outcomes among

young people in each country/regional context, and with each segment of the population of young people?"[23] Since the answers differ according to setting and the profile of the young people involved, it is important to incorporate a rigorous evaluation design when testing a new programme model, introducing a programme model into a new setting, or when scaling up a pilot programme for the first time.

Scaling up a pilot project leads to important differences, hence the continued need for evaluation. The population of young people from different regions in a country might live under quite different conditions than those in the pilot project, necessitating adjustments in the design. In addition, it is usually difficult to have the training and supervision operating at the same level of intensity as in the pilot programme.

In the sidebar below are the basic questions to be addressed in such evaluations.

Evaluation questions for new pilot programmes or newly scaled-up programmes

These programmes need to evaluate:

- Feasibility and acceptability. Is the design feasible and acceptable in this setting?
- 'Dose response' and cost. It is useful to experiment with varying levels of intensity, inputs and costs to ascertain the minimum necessary input to achieve the programme's objective for impact. (The designs of operations research programmes allow one to answer these questions.) Accordingly, an effective pilot programme would have several small-scale interventions with planned variations in settings that are similar.
- Lessons learned about best ways to implement the programme. Pilot programmes often experiment through trial and error until they learn the best way to implement the programme. Process evaluation is important to capture these lessons and communicate them in the final training materials that make larger-scale replication possible.
- Impact. Does the programme theory hold? That is, if the activities and inputs happened more or less as planned, do they produce the hypothesised impact on factors affecting young people's sexual and reproductive health?

When testing a new strategy for impact, it is best to use a quasi-experimental design, ideally pre- and post-test surveys with a control/comparison group.[24] This design allows one to attribute any observed positive impact to the programme (as opposed to external factors in the environment) with some degree of confidence. Many real-world situations do

not allow this level of rigor, however, and there are excellent guides in the evaluation literature to the strengths and weaknesses of other quasi-experimental designs that are less rigorous, but also less costly.[25]

Young people's participation in evaluation is important both because it is their right as beneficiaries of the programme to have a say in its design and evaluation, and because without this input, the programme evaluation will lack important information on acceptability, suitability, and factors in the programme's success or failure in achieving the desired impact. Without the input of young people, programme managers might know through research whether the programme had an impact or not, but they would not understand why. If the programme involves both male and female young people, programme managers might have to make special efforts to make sure that the evaluation represents girls' viewpoints accurately and fully.

Developing the outcomes and indicators for a programme is often challenging. For purposes of illustration, table 3.3 provides examples of monitoring and evaluation indicators for a national school-based SRH education programme.

CRC-Based Programming for Young People's Sexual and Reproductive Health

All UN agencies are committed to rights-based approaches based in the international human rights documents. For young people's programmes, all of which should incorporate a commitment to gender equality, UNICEF has linked its programming to two key treaties that bind the governments who ratify them: the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW).[26]

On substantive issues related to young people's health and development, and YPSRH issues in particular, the two General Comments from the CRC Committee cited in the box on key resources give excellent guidance. General Comments of the Committee on the Elimination of all Forms of Discrimination against Women also underscore women's right to be free from violence, from female genital mutilation/cutting (FGM/C),[27] and from discrimination in the prevention and control of HIV/AIDS.

Adopting a rights-based approach to programming for young people has several important implications.[28] This review cannot do the topic justice, but will very briefly summarise selected elements of this approach with important implications for advocacy and programming for young people's sexual and reproductive health.

Advocacy

Attention to the political, legal and regulatory environment is a key aspect of rights-based approaches to programming. Advocacy with and involvement of parents and national, regional, and community leaders is necessary to achieve a supportive community and political environment for YPSRH programmes, as well as to ensure sustained financial and political support for them.

At the community level, several programmes worldwide have found that it is useful to conduct a **participatory needs assessment** to determine the risks faced by young people. This strategy often defuses opposition to the programme.[29] In the initial stages of a programme, all of the relevant decision makers and sectors (including young people) should be involved in designing it, with support and ownership of the initiative constructed through dialogue and consensus-building.

Achieving the necessary support in the policy environment for YPSRH is an essential, continuing and long-term task.[30] Support of health-protective norms among at least some policy-makers in the political environment is a key facilitating factor in the implementation of YPSRH programmes, services and policies.

Key Resources for this Topic

Committee on the Rights of the Child, 2003. "Adolescent health and development in the context of the Convention on the Rights of the Child," General Comment 4 (2003), CRC/GC/2003/4. Available from website: http://www.ohchr.org/english/bodies/crc/comments.htm

Committee on the Rights of the Child, 2003. "HIV/AIDS and the Rights of the Child." General Comment 3 (2003) CRC/GC/2003/1 Available from website: http://www.ohchr.org/english/bodies/crc/comments.htm

Pais, Marta Santos, 1999. *A Human Rights Conceptual Framework for UNICEF*. Florence, Italy: International Child Development Centre, UNICEF.

Patel, Mahesh, 2001. "Human Rights as an Emerging Development Paradigm and some implications for Program Planning, Monitoring and Evaluation." Draft paper presented at UNICEF Global Consultation on Human Rights Approach to Programming, Tanzania, August 5–8, 2002.

UNICEF Executive Directive. CF/EXD/1998–04, 21 April 1998. Memo from Carol Bellamy on "Guidelines for Human Rights-Based Programming Approach."

First, as the diagram[31] on the next page illustrates, the approach moves from a needs-based approach to a rights-based approach. The two are related, but children's rights entail obligations from the state 'duty bearers', such as schools, that are in a position to affect the fulfilment of children's rights. UNICEF has developed three steps in situation analysis for rights-based programming: 1) to analyze the immediate, underlying and

structural causes of lack of fulfilment of children's rights, 2) to analyze the situation with regard to relevant duty bearers in their relationships with children whose rights are not fulfilled, and 3) to analyze the availability and control over resources – human, economic and organizational – in order to identify possibilities for action and structural causes of problems in fulfilment of children's rights.[32]

FROM NEEDS TO RIGHTS

NEEDS		RIGHTS
Child as object with needs	>>	Child as a subject with claims.
Needs only imply promises	>>	Rights always imply obligations

After the situation analysis, the next step is full participation of the subjects of rights in devising solutions. When children are 'subjects', not 'objects', they are accorded the right to participate and have a say in programmes and policies that affect their lives. When advocating for policies and programmes that protect young people's sexual and reproductive health, young people have the claim to the resources and services they need for their survival, their development and health, and their right to have a say in policies that affect their claims. The state and other duty bearers in their environment have the obligation to provide these resources and other services.

Implications of CRC Principles for YPSRH Advocacy and Programming[33]

All of the countries in the Arab States and Iran have ratified the Convention on the Rights of the Child (CRC), and most have ratified the International Covenant on Economic, Social, and Cultural Rights (ICESCR).[34] Both these treaties and subsequent interpretations establish governments' obligation to fulfil young peoples' right to access to SRH information, education and services. Controversies regarding fulfilment of this right arise because some health risks for young people arise from disapproved social behaviours, such as premarital sexuality or substance abuse. Therefore, advocacy for YPSRH programmes is both an initial and a continuing task. International human rights treaties and the process of reporting to the treaty bodies are essential advocacy tools.

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 young people's 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 reporting process is also an important opportunity to reinforce a positive and comprehensive

health and development approach to YPSRH. When only the Ministry of Health reports on YPSRH issues, these are overly medicalised. Involving other Ministries enables comprehensive reporting on young people's health and development that takes into account relevant political and socio-economic factors.

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.[35]

With variations depending on the specific 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 school enrolment and achievement, and other instances of discrimination or violence against women and girls (see annex III).

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 healthcare 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.

Because ratification of human rights treaties incurs government obligations under international law, the following pages will explain how some basic human rights principles – including CRC principles and certain principles highlighted in the health and human rights literature – pertain to State obligations regarding YPSRH and to programme and policy design. For readers involved in YPSRH advocacy, a related argument for advocacy purposes is provided for each principle.

Universality: It is useful to invoke the human rights principle of universality. Referring to the CRC, this means that all rights apply to:

> all children
> all the time
> everywhere
> without discrimination.[36]

> ***Advocacy argument*:** When certain young people's disapproved social behaviour is threatening their survival or health, the state's obligation to protect their survival and health still stands, because these rights apply without discrimination. Political and cultural opposition to providing SRH education and services to young people is not a justification for a State's failure to protect its young people and fulfil their universal rights.

Certain other articles in the CRC are cited as the CRC's general principles:

The best interests of the child shall be a primary consideration (Article 3.1). The survival, health, and development of young people are clearly essential to the concept of 'best interests'.

> ***Advocacy argument*:** When situations or behaviour affecting sexual and reproductive health jeopardise these interests, the state has an obligation to provide the SRH information, education and services that would ensure young people's survival, health and development.

Ensure to the maximum extent possible the survival and development of the child (Article 6.2). Signing the Convention incurs a positive obligation on the state to provide the resources and services that young people need, not just to survive, but also to thrive. This principle is interpreted to include state obligations to provide an adequate standard of living, to provide education, and to ensure "full and harmonious development of the child, including at the spiritual, moral and social levels."[37]

> ***Advocacy argument*:** Governments have the obligation to identify and give priority attention to the most vulnerable sectors of young people whose life, survival and development are most at risk, such as those in zones of conflict and involved in conflict, refugees, children who live and work on the streets, and young married girls.

Ensure that the child is protected against all forms of discrimination. (Article 2.2) Discrimination by socio-economic class, gender, ethnic group, or other factors is present in most societies. Disaggregation of data on young people by these relevant categories – as well as urban/rural location, schooling status, and marital status – is essential in order to detect and address discrimination and inequities in health status and in access to education and services.

> ***Advocacy argument*:** Governments have the obligation to identify instances of discrimination and rectify them. Discrimination makes young people more vulnerable to SRH risks. Extreme vulnerability due to their situation and to stigmatisation especially affects young people involved in commercial sex, those involved in substance abuse, young people living with HIV/AIDS, MSM (men who have sex with men,) and children who live and work on the streets.

Take into consideration the views of the child (Article 12). The CRC enjoins states to seek and take into consideration young people's input in programmes and policies that affect their lives. "The Convention envisages a changed relationship between adults and children. … Adults are therefore expected to create spaces and promote processes designed to enable and empower children to express views, to be consulted and to influence decisions."[38]

> ***Advocacy argument*:** Participation is young people's human right, and governments have the obligation to create the mechanisms to make this participation possible. Participation will enable programmes to be more effective.

Other accepted health and human rights principles – **access, gender, privacy and confidentiality** – are useful for programme planners because they point to important rights issues that YPSRH programmes need to address in order to be effective. 'Youth-friendly'[39] education and services address these principles by responding to young people's preferences, encouraging their participation, protecting their privacy and confidentiality, and training staff to be non-judgmental, welcoming and non-discriminatory. Discussion of these principles follows:[40]

Ensure that health systems are made accessible to all. Lack of access for young people to SRH services is often related to young people's lack of access to cash and/or means of transport to the service location, as well as to social stigma attached to young people's sexual activity or substance abuse. Girls might not be able to leave their home unaccompanied. Innovative programme strategies need to ensure this access, such as confidential hotlines, Internet chat-based advice and services in a variety of venues that overcome these barriers.

Address gender issues. In order to effectively address YPSRH issues and combat discrimination against girls and young women, programmes need to commit to active and explicit promotion of gender equality with boys and girls, and with their parents and the surrounding community, in all messages and activities. Examples of the required commitment might include:

- initiatives to prevent gender-based violence, advocacy to eliminate laws and policies that discriminate against girls and women
- educational modules stimulating both young people and adults to question gender roles and gender-based discrimination
- building life skills that enable young people to overcome the negative aspects of their socialised gender roles
- programme components that empower young women, giving them increased confidence, mobility, autonomy, skills and opportunities for education and livelihoods

Some popular models of young people's sexual and reproductive health programmes do not adequately analyse how gender discrimination affects who has access to their programme, and whether the programme meets the specific needs of girls and boys.[41] For example, youth centres often do not take restrictions on girls' mobility and access to opportunities into account, so that they end up serving mainly older boys. In some countries, peer education strategies appeal to boys' preferences better than to girls', possibly because their sexuality is less stigmatised than that of girls. Young married girls face various threats to their health and development, yet most of the current YPSRH programme models do not reach them because they are often isolated, with little mobility outside their homes. In summary, national policies and programmes for young people's health and development need to take the gender-specific needs and restrictions into account.

Provide privacy and confidentiality. Private communications with health counsellors or providers and confidentiality of personal health data are the right of any user of health services and are especially sensitive issues in sexual and reproductive health services. Studies from many countries have found that respect for the confidentiality of young people's health information and for their right to privacy is frequently lacking, and poses a key barrier to use of the services. In training service providers for young people, this principle needs to be emphasised strongly to make the services 'youth-friendly'.

In summary, respecting and fulfilling the rights of young people as defined in the Convention on the Rights of the Child and other human rights documents is essential to programme effectiveness. Understanding young people's constraints and preferences,

eliminating barriers to access, respecting confidentiality, and using advocacy to overcome political resistance to YPSRH programmes are effective and rights-based approaches to YPSRH programme design.

What Makes a Service 'Youth-Friendly'?

The concept of 'youth-friendly services' is closely related to human rights principles, because the elements pertain to key socio-economic barriers to access for young people, to the right to participation in the CRC, and to general health-related rights such as privacy and confidentiality.

The unique aspects of youth-friendly services have to do with special attention to:

- privacy and confidentiality
- finding out about young people's preferences and fulfilling these, including those related to service channel
- non-judgmental, warm, friendly interactions between providers and young clients
- responding to young people's particular barriers to access, which can be
  - physical (too far away or unsafe neighbourhood)
  - gender-based (restrictions on girls' mobility)
  - financial (clinic fees, or insurance schemes through which parents find out about clinic visits)
  - administrative (hours, appointment procedures)
  - legal (age of consent laws)
  - psycho-social (the aggressive and judgmental attitudes with which those in the community regard sexual activity among young people, particularly among girls and young women)

Comprehensive Programme Designs

As discussed above, the research on risk and protective factors for YPSRH has led to consensus internationally on the need for comprehensive programming. This section first describes the essential components of a comprehensive programme for young people, in order to fulfil their rights to health and development and to address their SRH risks effectively. Second, the section discusses some of the challenges and lessons learned in the coordination of multiple sectors of government and civil society in these comprehensive programmes.

Essential programme components for YPSRH

The following programme components have been identified in a wide variety of documents from UNICEF, WHO, UNFPA, UNAIDS, the World Bank, and major bilateral agencies such as USAID. In all of these components, **young people's participation** should be a guiding principle. Not only is this their right; such participation is a protective factor for young people's health, and it produces better programmes. If young people do not participate in the identification of their needs, in the design of the programmes to meet those needs, in the process of implementing them, and in their evaluation, the programme runs the risk of being irrelevant, or even harmful.

1. **Information (CRC Article 17): Provision of relevant and reliable sexual and reproductive health information** through multiple youth-friendly channels and strategies, which include provision of the information to the adults or older youth in young people's immediate environment, and in schools, media and recreation spaces. This information should include concrete ways of accessing counselling and services if needed.

   While provision of basic SRH information may seem less complex than the following components, ensuring the quality, appropriateness, and comprehensiveness of this information is difficult, especially in programs that rely on peer and community educators, who need to be trained and supervised. Young people should be involved in developing any informational materials, so that they use appropriate language and appealing images.

2. **Education (CRC Article 28): Education of young people through universal primary and secondary school education, technical schools, universities, and training programmes in life skills, with integration of SRH and gender issues in the curriculum.** Access to both formal and non-formal education is a key factor in both men's and women's well-being, but especially for women, in countering gender inequities and promoting sexual and reproductive health. Relationships between increased schooling and reduction of the risk factors for sexual and reproductive health problems hold for all socio-economic classes and in all regions of the world.[42] Non-formal education can take place in venues outside of the formal system, including youth organizations, community centres, sports and recreation programmes, work places, and religious institutions. Both types of education can build vocational and life skills, nurture healthy behaviours, build supportive relationships with adults, enhance self-esteem and self-confidence, and enhance other factors that protect health.

What is Life Skills Health Education?

"Life skills are abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life." (WHO definition). In the context of health education, life skills education (LSE) uses relevant and effective content and participatory learning experiences to develop skills needed to protect one's own health and prepare for responsible adult roles. Besides imparting the necessary knowledge, LSE promotes attitudes that protect health and discourage risk-taking behaviour. LSE enables the learner to practise psychosocial and interpersonal skills such as communication, negotiation, conflict resolution, decision-making and critical thinking skills, independence from peer pressure, and coping and self-management skills. LSE might also include skills to advocate for health-protective changes in policies and programmes.

Adapted from WHO, 2002, and UNICEF, 2003b.

3. **Access to Health Services (CRC Article 24):** Both married and unmarried young people have a right to health, and therefore to basic SRH services that are affordable, appropriate and confidential. The concept of 'services' includes access to counselling, basic healthcare, and medicines and other health products – including condoms and contraceptives. Examples of possible services include a telephone hotline, Internet-based counselling, training for pharmacy workers to be youth-friendly, community-based education and distribution of products, confidential networks of private health providers, and the traditional health clinic. Young people who are married, especially girls or young women, have special risks and constraints that services should know how to address. Most SRH services for unmarried young people are provided most effectively outside of a traditional health clinic setting, unless anonymity, privacy and confidentiality are assured and access from a wide geographic area is possible.
4. **Safe and Supportive Environments (CRC Articles 3,6 and 19):** Professionals in the YPSRH field and the human rights system recognise that, in order to promote health and development, young people need a safe, supportive environment in their families, among the other important adults in their lives, in their peer culture, and in key institutions such as schools, sports programmes and media. Some important 'safe' and 'supportive' elements are the following:
   - Adults support the right of young people to confidential SRH information and services
   - Young people are not subject to physical or sexual violence or abuse
   - Social context supports health-protective norms

In other words, promotion of health-protective norms for sexual and reproductive health among key individuals and institutions in the social environment is a necessary complement to provision of information and skills-building to the young people themselves. Community acceptance of these norms enables young people to translate new health-protective information and attitudes into health-protecting behaviour. "The available evidence suggests that youth-friendly service programmes work best when paired with other efforts aimed at changing community attitudes about young people's sexuality and the risks they face."[43]

5. **Adequate Standard of Living (CRC Article 27) and Vocational Education (CRC Article 28 b and d): Opportunities for livelihoods** provide young people, depending on their age, with the capabilities (e.g., skills, knowledge, self-confidence, marketing and business skills, decision-making ability), resources (e.g., access to education, social networks, credit, loans, housing, land, education, social networks) and, once they are old enough,[44] opportunities (e.g., entrepreneurship, working for pay, home-based work, domestic production) to attain an adequate standard of living, increase their life options and give them hope for the future. Such opportunities are a strong protective factor for health and development. Most programmes focused on health would provide these opportunities through linkage to programmes or agencies expert in this field.

   For many young women, access to education and/or livelihoods enables them to delay marriage until after age 18, and to enjoy more equality and independence once married.[45] It is common practice to deny young married women under age 18 access to both education and employment. In some countries in the MENA region, great advances have been made in women's access to education, but not in their access to employment. Discrimination by occupation is still widespread, so that women predominate in generally lower-paid occupations, while men predominate in other, higher-paid occupations. (See the situation analysis for a fuller discussion of this issue in the MENA countries.)

   On the other hand, in the MENA region, most young men cannot marry until they have a livelihood, and high levels of unemployment further delay marriage for many men. This delay often means that men have had multiple sexual partners before marriage, putting them at risk for infection with sexually transmitted infections (STI) if engaging in unsafe sex and, if undiagnosed or treated, putting their future wives or sexual partners at risk.

"Think comprehensively, act selectively":[46] multisectoral programme design

The discussion above of research on risk and protective factors shows that promoting sexual and reproductive health for young people must involve not only provision of health services, but also efforts to change socio-cultural norms; ensure opportunities for education and livelihoods; and address other risk factors that threaten young people's health. Living in poverty often translates into lack of access to information, education, and services, and, in numerous ways, exacerbates most health threats to young people. Access to opportunities for education and livelihoods is a key protective factor for the health and development of young people, helping them to raise their standard of living, giving them hope for the future, and decreasing their vulnerability to health risks.

Because risks are associated with multiple factors in the environment, multisectoral programme design and coordination are necessary for prevention programmes to have sustainable impact. As youth-serving programmes adopt more effective, comprehensive designs to address health and development issues in tandem, they need to acquire new skills, such as community outreach or youth participation. They also need to involve new partners in different sectors beyond health and education, such as those involved in youth employment, agriculture, or the media.

Many programmes struggle to focus more effectively within this broader framework and too often end up with unwieldy, overly ambitious objectives and work plans. Young people's sexual and reproductive health programmes cannot do it all. Comprehensive, multisectoral programming is best implemented through coordinating mechanisms and partnerships of organizations and networks. This coordination brings its own challenges, but it is the way forward. The section on 'lessons learned' below offers some guidance.

Multisectoral approaches demand of each sector that they determine their most appropriate role given their expertise and their channels of access to the population. The challenge for each sector is to bring comprehensive strategies to life in a specific programme, creating partnerships so that the sector's resources are used to best effect. Table 3.4 analyzes which sectors have the comparative advantage in access to distinct populations of young people,[47] while table 3.5 analyzes the comparative advantages of each sector for different programme models for YPSRH. The tables are not an exhaustive list of possible sectors involved in YPSRH programmes. Indeed, many programmes have been highly creative in their outreach to sectors not traditionally involved in youth programmes. For example, the LoveLife Programme in South Africa has involved the public water agency, and placed health promotion messages on water tanks in rural areas.[48]

This analysis of sectors and youth populations is not always clear-cut. For example, agriculture sector programmes probably have the best access to rural young people – unmarried and married – in many countries, especially where health or education coverage is low. In this situation, adding a SRH component to a programme run by an Agriculture Ministry may be the best way to promote the health of young people in rural areas. However, if gender analysis of the profile of beneficiaries of the Agriculture programme shows that few young women are involved, then planners need to design another strategy – possibly with a different sector – for reaching young women, while working with the Agriculture programme to correct the discrimination against women.

Table 3.5 suggests which sectors are best suited to offer each programme component discussed in this section directly (information, education, services, etc.). Some of the observations in the tables are tailored to the socio-cultural context in the Arab Countries and Iran. For example, in socially conservative settings, the health sector is less able to serve sexually active unmarried young people in a clinic setting.

However, through partnerships, each sector's programme can be comprehensive, and thus more effective. The health sector may not be suited to run broad-based vocational training programmes to increase access to livelihoods, but the sector could use its special strengths and facilities to expand such opportunities. For example, a Ministry of Health's adolescent health education programme could run a volunteer internship programme in health clinics and hospitals for young people, with referral mechanisms for training to facilitate their entrance into a health career. Conversely, while employment programmes for young people are not best suited to offer health education, they could partner with health organizations to provide avenues to health careers along with health education, and/or they could invite professionals from the health sector, or NGOs working against violence against women, into their vocational training courses in order to integrate SRH education. In such partnerships, both sectors gain. The health sector gains access to a population of young people who rarely attend health clinics, and vocational training programmes gain health protection for their students, thus decreasing desertion rates.

When planning multisectoral YPSRH programmes at the national level, a coordinating mechanism, such as a Youth Ministry,[49] is necessary to avoid duplication of efforts and enhance the initiatives of all sectors involved in young people's health and development. Another invaluable function of a Youth Ministry is to support and facilitate the political participation of young people and their organizations. The organizations supported by the Ministry can then serve as the vehicles for achieving young people's input into the design and evaluation of programmes and policies affecting them.

An Example of the Potential Role of a Youth Ministry

A Ministry of Health has developed health promotion educational materials for young people, and young people should participate in their design, yet the Ministry does not have access to large numbers of this age group through their service facilities. A Youth Ministry could play a much-needed coordinating role, putting the educational materials designers in touch with young people's organizations and programs. The Youth Ministry arranges for numerous youth organizations to provide design input into the educational materials, and then arranges channels for dissemination of these materials with the Youth Ministry programs (often centred on sports and recreation), and with programs of other agencies, such as Women's Affairs, Education and Labour.

Lessons from multisectoral efforts: In national programmes, multisectoral coordination needs to happen at multiple levels – from Ministries to state/provincial levels, and then finally at the community level. This coordination is not easy, for many reasons. Most government and international agency bureaucracies are vertically organised. They are organised for different purposes, so their goals differ. Their disciplinary training differs, so that they literally speak different languages that have evolved through internal communications in consensus-building and through different professional tracks and literature. Their budgets are distinct, usually insufficient for the identified needs, and jealously guarded. Even within a large NGO or foundation, it can be challenging to organise collaboration between two or more divisions in the organization.[50] New large consortia with big budgets divided up among members tend to be riddled with tensions and take as long as a year before consensus on basic objectives, division of labour and budgetary expenditures, operating principles and work plans enable the programme to begin.[51] Often the source of conflict in multisectoral strategies is the distribution of programme resources – funds, the vehicles, staff, etc.

Achieving multisectoral coordination is easier at the community level, where the main actors involved know each other through social networks and where there are fewer logistical barriers to face-to-face meetings, which are tremendously useful for resolving complicated issues and building trust.

However, one difficulty with promoting the multisectoral approach at the community level in resource-poor settings is that frequently one person does all the work: the HIV/AIDS programme, the young people's programme, the malaria and tuberculosis programmes, the immunization programme, etc. This lone person might be rural health-post staff, a community outreach person in a municipality, or a community health promoter.[52] Strategies that enable over-burdened community-based personnel to engage and train other community members – in this case young people themselves – are the best solution to this difficulty for YPSRH programmes.

Some lessons from multisectoral efforts are the following:[53]

- **Support from high-level decision makers at the national level is essential.** The political will to achieve true coordination is important to overcome the above-mentioned barriers to multisectoral work. Achieving this support is an important aspect of YPSRH advocacy, since the sensitivities attached to these issues often weaken political will.
- **Decentralization of political and financial authority to local levels favours multisectoral efforts,** in countries where this has taken place. The synergy from multisectoral cooperation happens much more easily at the local level than at the national level. National ministries can supply the mandate, training and resources necessary for the local efforts, with clear agreements so that local governments will assume long-term responsibility for the programme. To achieve the needed community involvement and young people's involvement in YPSRH programme design, having some decision-making authority at the local level is essential.
- When partners do not have a history of working together and the programme is large and complex, **adequate planning time must be allowed.** Often a period as long as six months to a year is needed before implementation can commence. The partners need to reach consensus on key issues, begin to speak a common language and engage in joint planning. Agreement on the appropriate YPSRH interventions and educational materials can take time.
- The planners of a multisectoral initiative should **divide responsibilities and resources transparently and clearly** once the objectives of the programme are clear.
- Such consortia do not work without an **overall coordination mechanism.** For this reason, this review recommends strengthening the Ministries of Youth and Sports that exist in Iran and most Arab States, providing them with an adequate budget along with the mandate of coordinating multisectoral efforts, incorporating SRH issues (which few do) and fostering young people's participation. The coordinating function involves convening the partners, coordinating their efforts and engaging in advocacy for the programme.
- **Advocacy activities** must be figured into the work plan and budget of the coordinating agency – in particular, time and resources for a programme leader to deal with political challenges and resistance that often accompany YPSRH programmes.

The process of reporting to the relevant human rights treaty body is an important opportunity to reinforce multisectoral coordination. As mentioned earlier, often it is the Ministry of Health reporting on YPSRH issues, thus medicalizing issues that are strongly influenced by political and socio-economic factors. Involving other Ministries enables comprehensive reporting on young people's health and development.

Commitment to Gender Equality and Women's Rights

Promotion of gender equality and equity[54] are central to a rights-based approach to programming. The UN system and all State parties to CEDAW have an obligation to attempt to eliminate discrimination against women. At the International Conference on Population and Development (ICPD) in 1994, every government in the United Nations signed the Programme of Action,[55] a consensus agreement that highlights the central goal of women's empowerment to fulfil their human rights, and to enable all health and development efforts. One year later, at the Fourth World Conference on Women in Beijing, every government in the United Nations signed the Platform for Action, which touched on every aspect of women's rights and empowerment.

Furthermore, from the perspective of public health, there is now widespread consensus that addressing discriminatory gender norms is highly relevant to the success of sexual and reproductive health promotion programmes.[56] Social and sexuality norms differ for young men and young women, affecting their constraints, their behaviours and their risks. Therefore, YPSRH programmes need to address gender issues with both boys and girls, with a special focus on girls' empowerment.

In many countries, gender roles for both girls and boys are in enormous flux, creating a severe generation gap and communication difficulties between adults and children, especially adolescents. These changes are more marked for girls and young women as their average level of education increases and as more women enter the labour market. This generation of young people's growing access to global mass culture through television and the Internet, increased rural-to-urban migration, and rapidly increasing access to educational opportunities contribute to a breakdown of traditional cultural norms related to gender and sexuality.

This report integrates attention to gender issues into most chapters and issues. Therefore, this section will only briefly discuss the process of gender mainstreaming and some of the main gender issues that need to be addressed in YPSRH programmes, first for girls and young women, and then for boys and young men. These issues should be included in situation analyses, the educational content of programmes, and evaluations. These issues have been found to be pertinent in most regions in the world,

including the Arab States and Iran. The section concludes with a reflection on the mainstreaming of gender issues within YPSRH programmes.

The Process of Committing to Gender Equality

When any organization or programme decides to make a commitment to gender equality, it is helpful to visualise the organizational change process for planning purposes. In most societies, commitment to gender equality is uneven, so a programme's staff and stakeholders need to be involved in a participatory process leading to this commitment. The process generally has three components, which can be facilitated by training, supervision and political will at the highest level of an organization.[57]

> **Recognition that gender inequities and roles are socially constructed** and thus not inherent and foreordained in the natures of both sexes. Realizing that "it does not have to be this way" is the key consciousness-raising result, and can often be achieved in a first participatory workshop.

> **Understanding and addressing the epidemiological relationship between gender inequities and roles, and SRH health risks** for each sex. In the YPSRH field, the interaction between gendered norms of male and female sexuality and their health risks are important to understand, as well as the role of discrimination and violence against women in their gender-specific vulnerability and risks.

> **Commitment to promote gender equality through active interventions** with individuals and socio-political institutions. A programme shows its commitment through devoting human and financial resources to address these issues, such as gender sensitivity orientation for staff, training staff to address violence against women, including these issues in its educational programmes, or advocating in the political arena for laws that increase gender equality.

Key Gender Issues for Girls and Young Women

In most 'patriarchal'[58] societies, women have an inferior status and lack political, social and economic power. The political context leaves them unrepresented in spheres of power, while laws, policies and long-established practices in State and private institutions reinforce discrimination in multiple spheres of social and economic life. Norms regarding proper male and female behaviour and occupations (a.k.a. 'gender roles'), women's low status and power within families, and their relative lack of opportunities for education and employment are not only highly discriminatory against women, but also make them very vulnerable to health risks such as maternal mortality and morbidity, physical and sex-

ual violence, mental health problems, and sexually transmitted infections, including HIV/AIDS. The father or older male siblings may engage in physical violence against female family members. These trends may be accentuated for girl children and younger women, who tend to be the lowest status members of their households, whether within their family of origin, or as young brides. Neglect of, and discrimination against, girls and women holds serious consequences not only for their own health, survival, productivity and coping capacity, but also has very negative implications for overall family and community well-being and progress.

As a result of their dependence, lack of autonomy and vulnerability to violence, women are often unable to negotiate the terms of sexual relations with men, making them especially at risk of contracting STIs even if they are married and monogamous. "Women have less control than men over initiation of sex and the nature and conditions of sexual encounters. This fundamental power deficit in sexual decision-making makes women, and especially young women, profoundly vulnerable."[59] Few women are able to negotiate condom use within marriage if they suspect their husbands of having other sexual partners. Young married women marrying more sexually experienced older men are especially at risk. Both unmarried and married young women suffer from multiple barriers – including those related to state policies and to the socio-cultural context – to access to the sexual and reproductive health services that they need. This vulnerability cuts across all countries studied in a recent UNAIDS report.[60]

The following common examples of the negative aspects of gender systems are provided to give the reader some guidance on what to look for when analyzing the level of gender discrimination against young women in any given context.[61] These examples represent trends across several regions in the world, although within regions and within countries there is always diversity; some countries and regions are more equitable than others in policies, level of discrimination or in daily life. When conducting local needs assessments on socio-cultural issues relevant to YPSRH, the following gender issues should be included in the assessment, to see whether or not the trend is present in the local context.

> A serious human rights violation in most societies is violence against girls and women, including physical, mental and sexual violence – also called 'gender-based violence'. Specific forms of violence discussed in the UN human rights system include all kinds of violence in everyday life, such as physical beatings or sexual abuses in the family, 'honour killing', sexual harassment at the workplace or in educational institutions, marital rape, sexual exploitation, and traditional harmful practices such as female genital mutilation/cutting.

> The nutritional and/or healthcare needs of girls and women may be given lower priority than those of males, potentially resulting in severe

consequences for their health in general. Anaemia, especially during pregnancy, is common, and severe anaemia is life-threatening to the pregnant young woman and her child.

- Girls are often discriminated against when the family makes choices about school enrolment, or they are withdrawn from school when they reach puberty.
- In some cultures, girls have little choice about their marriage partner. Early marriage is more frequent for girls than for boys. Often the legal marriage age is lower for girls than for boys, and many girls marry much older men. The CRC recommends that the minimum age of marriage be 18 years for both sexes.
- In more conservative cultures, restrictions on girls' and women's mobility outside the home make it more difficult for them to have access to education, livelihoods and recreation opportunities, as well as to sexual and reproductive health services.
- Girls have much less access to opportunities for sports and exercise than boys do, with negative consequences for their physical and mental health.[62] Sports impart self-confidence, self-esteem, and life skills such as working with a team, learning to accept feedback on errors, gaining both physical and mental confidence and strength, accepting defeat and success gracefully in competition, and working hard to do one's best.
- Girls and women tend to suffer discrimination in employment, with segregation into the lower-paying segments of the labour market. Female-dominated professions having significantly lower average wages than male-dominated ones. Girls and women may be informally or formally barred from some occupations, such as the military or engineering.
- There is a sexual double standard, in which men have relatively free rein, while women – especially young women – are severely constrained and punished for infractions of the rules binding their sexual behaviour. When such infractions occur, or are even suspected, girls and women in some cultures are at risk of violence from male members of their family of origin or from jealous husbands, often leading to severe injury or death.
- The civil codes of many countries discriminate against women in property rights, inheritance, ability to manage one's own assets, access to health services or procedures without parental or spousal consent, rights to confer citizenship on offspring, and in rights to a proper share of family assets upon divorce.

In any country, the reporting process to the CEDAW Committee is an invaluable opportunity to collect data on these issues for the country report. The comments of the Committee to the country highlight important women's rights issues that need to be

addressed. Annex III includes observations on each country in the MENA region by international treaty bodies, mainly the CRC and CEDAW Committees.

Key Gender Issues for Boys and Young Men

In general, boys and men do not suffer the overt discrimination and lack of access to opportunities experienced by girls and women, although boys and men belonging to marginalised groups – such as ethnic minorities or children who live and work on the streets – do suffer from similar discrimination and exclusion. However, certain aspects of the definitions of approved masculine behaviour in many cultures pose risks to the health and development of boys.[63] For example, boys and young men are more apt to:

- Die or suffer injuries from violent incidents, usually from peers in male-on-male violence. Risks are especially high in zones of conflict, where there is ready access to small arms among the general population.
- Exhibit extreme prejudice, and often exercise violence, against homosexual men.
- Be involved in armed conflict (e.g., in Iraq, OPT and Sudan,) with high risks of injury, disability or death.
- Be more subject to severe corporal punishment than girls, both at home and at schools. Boys are supposed to be able to 'take it', and are more apt to question the authority of the father.
- Be taken out of school to work and provide for parents and siblings. In 13 countries in the Arab States and Iran, secondary school enrolment rates are actually higher for girls than for boys.
- Take risks that result in accidental injury or death. For example, the Gulf States have experienced a sharp rise in automobile accidents involving young men.

The following characteristics of male gender roles in many countries have a direct effect on the reproductive and sexual health of young men and/or their sexual partners. Men tend to:

- Be more reluctant to seek healthcare when ill, thus increasing the probability of serious health problems.
- Exercise physical, sexual and/or emotional violence against their female partners, and restrict their partners' mobility and access to SRH services.
- Have multiple sexual partners, especially if they migrate away from their home for employment, thus increasing their risk for sexually transmitted infections.

> Fail to respond to messages about reducing risk and 'safer sex' in HIV prevention programmes because risk-taking is associated with perceptions of manliness, especially for young men.

It is now clear from more than a decade of social science research on sexuality that sexual norms associated with masculinity — early sexual initiation, having multiple partners, being the initiator and aggressor, and prejudice against homosexual men — are common to many cultures in all regions of the world. **These masculine sexual norms are among the main driving forces behind the HIV/AIDS epidemic and other sexual and reproductive health problems, including sexual violence.** It is during the period of adolescence, when young males are most susceptible to social pressures to conform to masculine norms, when initiatives to transform these norms in order to promote health and gender equity will be most productive.

Gary Barker (2000) has developed a framework for describing the characteristics of young men who are 'gender equitable', thus aiding programmes in setting their goals and proposed strategies for changes in attitudes and behaviours. The framework helps to identify 'positive deviants', members of the community who exemplify these attitudes and behaviours and have found feasible strategies to carry them out.

The following list adapts and expands his framework (developed in Brazil) for the Arab Countries and Iran, and describes the characteristics of 'gender-equitable' young men. These characteristics can be transformed into objectives and indicators for programmes working with boys and men on gender issues:

1. They are **respectful in their relationships with young female relatives and promote their access to opportunities.** They promote their access to resources within the family (such as food and funds for healthcare). They support young women's mobility, i.e., their ability to go outside of the home to take advantage of opportunities for education, livelihoods or recreation.
2. In contexts where young men date their female peers or when describing their ideal marriage partner, they **seek relationships based on mutual respect, equality and intimacy** rather than domination and sexual conquest. They believe that men and women have equal rights and responsibilities, including in the area of sexual behaviour.
3. They assume shared **responsibility for reproductive and sexual health** issues with their wives or sexual partners. This includes taking the initiative to discuss reproductive health concerns with their partner, using condoms, or assisting their partner in acquiring or using a contraceptive method.

4. **They do not use or condone violence against women** in their current family or intimate relationships, and are opposed to violence against women in general.
5. They seek to be **involved fathers,** and take financial, care-giving and healthcare responsibility for their children, whether or not conceived within a legal marriage. For those who are not yet fathers, they hold these beliefs.
6. If married or living in union, **they assume their fair share of household tasks,** especially if their wife works outside the home. If unmarried, they hold beliefs that support men's shared responsibility.

Mainstreaming Gender Issues

Working to promote gender equality among young people is particularly important because at this stage in the life cycle, young people are constructing their adult identities and norms. However, in many settings, gender equality is not a mainstream social norm, so that the first step in implementing an educational or training programme that includes gender issues is winning over and educating the staff – both the adults and young people – who will promote the new gender norms. This review will make two points about the process of incorporating gender equality promotion in YPSRH programmes, and refer the reader to additional resources.

Resources on Integrating Gender Issues into Young People's Programs

CEDPA Training Manual on Life Skills Education."Choose a Future! Issues and Options for Adolescent Girls" http://www.cedpa.org/keyissues/youthapp.html

The Promundo Institute Website in Brazil has excellent publications on working with boys and young men, including training guides for life skills educators developed by Barker and colleagues in other organizations: Project H Manual Series 'Working with Young Men' and accompanying video: http://www.promundo.org.br/english/public.asp

Plan a long-term process of training and technical assistance for staff in programmes working on these issues.

Changing gender norms is a long-term process of cultural change, both within organizations and society. For an organization to work on gender, its own staff need ongoing inputs and support. One-shot training workshops will only take the first step in the

process, and must be followed by ongoing provision of resources, technical assistance, supervision and evaluation. Resistance to integrating these issues occurs within all organizations, including those with the mandate to promote women's empowerment. In countries where there is great cultural resistance to gender issues, the process of integrating gender equity into health and development work is uneven; some staff and stakeholders will be opposed, others indifferent. It helps to have a long-term vision of the process of cultural change within organizations and society, to work with staff and social leaders so that a subset of them are committed to and comfortable with working on these issues, and to provide continual technical support to these individuals, so that they can work with community members, parents and young people.

Key Resources on Integration of Gender Issues

Rao, Aruna, Rieky Stuart and David Kelleher, 1999. *Gender at Work: Organizational Change for Equality*. West Hartford, CT: Kumarian Press.

WomenWatch: Gender Training Tools and Resources. Links to resources and training packages from UN agencies. http://www.un.org/womenwatch/asp/user/list.asp?ParentID=10879

Incorporate advancement of gender equality into expected results and indicators

Gender equality results and indicators should be included in evaluations of impact and performance. Without this mainstreaming of gender issues, other interventions such as gender training courses will have no lasting impact. Any programme that uses a results framework, or a 'log frame', will identify long-, medium- and short-term objectives. Objectives related to gender equality need to be present in more than a token fashion. If a YPSRH programme has a goal of promoting gender equality, then the evaluations of staff need to include assessment of how well they do this and how committed they are to the goal.

Young People's Participation

This section discusses the reasons for the importance of young people's participation in YPSRH programmes and policy-making, and gives general programme design guidelines on participation mechanisms in order to enhance their impact and sustainability. The section then offers an in-depth discussion of the key issues of representation and internal democracy when designing young people's participation mechanisms in a given programme or geographical area.

A fuller exploration of peer education programmes, one of the main models through which agencies organise young people's participation in programme implementation, is in the following section on International Evidence on YPSRH Programme Strategies.

Why is Young People's Participation Important?

There are three mutually reinforcing arguments why young people's participation in programme design, implementation and evaluation is important, based on principles of human rights, adolescent development and youth-friendly approaches.

As discussed earlier in this chapter, children's and adolescents' participation is a key principle in the Convention on the Rights of the Child.

> *"In its most basic sense, adolescent participation can be defined as adolescents partaking in and influencing processes, decisions and activities. Under the Convention on the Rights of the Child (CRC), participation is a legal right for all adolescents, and an end in itself. Because it is a right, it is an inalienable entitlement, not a matter of goodwill or charity. But it is a right, not an obligation. Therefore participation must always be voluntary, and never coerced."*[64]

As mentioned in the section on comprehensive approaches, young people's participation is also important because opportunities for participation are recognised by youth development researchers as a crucial element of human development at this stage in the life cycle.

The importance of young people's participation in sexual and reproductive health programmes and policies also stems from the principles of youth-friendly approaches, which must respond to young people's preferences. Having young people weigh in on their preferences for how services and education are provided, and for the types of educational materials to be used, is often key to the effectiveness of YPSRH programmes. While no global study has made the definitive case for young people's participation improving the effectiveness of programmes, there is a wealth of anecdotal evidence, and it is the commonly accepted wisdom in the YPSRH field.

An experience from Tunisia illustrates the need for young people's input into programme design. It shows that young people have essential information, without which programmes will fail. The Office Nationale de la Famille et la Population (ONFP) organised a new 'beach programme' for young people with the aim of delivering health messages focusing on HIV/AIDS. ONFP has asked ATL[65] (an NGO) to implement the programme on three beaches. Unfortunately, ONFP didn't initially involve young people in planning this project or in the choice of beaches and games, and at first it was not successful. The NGO's evaluation meetings after each event, which involved young people, enabled them

to choose the beaches where their target audience of young people congregate as well as games that would attract large numbers of young people, with whom the ATL staff could then initiate health education.[66]

Key Resource on Young People's Participation

There are many resources to give guidance on this topic. Rajani is the most comprehensive, while the YouthNet publication gives advice specific to YPSRH programs.

Family Health International, YouthNet Program, 2005. *Youth Participation Guide: Assessment, Planning, and Implementation*

Rajani, Rakesh, and UNICEF. 2001. *The Participation Rights of Adolescents: A strategic approach*. UNICEF Working Paper Series. New York: UNICEF.

Strategic and Sustainable Approaches to Young People's Participation

Young people's participation in YPSRH programmes carries special challenges, because the topics are controversial and taboo in many cultures. There are many possible vehicles or channels for this participation. For example, many Youth Ministries sponsor national young people's organizations that can interact with and convene several sectors of government. However, these Ministries tend to avoid SRH issues, so that often these youth organizations are not linked with the design or implementation of SRH health programmes and policies.

'Strategic' as opposed to 'project' approaches take a long-term view, seeing each intervention as part of a broader multi-year process.[67] Strategic initiatives are embedded in stable institutions and programmes, thus enhancing the sustainability of channels and mechanisms for young people's participation. This approach builds capacity and support in national and local governments, in organizations, and in the communities where a programme works – both among young people and among the leaders and parents in the communities. The following list describes some of the main elements of such an approach.

> **Support for situation analyses of young people's well-being** to spur wider understanding, dialogue and action, with the active involvement of adolescents, parents and community leaders in the analysis and in all aspects of programme design. There are excellent guides on participatory appraisals involving young people.[68]

> Giving high priority to **participation efforts in settings and practices that are experienced by young people on a regular,** day-to-day basis. This makes participation more sustainable.

- **Mainstreaming young people's participation in key institutions and processes.** Presently many adolescent participation activities are held on an ad hoc basis, where the duration, settings, levels and terms of participation are set at adult discretion. Examples of ad hoc approaches include special young people's conferences or meetings, although these may be useful when they intentionally catalyze follow-up actions that lead to mainstreaming.
- **Support for the formation and development of young people's associations** that maximise the space for their democratic participation.
- **Economic policies and investments that are supportive of child and adolescent well-being.** If basic social services and livelihood opportunities are not secured, young people might not be able to participate in any activities unrelated to basic survival. Programme effectiveness is compromised when the young people most at risk cannot participate.
- **Advocacy for young people's participation at national and global levels, and stimulating public dialogue on the issue.** Advocacy is necessary to achieve sustainability in young people's participation mechanisms.

Strategic approaches to youth participation help to maximise sustainability, but the necessary long-term commitment from the adults in young people's environment is often lacking. Indeed, the path to implementing youth participation has many obstacles, not the least of which are the serious questions about youth participation efforts expressed by the staff in many youth-serving agencies. How to achieve real participation? Who should participate, and how to motivate them to do so? How to share power when decisions are made at much higher levels? How can one expect a Minister to take an adolescent leader seriously? The key resources below address some of these questions. This report will focus on the issues of democracy and representation, pointing out some common dilemmas and pitfalls in the implementation of young people's participation efforts, particularly in peer education programmes. These points are most useful for staff in charge of implementing these initiatives.

Democracy and Representation: Key Issues in Design of Young People's Participation

'Representation' refers to the extent to which an organization or youth-serving programme involves the appropriate range of young people in their programmes or initiatives. 'Democracy' refers to internal power-sharing with young people within an organization or programme. Analyzing representation is an important way to determine

whether the programme addresses the CRC general principle on freedom from discrimination, while analyzing internal democracy determines the extent that the CRC principle of respect for the views of the child is fulfilled.

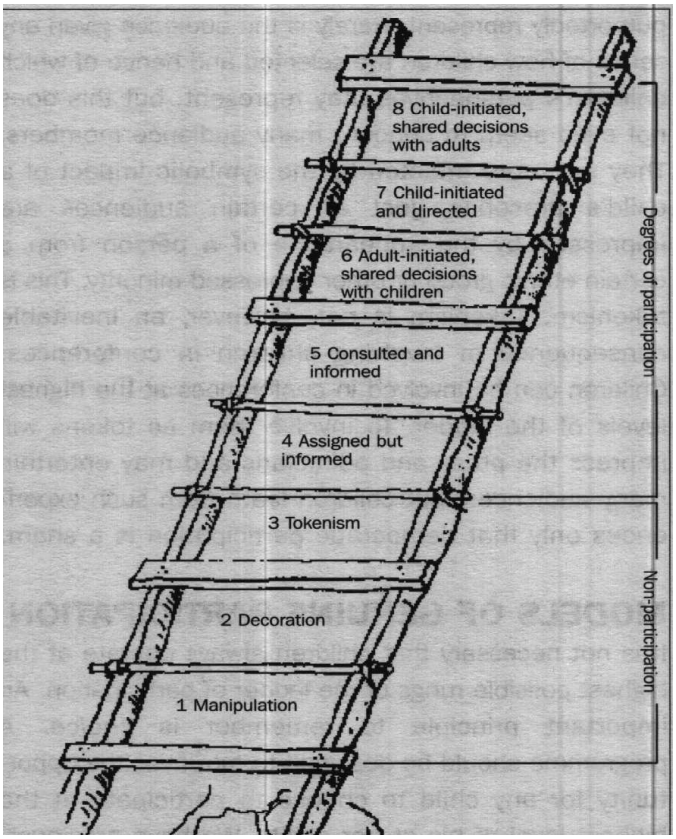
Representation: One of the key issues in representation is social exclusion. Who is marginalised from power in the community and/or not represented in the group? In all efforts to increase representation, one of the first steps is analyzing gaps in the organization's social network, searching for groups of young people that are not reached through the usual outreach strategies.

Young people's membership organizations, even those with very large memberships, do not necessarily represent the full spectrum of young people and their needs in their country, district or city. Most young people's organizations are based on social, religious or political networks that exclude some groups, whether the exclusion is based on sex, age, disability, marital status, schooling status, geographic location, income group, political party, religious affiliation or ethnicity.

Officials or programmes aiming to consult with a spectrum of young people, or organizations serving young people, should analyze the numbers and membership composition of the organizations that they plan to work with in order to discern gaps in their representation. The young people's organizations with the largest mass base tend to be religious organizations, an arm of a political party or a mass organization founded by government. In some countries, the Scouts and Girl Guides have almost national coverage. Most young people's organizations under-represent involve young women, or young people who are out of school, living in rural areas, disabled, or ages 10–14. In many such organizations, young people with high levels of education predominate.

Youth-serving organizations are not mass membership organizations, but rather semi- or wholly professional outfits or NGOs that carry out social, educational or health activities on behalf of certain sectors of young people. These organizations serving young people can have useful experience and expertise, and can sponsor young people's participation, but cannot claim to represent large numbers of young people.

Internal Democracy: Internal democracy relates to how free, effective and meaningful young people's participation is in a programme, organization, or policy-making process. This is a complex issue to address, because most organizations and government agencies have structural hierarchies and decision-making procedures that do not allow for involvement of 'beneficiaries' of any age. Other limitations on young people's input into organizations in particular include contractual obligations that must be fulfilled, and legal mandates. Yet, if a policy is meant to benefit young people, and if an organization is



Roger Hart's 'Ladder of Participation': A tool for assessing levels of participation, from Hart 1997:41.[69]

formed to serve their needs, it is imperative that the young people themselves have an effective voice in as many decisions as possible. But which decisions? And how should the input be organised? These simple questions are extraordinarily difficult to answer to everyone's satisfaction.

For various reasons, then, adults involved in organizations or programmes serving young people do not put these principles into practice. Roger Hart's 'Ladder of Participation', is a useful framework for thinking about stages of participation, with the caveat that the highest rung of the ladder is not always appropriate. The goal for internal democracy should be, at a minimum, to rise above the level of tokenism, and then to clearly identify what level of participation would be best in a given context. The following table – from Rajani's 'Participation Checklist' – gives concrete and contrasting examples of 'real' and 'false' (or token) participation, helping to visualise the kinds of interactions that a decision-making process or programme should aim for.[70]

TABLE 3.1

Real adolescent participation checklist[71]

When is participation REAL?	When is participation FALSE?
Is it voluntary? Real participation is something a young person should want to do.	If adolescents are made to demonstrate against their will, or forcibly 'volunteered' into committees.
Is it equitable? Real participation is inclusive; it does not discriminate on the basis of sex, wealth, rural/urban location, ethnicity, disability, etc.	If activities are only practically accessible to rich or urban adolescents, or only boys are asked questions, or only the smart ones are selected for meetings.
Is it valued? Real participation requires all participants, including adolescents, to be valued, listened to and taken seriously.	If adolescents are present, but get little chance to participate. When they do, people don't listen carefully or take adolescents' views into account.
Is it respectful? Real participation means addressing each other with respect and care, not derision or paternalism.	If the chair of the meeting ignores the adolescents or speaks to them in a way that shows s/he does not value their presence or what they have to say.
What's the point of it? Real participation requires young people to see the value of doing the exercise.	If adolescents are simply told what to do, but they don't really know or understand why they are doing it.
Does it matter? Real participation happens when the area or issue is important or of interest to young people.	If adolescents are made to participate in something that they don't care much about and feels like a waste of their time.
Does it make a difference? Real participation means young people's contributions have an influence and make a difference.	If adolescents are asked for contributions that make no difference whatsoever in influencing thinking or changing conditions.
Are the physical arrangements fair and conducive? How the seating is arranged makes a big difference.	If the adults sit in chairs while adolescents are on the floor, the room's periphery or under the hot sun.
Is it done in a language that adolescents understand well? Real participation requires adolescents to feel competent and comfortable in the medium of communication.	If discussions are held in English in a rural district, or the manner is very formal and full of 'big words'.
Are the rules fair for all? Real participation is done in a manner in which everyone can participate equally and comfortably, and often involves adolescents in making the rules.	If some adults dominate, while adolescents don't get a chance or are cut off too early. If adolescents are made to contribute in ways they do not understand or like.
Are the child participants adequately informed and prepared? Real participation means adolescents have had enough time, opportunity and support to prepare.	If adults have experience and information whereas the adolescents are just pulled in with little sense of what is happening and time to prepare.

continued

(Table 3.1 continued)

Real adolescent participation checklist[71]

Are the allowable roles fair? Real participation assigns roles and responsibilities fairly, and allows everyone to play a role they are capable of whenever possible.	If adults make all the decisions and rules while adolescents are relegated to menial roles.
What's the level? Real participation goes beyond show and allows young people to initiate ideas, make decisions and take actions to the maximum extent of their capability. (see R. Hart's ladder for a tool)	If adolescents are told to participate in certain ways without having a say in the content or method of participation, or if adolescents are only consulted when they are also capable of responsible decision making.
Is it honest? Real participation respects ethics, avoids manipulation and is clear in its purposes and methods.	If adolescents are not told the truth or deliberately left in the dark about what is happening.
Is it safe? Real participation takes all necessary steps to ensure no participant is endangered.	If confidentiality is not maintained where appropriate, such as when the adolescent who tells the truth about something is punished.
What happens afterwards? Real participation is clear and transparent about how the output of the participation will be taken forward, and how it connects with other processes. It often aims to institutionalise participation for sustainability.	If adolescents participate actively on something important but it is not clear what follow-up will take place or what will be done with their contribution. Session report is not shared or checked with adolescents.

Increasing young people's capabilities to participate fully in decision making should be a central focus of participation mechanisms. The means to achieve this are training, technical assistance and, above all, practice. All three can be realised by:

> Making the key institutions involving young people more democratic and representative

> Investing in building capacity for leadership within different types of young people's associations.

If young people–led organizations in which young people can learn organizational and leadership skills do not exist, governments and youth-serving programmes should help them to be formed.

Internal Democracy challenges and solutions: In organizations serving young people, high internal democracy can be a challenge because the staff are accountable to funders and others, and are hired for their professional skills. In these cases, high internal democracy could still be achieved by having young people share in the key decisions of the organization, and in its oversight.

Success in securing funding can turn a membership young people's organization into a professional NGO, resulting in less internal democracy. In some of the more institu-

tionalised youth-serving organizations that lack sufficient rotation in leadership, each passing year brings with it a maturing leadership, thereby decreasing the presence of young people in the leadership.

Solutions vary, and most have to do with increasing the level of internal democratic mechanisms.

> Some young people's NGOs have external Boards of Directors with a quota for adults, thus guaranteeing a majority voice for young people in the governance of the organization.

> Some organizations have found it helpful to write age, representation, and rotation requirements for the staff leadership into the by-laws or other governing rules.

> Young people's organizations should always plan for rotation and turnover, with career ladders, on-the-job training, and delegation of responsibilities by top staff so that a next generation of leaders is always ready to assume responsibility.

IPPF provides an example of power sharing with young people.[72] They held a Youth Parliament in which young people from around the world wrote a manifesto, were supported to form a global network of young people, and decided to "revise the governance structure of IPPF so that at least 20 per cent of the members of the Governing Council, the main decision and policy-making body of IPPF, will be young people under the age of 25."

Use of analysis of representation and democracy: Table 3.2 is an evaluation tool originally developed to analyze representation and internal democracy in organizations serving young people; it provides a useful framework for analyzing these issues. However, neither the table nor the preceding discussion of these issues intend to suggest that only the highest levels of representation and democracy are acceptable structures for YPSRH programmes. It is completely legitimate and beneficial to form a programme for the benefit of university students, young people in secondary schools, or any distinct sector of young people. It is usually appropriate and necessary to retain ultimate decision-making authority in the hands of the paid staff and Board of Directors of an organization. Rather, the discussion and framework aim to make programme strategy decisions conscious and intentional. Programme designers need to analyze whom they are serving, whom they are involving, whether those they are involving in participation actually represent the population served, and where the gaps are in both service and participation. Once those excluded are identified, alternate plans to reach the excluded groups can be made by the range of organizations involved in a particular community or setting.

TABLE 3.2

Evaluation tool to analyze internal democracy and external representation levels in YPSRH programmes involving young people in peer education and services[73]

	Low level of Democracy (D) Staff train educators to carry out programme activity.	**Medium levels of Democracy** Staff consults and informs educators, and takes input seriously.	**High level of Democracy** Staff shares decision making with educators.	**Highest level of Democracy** Staff hands main decisions and implementation of programme to young peer educators.
Low Level of Representation (R) Staff from service recruit young people according to certain criteria,[74] usually including leadership abilities.	Low R Low D	Low R Medium D	Low R High D	Low R Highest D
Medium Level of Representation Peer educators organise consultations with the young people served, so that the beneficiaries have an input into design, implementation and evaluation.	Medium R Low D	Medium R Medium D	Medium R High D	Medium R Highest D
High Level of Representation Young people from different organizations and sectors elect the peer educator group and exercise oversight over the programme.	High R Low D	High R Medium D	High R High D	High R Highest D

Note: Any combination of levels is possible, but certain combinations are probably less sustainable than others. For example, it seems likely that a High R/Low D peer educator group, elected by community young people, would tend to demand more power-sharing within the programme. For visual purposes, this is a matrix, but in reality the range from low to high is a continuum and could include more scenarios than listed here.

Young people's involvement in national SRH policy making

Young people's participation in national policy-making is important for all the reasons named above, but is more difficult to organise and sustain because representation of young people's organizations from the diverse areas of a country takes time to organise and gather funds for their travel. Furthermore, often there are barriers to participation by young women if it involves travel to a city far from home, so that special efforts need to be

made to make sure that young women are represented. However, the outcome is worth it, because policies devised with young people's input are more likely to address real needs and respond to young people's preferences and constraints. Programmes and policies that are centrally designed by officials out of touch with the needs and preferences of a diverse set of young people risk wasting scarce resources in ineffective strategies.

Taking Young People's Policy Input Seriously in Sudan

The UNGASS on Children in 2002 (in which two Sudanese young delegates participated) stimulated international and national agencies in Sudan to programme with more young people's participation. The main objectives of UNICEF Sudan's 2003 activities were to educate young people on the World Fit For Children (WFFC) goals and the provisions of the CRC, to support them in designing their own plan of action and to build their capacity to enable them to actually implement it.

After the first national youth forum (2001), dedicated to 'Partnership with Children', in April 2003, UNICEF held a 2nd National Youth Forum in partnership with the National Council for Child Welfare (NCCW) and a number of national and international NGOs. This second forum aimed to involve Sudanese young people in setting priorities for implementation of WFFC goals. Fifty young delegates (drawn from 22 of the 26 Sudanese states) attended; they were elected by their peers during preliminary forums in the states, balanced by gender, and included an additional eight delegates representing both children who live and work on the streets and orphans, who were selected by the Sabah Association, a national NGO.

To ensure good understanding of the 10 WFFC goals, the participants re-wrote them in a child-friendly way and made linkages with the CRC articles. At the end of this plenary session, the young people selected four themes that they considered priority areas for the children of Sudan. These four themes laid the basis for working on the Youth Action Plan:

1. Combat HIV/Aids
2. Educate every child
3. Listen to children and ensure their participation
4. Protect children from war

The outcome was the drafting of a National Youth Action Plan, considered by all partners as concrete, realistic and feasible. This successful experience led the National Council for Child Welfare to integrate key elements of this National Youth Action Plan into its design of the National Action Plan for Implementation of WFFC.

After the Forum, in order to build capacity of the young people to participate effectively in the implementation of the WFFC goals in their communities, about 180 young people from six states received training in peer education and negotiation skills. In 2004, NCCW and UNICEF worked on keeping the momentum on the WFFC and the young people's action plan through further education, training, recreational activities, and building community support for young people's initiatives.

Based on personal communications from Sandrine Martin of UNICEF Sudan in 2003, and the report from the 2nd Youth Forum.

Young people's involvement is especially important when setting sexual and reproductive health policy for young people, since these policies often raise controversies, and adult policy makers tend to be divided on the issues. Even those who are sympathetic to young people's sexual and reproductive health and rights are subject to political pressures that make them less committed advocates than young people would be on their own behalf. This example from Sudan is an example of the benefits derived from involvement of young people.

Advocacy and Community Involvement

Advocacy and community involvement merit special attention in YPSRH programme design for several reasons. Advocacy is necessary to promote national and municipal policies that fulfil young people's right to access information, education and services in order to protect their sexual and reproductive health. The goals of YPSRH programmes and policies, including improving gender equality, ending gender-based violence, and removing the stigma and discrimination related to HIV/AIDS, can give rise to resistance in many settings. Programmes that truly protect young people's health need to overcome these obstacles in the political and social environment through advocacy.

Advocacy is essential to ensure the sustainability of programmes, so that the new cohorts of young people coming into adolescence have continual access to YPSRH programmes. Community involvement is essential to sustainability at the local level and to effectiveness, since communities provide the safe supportive environments needed to protect health.

Who conducts advocacy, and with whom? This discussion does not just refer to the advocacy of civil society organizations directed to decision makers in governments. The resistance to YPSRH programmes occurs within government ministries and within both public and private organizations – with some decision makers more committed to YPSRH than others. Therefore, most advocacy takes place in 'policy dialogue' among colleagues or policy makers, and this discussion is directed to advocates at many levels, and in many sectors.

Community involvement is an essential aspect of advocacy at the grassroots level. As explained earlier, given the risk and protective factors for YPSRH, young people need a safe and supportive environment in order to protect their health. At a minimum, eliminating and preventing violence and abuse in families and communities is an essential intervention to achieve safe and supportive environments. Connection to supportive adults is perhaps the single most important protective factor for a young person. This connection can be achieved through strengthening the young person's relationships with their family, with schools, with religious and community organizations, and/or with any programme that provides them access to supportive adults. The adults in young people's

environment should not only be personally supportive, but also actively promote young people's health. Educational interventions with families, schools, religious organizations, community leaders and other community or youth organizations are necessary to increase support for young people's access to information, education and services related to sexual and reproductive health, and for any YPSRH programme based in the community.

Key Resources on Advocacy and Community Involvement

Greene, M., Z. Rasekh, K. Amen. 2002. *In This Generation: Sexual and Reproductive Health Policies for a Youthful World*. Washington, D.C.: Population Action International.

Shah, Meera Kaul, with Rose Zambezi and Mary Simasku, 1999. *Listening to Young Voices: Facilitating Participatory Appraisals on Reproductive Health with Adolescents*. FOCUS Tool Series #1. Washington, D.C: Focus on Young Adults.

Advocates for Youth. Advocacy Kit. http://www.advocatesforyouth.org/publications/advocacykit.pdf This publication is geared to a US audience, but could be adapted easily to any other context by inserting data and messages appropriate to another audience. The basic elements of advocacy efforts are universal.

Advocacy: gaining political and administrative support

This section will briefly outline the main considerations in planning the advocacy component of a YPSRH programme, including a special focus on the advocacy challenges when scaling up these programmes. The section will then provide basic guidelines on the involvement of young people, parents and community leaders in programme design.

In most countries, the policy environment poses major barriers to implementing YPSRH programmes and services. These barriers can be legal, regulatory or attitudinal. For example, age-of-consent laws for confidential services might pose legal barriers to the use of services by young people, while a Ministry of Education regulation might bar pregnant or married young women from secondary schools. Attitudinal barriers apply in many situations. For example, although no regulation forbids such programmes, education officials in most MENA countries are reluctant to implement comprehensive and scientific SRH education in the schools. Political and administrative resistance can take place at all the levels at which there are decision makers involved in a YPSRH programme: national, sub-national, and municipal. These barriers need to be identified early in the programme design process so that advocacy to eliminate them can be built into the programme planning, while short-term interventions are designed that take these barriers into account.

Advocacy Arguments: Arguments based on demographic data and evaluation research are often helpful with decision makers. In MENA countries, the youth modules of the PAPFAM surveys are useful for YPSRH advocacy purposes when they include the relevant questions, as are studies such as the micro country-level YPSRH surveys in Djibouti. Chapter two summarises available YPSRH data from the region. A separate Policy Report by the same authors is available from UNICEF MENA Regional Office that summarises the main advocacy arguments arising from international evidence and regional data.

Advocates can use international evidence showing that SRH education does not lead to earlier or increased sexual activity. To the contrary, it helps delay it when given before a young person becomes sexually active.[75] Programmes that promote abstinence alone have been shown to be less effective in preventing unwanted pregnancies and STIs than those promoting both abstinence and protected sex.[76] Furthermore, many abstinence-only programmes exaggerate failure rates of contraceptives and otherwise discourage their use, thus putting sexually active young people more at risk.[77]

Researcher Kate Bond[78] gathered advice from experts worldwide on strategies to obtain this political and administrative support. The following list of key questions – adapted from the original – could help to plan for advocacy strategically with a target institution or programme.

- How could incorporating YPSRH programmes help to achieve the institution's or programme's mission and goals?
- What are the possible positive and negative impacts of integrating YPSRH activities? What is the best way to take advantage of the former and mitigate the latter?
- What processes are required to gain commitment and support from senior management and/or policy makers?
  - What are the key concerns, sensitivities and priorities among these relevant stakeholders?
  - Where in the structure is resistance strongest? Where is support strongest? How can supportive allies be used to address the resistance?
  - What type of data or evidence is required to make a compelling case?
- What are the sources of resistance and primary concerns among staff who would implement a programme? (e.g., teachers, workplace educators, youth-serving organizational staff)
  - What support is needed to address these, and how can it be provided to those who would take an active role?
- How could young people's involvement stimulate support? How could their participation be strengthened?

> Could media play a useful role in this process? Are there sympathetic media outlets or professionals who could address concerns and sensitivities?

Advocacy and Scaling up YPSRH Programmes: Because scaling up requires major investments, usually by a government, advocacy is a key element in scaling up YPSRH programmes. The recommendations in this review related to scaling up involve advocacy with governments to include YPSRH elements in the programmes and activities of diverse Ministries (such as education, sports, labour or culture) and institutions (such as the military) capable of reaching large sectors of young people.

In the context of HIV/AIDS programmes and the stigma attached to the disease, Jocelyn DeJong[79] notes that, because of cultural and political resistance, the explosion model of scaling up is rarely feasible.[80] YPSRH programmes encounter similar resistance due to the stigma attached to young people's sexual activity. Therefore, most YPSRH programmes scale up incrementally, ideally starting with a well-evaluated pilot phase in which all the agencies that would scale it up have full involvement and ownership.

Besides the advocacy needed to get them started, large-scale programmes also need investments in advocacy during their implementation because they are more visible; they attract more positive and negative attention. This increased visibility makes it doubly imperative to secure political and administrative support and community involvement. When a programme is scaled up, both favourable and negative articles may appear in the national media; negative articles can generate political pressure from conservative groups, making it more politically costly for elected officials to support the programme.[81] Meeting such challenges is time-consuming for the programme directors, and **designers need to build time for advocacy into budgets and work plans.**

Overcoming administrative and staff resistance in scaling up a pilot YPSRH programme is a related advocacy task. When a programme is small, it is easier to find staff who agree with the programme's values. When a programme goes nationwide, existing staff in the implementing organizations may not hold these values and support YPSRH programmes. They do not just need training; they need to undergo participatory workshops that enable personal reflection and attitude change. Only through such processes can staff shed deeply-held attitudes so that they accept YPSRH goals and actively commit themselves to working for them. The bottom line is that staff need to be committed enough to YPSRH principles that they can serve as convinced advocates when they run into the next level of resistance among leaders in the communities where the programme operates. Staff who retain judgmental and non–'youth-friendly' attitudes should not continue to work in a YPSRH programme, and should be reassigned to a programme serving adults.

In general, **'youth-friendly approaches' necessitate continued and supportive training and supervision that focus on the elements of this approach,** since they run counter to the prevailing cultural tendencies. First of all, many teachers or youth-serving staff are uncomfortable dealing with issues related to sexuality, which is a deeply taboo topic in many cultures. Continuing education and support is needed to increase their comfort level.

Second, the participatory educational methods needed to truly build skills and promote attitude and behaviour change among young people in SRH education programmes are also new in most cultures. The pedagogical approach familiar to most adults and hegemonic in the school system is top-down and didactic. Therefore, fear of and resistance to participatory approaches is another important source of staff resistance. Adult facilitators and schoolteachers need training and follow-up support if they are to use this methodology. 'Quality control' in supervision of the programme staff needs to include this issue of methodology and provide the necessary professional and emotional support to help staff adopt these new skills-building methods.

Parental and Community Involvement

Parents, community leaders and local government officials are the 'gate-keepers'. Without their support and approval, only the oldest and most independent young people (usually male) will be able to participate in a YPSRH programme. Therefore, community and parental involvement should be secured at the earliest stage. This supportive involvement is also necessary, as mentioned earlier, to create the 'safe, supportive environments' that are an essential component of all YPSRH programmes.

Decentralization of government authority obviously favours such efforts. Decentralization allows more opportunities for meaningful input by community members and young people; it facilitates decision making based on locally generated evidence about needs, along with community-based dialogue. However, even in a country where central Ministries still make the bulk of programme decisions, the design of a scaled-up programme can be negotiated to include flexibility in a range of design decisions so that programmes can be adapted to local needs.

Gaining community support: Worldwide, YPSRH programmes have experimented with community involvement strategies, to overcome the sensitivities and resistance often associated with YPSRH issues. Currently, most YPSRH programmes use two main strategies to gain initial acceptance of a programme.

Participatory needs assessments: Such assessments generally involve community leaders, parents and young people, using both participatory and confidential information-gather-

ing techniques. Some YPSRH projects have noted that often it is enough to have a 'question-asking' exercise, in which the young people submit their questions related to SRH. Parents, upon reading the questions, realise that they do not feel competent to fill young people's information needs.

Whatever the participatory needs assessment method, the information from the data collected from young people often 'removes the blindfolds', helping adults to realise that young people's health needs to be protected. Once parents understand the necessity of a programme and feel that their input is taken seriously, their opposition to the provision of SRH information and education to young people usually ceases. A recent overview of young people's SRH programmes[82] found that all but one of 21 multi-site programmes successfully secured approval and involvement from parents and community leaders:

> *"In the experience of several projects, when a participatory community-based needs assessment [on a full range of young people's development issues] includes questions on sexual and reproductive health, the resulting information on health risks and problems is easily accepted and addressed, and can then be included in the programme along with other development needs without causing controversies."*

Incorporating education or livelihoods components: In this same overview, most of the projects incorporating education or livelihoods components (10 out of the 21) stated that these were necessary in the cultural settings they worked in to secure parental and community support. In some of these cases, the implementing agency had tried more vertical SRH approaches previously, and been unsuccessful. The following quote explains these benefits.

> *"Almost half (43 per cent) of [YPSRH programmes] said that their ability to involve large numbers of young people, and the level of parental and community support they achieved, would not have been possible without including both attention to safe, supportive environments, and increased access to opportunities. These mutually reinforcing strategies respond better to the felt needs of community leaders and parents, and provoke much less resistance than vertical sexual and reproductive health approaches. Community support makes programmes both more effective and more sustainable."*[84]

Involvement during the YPSRH Programme: Once initial support allows a programme to be implemented, meaningful involvement of community organizations and parents is essential to the effectiveness and sustainability of the programme.

Promoting health-protective norms in the community: When existing norms pose obstacles to young people's health, such as those supporting discrimination against women and FGM/C – or opposing young people's access to SRH services – only community involvement will help change these norms to be health-protective. Active interventions such as parent-education programmes and entertainment education to promote these new socio-

cultural norms are thus often an essential component in providing 'safe and supportive environments' for young people's health and development.

Community involvement is also necessary for the sustainability of YPSRH programmes. When parents and the community support a programme, they do so with volunteer labour, and with various strategies to secure the means to keep the programme going. They will advocate with local or national governments to continue a programme that is threatened with being discontinued.

Evidence and Guidelines on YPSRH Programme Strategies

The next major section in this chapter applies these cross-cutting YPSRH programme design principles to specific YPSRH programme strategies or models. It also highlights evidence on effectiveness, or lessons learned on implementation, that are pertinent to each model.

While the previous section concentrated on principles of YPSRH programme design that can be applied to all types of YPSRH programmes, this section concentrates on the international evidence about specific YPSRH strategies or models most frequently implemented in the Arab States and Iran. These strategies are: school-based SRH and life skills education; SRH education integrated into youth development programmes; peer education; youth centres; confidential counselling channels; youth-friendly health services; and media or entertainment education. These strategies are not – and should not be – mutually exclusive. For example, a school-based programme might have a peer education component and employ entertainment education.

The authors of this review applied the international evidence on YPSRH in general, and on each programme strategy, to the results of the situation analysis in chapter two in order to formulate the Policy, Programme, and Research Recommendations in chapter four. Whenever appropriate, the text in this chapter will explain when certain evidence has direct bearing on these recommendations. In general, the programme recommendations in this review favour strategies that can be mainstreamed into institutions that reach large numbers of young people, and that address or circumvent the political and social barriers to YPSRH programmes in this region.

Unfortunately, the review of international evidence on specific programmes found a striking lack of evaluation evidence on YPSRH programmes in the Arab States and Iran. Therefore, most of the evidence cited here is from Africa, Asia, Latin America and the United States. While some of these countries also have predominantly Muslim popula-

tions, the cultural differences are significant. There is an urgent need for better evidence from the Arab States and Iran generated by YPSRH programme evaluations.

The next section begins with an extensive discussion of health and life skills education that includes SRH issues, because such programmes can be implemented in so many venues and sectors, and because, worldwide, this is the type of YPSRH programme most commonly scaled up to achieve national coverage, usually within the school system. The remaining programme models are those most commonly found in the literature and are not presented in order of priority. The discussion of evidence on the other models is not as complete, but the reader is referred to other resources in each case.

For each strategy, this review identifies the sector of the youth population best served by the strategy, the potential benefits of the strategies, the challenges inherent in the strategy, and guidelines to help face these challenges.

School-based Health and Life Skills Education Programmes

To enhance protective factors for YPSRH, programmes should take a positive 'youth development' approach to YPSRH, integrating these issues within an holistic curriculum of life skills health education.

Late primary school and secondary school-based programmes can be an efficient way to reach large numbers of young people and their families. While universities do not have such high coverage, evidence from Tunisia suggests that school-based programmes at universities, using small group meetings or peer counsellors in dormitories, have the potential to be highly beneficial. In this region, several informants suggested that students who come to urban universities from rural areas and are cut off from the support of their families are very vulnerable to SRH problems.[85]

School-based programmes need to include both information and skills-building in order to promote healthy behaviour,[86] and ideally a referral system to health services. However, evidence shows that social barriers to young people's use of off-site medical clinics are so numerous that school-based referrals rarely result in significantly increased service use by secondary school students. Young peoples' preference in most regions seems to be to go to pharmacies or to private medical offices.

Other essential programme components were mentioned in the section on programme design, including parental and community involvement and ensuring that schools have a solid link to future livelihoods.

School-based programmes provide a resource to reach and educate large populations of potentially under-served youth. Below is an analysis of international evidence on the key facets of school-based initiatives: the segment of the population of young people served, the benefits, and the challenges.

Key Resources for this Topic

SIECUS, 2004. *Developing Guidelines for Comprehensive Sexuality Education*. Accessed August 2005 at: http://www.siecus.org/pubs/guidelines/guideintl.pdf

UNICEF 2003. "Lessons Learned about life skills-based education for preventing HIV/AIDS related risk and related discrimination." Available at website: http://www.unicef.org/programme/lifeskills/lessons/index.html

Segment of population of young people served: In-school young people, generally in secondary schools. In many countries, including some in the MENA Region, night schools are a relatively unexplored opportunity to serve large numbers of low-income working young people who would benefit greatly from SRH and life skills health education.

Benefits:

- Such programmes can achieve substantial national coverage of diverse sectors of young people, especially in countries where the secondary school enrolment rate is high. School-based programmes are more easily and frequently scaled up than any other YPSRH strategy.
- Such programmes provide young people with basic information on SRH, except in cases where the teacher, school director or school system censor out basic SRH content.
- The life skills component in the curriculum promotes young people's development, teaching important communications and decision-making skills that protect young people's health and promote their well-being.
- Such programmes are a golden opportunity to enable young people to re-examine traditional gender roles, with the goal of achieving greater equality for girls and women within families and in society as well as freedom from violence in the home.
- Accompanying parent SRH education can help to resolve communications difficulties on these issues between parents and children, overcoming the generation gap that was identified in the situation analysis in the MENA region.

Challenges and Solutions: (The challenges are underlined, and possible means of meeting the challenges are in italics)

- In settings where substantial numbers of young people – male and/or female – are out-of-school, school-based programmes do not serve important segments of the population of young people who may be more at risk for SRH problems than in-school young people. *Local and national authorities need to support complementary strategies* directed to reach these other vulnerable segments of the population, who might be young married women, school drop-outs, children and young people in institutions, working children, children living and working on the street, young men in the military or unemployed young men.
- Many school systems have a vertical, didactic pedagogic culture, making it difficult to train teachers in the most effective experiential methodologies for behaviour change interventions so that young people acquire the requisite skills to incorporate healthy behaviour. In order to achieve skills-building, *standardised teacher training and follow-up technical support* for these programmes should include participatory, *experiential modes of learning*. This new pedagogical skill is transferable to other subjects and benefits educational quality and young people's participation in general.
- The most effective programmes start at pre-puberty (ages 10–14) with age-appropriate information and skills-building, followed by continuous instruction throughout secondary school. However, implementing life skills and health education programmes at those ages – which correspond to the upper grades of primary school or to preparatory school – is often controversial if the curriculum includes SRH components. *Diplomatic and sustained dialogue including information on SRH needs* with parents, school directors and education officials is needed to overcome this challenge. The 'Better Life Options' programme of the Centre for Development of Population activities (CEDPA) in Egypt successfully gained support from parents when creating a programme for this age group.
- Selective censorship of the SRH content of the curriculum (whether based on a text or locally available materials) is common. *Local data collection on young people's concerns and needs related to SRH* is an essential part of programme design. When analysis of the data involves parents and teachers, it can also help overcome this obstacle by adapting the content to local needs. *Teachers need sustained support and training to overcome their discomfort with sensitive subject matter.*
- In general, parental involvement decreases at the secondary school level,[87] for a variety of social and logistical reasons. (Often, the secondary school is farther from the home than the primary school.)

Schools need to devise *creative strategies to reach the parents* of their students in a complementary parental education component of the life skills health education programme.

> Efforts to implement a nation-wide curriculum often stimulate undue controversy centred on the content of the curriculum, resulting in censorship of necessary content. *National ministries can allow decentralised decision making*, by validating several curricula and SRH education resources, and letting local school systems choose which to adopt.

Integration of SRH into Youth Development Programmes

As emphasised throughout this chapter, organizations that specialise in SRH should seek partnership with organizations working on young people's development in order to reach diverse sectors of young people with complementary strategies. Involvement in youth development programmes expands opportunities for education, livelihoods, and participation, as well as for connections with supportive adults. All these opportunities help protect young people from sexual and reproductive health risks. In the category of youth development programmes, we include religious youth programmes, non-formal education and literacy programmes, sports and recreation programmes, involvement in creative arts, and livelihoods/vocational training opportunities. Access to livelihoods is a key topic in the Arab States and Iran, since the situation analysis showed that the youth unemployment rate is one of the highest in the world. With regard to SRH risks, lack of access to employment can delay marriage for men until their early 30s or later.

Youth development programmes have the opportunity to reach a varied population of young people. Like school-based programmes, these programmes present many important benefits and opportunities, as well as challenges. The discussion below explores elements of programmes that integrate youth development with SRH education.

Segment of the population of young people served: Varied, depending on the programme. This strategy can reach out-of-school young people.

Benefits:

> Mainly, this strategy provides the benefit of access to large numbers of young people, and is not dependent on their involvement in the school system.

> The strategy is cost-efficient because the programme is already in place; only the YPSRH component needs to be added.

> As mentioned above, this strategy provides mutually reinforcing and beneficial effects for health promotion.

> **Integrating SRH education in religious youth groups** and in religious education is relatively unexplored. Many experts interviewed for this study recommended this strategy as one capable of reaching large numbers of young men and women.

> Especially for young women, the **income from livelihoods** – whether a formal sector workplace or other income-generation opportunities – serves as a protective factor against early marriage and could enhance the impact of the health-related interventions.[88] Conversely, for young men, access to livelihoods can help them to marry in a timely fashion; where unemployment is high, the average male marriage age is generally viewed as too high, leading to marked age disparities in married couples. These disparities, in turn, have been shown to be associated with higher SRH risks for both men and women.

> **Sports programmes** are a relatively unexplored but excellent potential opportunity for integration of SRH education.

Regular participation in sports is common for boys and young men, and an ideal venue for reaching them. Coaches or team leaders are respected and could be trained in SRH topics, and young men in the same league can serve as peer educators for younger boys. At the least, these leagues could distribute educational materials.

Female participation in sports is much less frequent, and girls' and young women's health suffers in many ways as a result. In studies in the United States of America,[89] sports have been shown to provide multiple benefits to girls, including increasing self-esteem, better physical and mental health, and reduced risk of obesity and chronic diseases later in life. Undoubtedly, participation in sports helps build important social skills, counters female stereotypes of passivity and weakness, and provides players with a close connection with a

Key Resources for this Topic

Brady, Martha 1998. "Laying the Foundation for Girls' Healthy Futures: Can Sports Play a Role?" *Studies in Family Planning,* Vol. 29, No. 1. (March 1998), pp. 79–82

Meyers, Carey and Jennifer Sebstad, "Offering Adolescents Safe and Appropriate Livelihoods and Economic Skills" in Population Council 2003 (includes a list of other resources at the end of the chapter)

Population Council and ICRW, 2000. *Adolescent Girls' Livelihoods: Essential Questions, Essential Tools: A Report on a Workshop*. New York and Washington: Population Council and ICRW.

Esim, Simel, Anju Malhotra, Sanyukta Mathur, Guadalupe Duron, Charlotte Johnson-Welch, 2002. *Making It Work: Linking Youth Reproductive Health and Livelihoods*. Washington, DC: International Centre for Research on Women.

trusted adult. Young people's development and health programmes should initiate sports programmes for girls, as should Ministries of Youth and Sports, if these do not already exist. Parents and community leaders need to be appropriately involved when integrating SRH and gender equity education, so that the SRH component does not have a negative impact on girls' participation in sports.

Challenges and Solutions: (The challenges are underlined, and possible means of meeting the challenges are in italics)

> Many young people's development programmes are unwillingly to integrate gender or SRH topics that they view as controversial, or that they do not personally support. Patient personal advocacy and persuasion of the benefits may be needed. *Carrying out some simple participatory data collection* on health needs among the young members of the sports league or the livelihoods programme – and confronting the adults in charge with the results – might be the most effective strategy to create a working partnership. Other incentives could be financial, with *donor grants, including contribution to both SRH and non-SRH activities, to promote both health and development.*

Confidential Counselling Programmes

This is the main type of 'youth-friendly service' recommended in this review, since it relies mainly on private and confidential communications. These programmes establish a mechanism that connects seekers of information, advice, support, and referrals with counsellors who are trained to respond to a variety of health and relationship issues appropriately. Needless to say, the 'youth-friendliness' of the trained counsellor is of utmost importance, as is the issue of confidential access for those seeking these services. One key challenge in these programmes – except for Iran's premarital counselling programme – is adequate marketing so that the service is well-known, complemented by adequate capacity to respond to the demand.

The first two models discussed could use either adult or peer counsellors. (See next section on peer education programmes.) The population served, the benefits and the challenges are discussed below.

Segment of population of young people served: These programmes can reach out to a mass audience of young people through various confidential and private mechanisms, providing SRH-related information, counselling and referrals for services. Two of the recommended models depend on access to either a telephone or the Internet, and therefore would be less accessible to rural or very low-income young people.

Benefits:

- In the MENA Region, where premarital sexuality is highly stigmatised and young people have almost no access to information and guidance in order to protect themselves if they are sexually active, this programme strategy would fill an important void.
- Confidential counselling strategies can also serve as a source of referrals for youth-friendly medical services in the private or public sector, and arrange financial subsidies for treatment if needed.

Types of strategies:

- **Telephone hotlines:** This model has proved to be very popular in several settings, including Egypt, Lebanon and India. (See the sidebar in chapter two about hotlines in Egypt.) **Hotlines need adequate publicity** to generate demand for the programme, so that they are not under-utilised. They then need to **ensure adequate capacity in numbers of counsellors, number of phone lines**, etc., to keep up with the demand.[90]

  Much evidence exists on the feasibility of these models, and on their potential for reaching high coverage of the population of young people. One of the best-known programmes, the Tarshi programme in India,[91] reported that in the 5-year period from 1997–2002, they received over 45,000 calls, with adolescents forming the bulk of callers.[92] Tarshi also analyzed the profile of those consulting and the content of consultations, which provides useful evidence to guide YPSRH programming.
- **Internet, email and/or chat technology:** Where literacy and educational levels are high, the growing accessibility of the Internet through Internet cafés, schools and home computers could make both dissemination of information and confidential counselling available to many urban young people, if they have sufficient privacy for their Internet use. Websites can provide a wealth of information in 'youth-friendly' fashion. CDs can also provide information for young people with access to computers, but Websites and chat technology carry greater guarantees of privacy for the young computer user. As with telephone hotlines, the **success of this model depends on adequate marketing and on having sufficient counsellor capacity for the demand.**
- **Premarital counselling:** (See sidebar in chapter two, and chapter in Greene et al 2002.) This model could be made universal if it is done through marriage registrars (both religious and civil) or an established government programme using health professionals as counsellors, as in Iran. For young people in families living without access to a telephone

or computer, this is often the only venue available for confidential counselling, unless an extended family member can play this role.

- **Benefits:** Premarital counselling can be an important venue to meet multiple goals. In prevention of early marriage, counsellors could detect suspected cases of falsification of the young brides' birth certificates. In countries where marriage under 18 is legally allowed, the counsellor could provide information on the health risks of pregnancies at young ages (in order to encourage delay of the first birth) and provide information and referrals for contraception. Such counselling is also an opportunity to talk about mutual respect in gender relations and to convey messages against gender-based violence. In cases of legal early marriage, the counsellor could work with the family to promote the young woman's continued education and access to development opportunities.

Challenges and solutions for all confidential counselling models:

- **Adequate training and supervision** of the counsellors. All of the literature about how to train providers to be 'adolescent-friendly'[93] is especially pertinent, and the major investment of these programmes is in training and supervision of the counsellors.
- **Sustainability:** In most cases, since the goal is broad coverage, users do not pay for the service, and governments or donors must foot the bill.
- **Evaluation of such models for impact on behavioural and health outcomes** is scarce, and little evidence exists. Evaluations would enable proponents of these models to advocate for the value they provide.

Peer Education Programmes

Peer education programmes involve members of the 'target', or beneficiary population of young people, in providing information and in the educational or advocacy activities of the programme. For example, a programme serving children who live and work on the street might recruit leaders within the groups of children and train them to work among their peers. A recent survey of 500 programmes worldwide reported that more than 70 per cent of YPSRH programmes worldwide use some element of peer education.[94] It is important to ascertain young people's preferences; **when they prefer receiving information and counselling from peers, this is the strategy of choice.**

While peer education has many important advantages, it is not always the most effective or appropriate strategy to achieve the programme goals. The AIDSCAP/FHI manual on

peer education programmes cited in the following sidebar provides a useful list of questions to help programme designers determine whether or not to use peer education as part of their programme strategy.[95]

Peer education programmes are based on the assumption that young people prefer to receive information and education from their peers. In fact, this is not always the case. Some studies have shown that **in certain settings or countries, young people of one or both sexes do NOT prefer to receive information or counselling from peers,** but would rather interact with a trusted adult.[96] Each programme needs to involve young people in defining how they would prefer to get information, education and services. Preferences regarding the provider of information and counselling may also differ according to the age of the young people, and according to the issue being addressed.

Key Resources for this Topic

AIDSCAP/Family Health International (FHI). 1997. *How to Create an Effective Peer Education Project: Guidelines for AIDS Prevention Project*. Arlington, VA: Family Health International. PDF file available at website: http://www.fhi.org/en/HIVAIDS/Publications/manualsguidebooks/BCC+Handbooks/peer education.htm

Horizons Project 2002. Peer Education and HIV/AIDS: Past Experience, Future Directions. PDF file on website: http://www.popcouncil.org/pdfs/peer_ed.pdf

Segment of population of young people served: Peer education strategies can take place in a wide variety of settings and sectors. The model is flexible and can be applied to both rural and urban programmes that work with either female or male young people, or both. It can also be used with either married or unmarried young people in diverse settings such as community centres, health clinics, workplaces, the military, universities, secondary schools, sports programmes and recreational spaces. It is often the approach of choice for serving hard-to-reach and marginalised young people such as male or female commercial sex workers (CSW), indigenous ethnic minorities, and intravenous drug users (IDU).

> Young men and women may have different preferences, and differ in their ability to act as educators. There is some evidence that boys may be served better than girls who have less mobility and less ability to do outreach. There is evidence from African countries that peer education served more boys than girls, and that girls often preferred to receive information from someone older than themselves.[97]

Benefits:

- Several reviews of evaluations of peer education programmes have shown that they can be effective behaviour change interventions[98] when they have increased support for health-promoting norms in the peer groups and increased referrals to fixed site services.
- **Messages and communication are more likely to be appropriate for the specific population of young people served, because they are fashioned from within the group.** To achieve this advantage, recruitment criteria are key. The peer educator should be a natural leader among the group the programme aims to reach. Peer educators can then serve as the reviewers of educational materials and messages for the programme. Some programmes do the programmatic equivalent of a 'convenience sample', with the staff's younger siblings and children, and their friends, forming the 'youth group'. Often, these young people tend to be more middle-class, and so this advantage is lost if these 'peers' work in low-income neighbourhoods, and not among their actual peers.
- **Peer educators are accepted** by their target audiences, a real advantage among groups that suffer discrimination or social marginalisation, or among linguistic and ethnic minorities. There are favourable reports on these programmes among university students in Tunisia.[99] It seems reasonable to assume that when young people prefer receiving information and counselling from peers, this strategy would be most effective.
- Peer education is a **vehicle for increasing young people's participation** in young people's health and development programmes. Several evaluations have shown the positive benefits to peer educators themselves from the training and leadership experience that they gain through their participation.

Challenges and Solutions: (The challenges are underlined, and possible means of meeting the challenges are in italics)

- High turnover: Young people are often in transition in their lives, and move on to educational programmes, employment and/or marriage. Programmes need to plan for this turnover, so that *training new educators takes places at least 2–3 times a year*. Since most programmes do not include monetary incentives for the peer educators, keeping them motivated to keep turnover to a minimum requires active encouragement, incentives and supervision.
- Ensuring quality of information and messages. Young people can be as judgmental as adults about premarital sexuality! Being young and a

peer does not guarantee being 'youth-friendly.' Screening criteria for recruits should include attitudes on sexuality, and *training should encompass attitudinal issues*. Since peer educators are not as trained as professionals, the information they provide orally needs to be tailored to their level of training. Good educational materials are a necessary complement.

> *Substantial investment in training and supervision* is the basic solution to both points above.

> Peer education does not guarantee 'free, effective, and meaningful' participation. Programmes can vary widely in the level of internal democracy (i.e., the degree of peer educators' participation in decision making). Representation is another issue (i.e., how well the peer educators represent the diversity of the population of young people serviced by the programme). Young people's participation need to be intentional and planned to address these issues. (See table 3.2 in 'Young People's Participation' section.)

Cost-effectiveness is often cited as a benefit of peer education programmes, but there are no studies confirming this. Most peer education programmes provide non-monetary incentives to the peer educators, while reimbursing for expenses. Programmes that provide a small stipend have less turnover in educators, and possibly lower training costs as a result. Because of high rotation among peer educators and their lack of professional training, ongoing training and supervision is essential to maintain adequate quality of information and counselling. It would be useful to conduct a study that compares costs and outcomes of peer education and adult-provided education in similar settings; most of the evaluations have compared peer education to no intervention at all.

Youth-Friendly[100] Counselling and Health Services

The most typical intervention in such programmes is that counsellors and health providers receive training in youth-friendly approaches and assistance in adapting their services to young people's preferences. These services include clinic-based services, as well as other services, such as pharmacies and private doctors' or midwives' offices. Much of the literature on this programme approach emphasises fixed-site clinical services, and recommends aspects of service quality (i.e., non-judgmental attitudes) that are as important for adults as they are for young people. However, the non-fixed-site programme models, such as the confidential counselling mechanisms described above, also need to include training in youth-friendly approaches.

Recommended examples of youth-friendly SRH services that might be appropriate for the MENA region and could reach large numbers of young people of both sexes include:

> the **confidential counselling models** described above

> **networks of pharmacists trained to be youth-friendly**. Having free educational SRH materials available in pharmacies would be beneficial. Pharmacies can provide most contraceptives if they are trained in simple screening questions, and certainly can provide condoms. They could possibly play a limited role for treating common RTIs.

> **networks of private medical professionals (doctors, midwives or nurses) trained to be youth-friendly.** Use of private doctors is high in the MENA region, even among low-income families. Clients of the counselling services or those reached by peer education programmes could be referred to this network of youth-friendly pharmacists or medical professionals. The referral system should arrange for subsidies if necessary. A private medical office is a much more private venue than a public clinic.

Segment of the population of young people served: The main challenge facing youth-friendly health services is gaining access to the population of young people that needs the services. Marital status, socio-economic status and gender are determining factors in access. Therefore, a substantial discussion is in order.

In general, due to social stigma, sexually active unmarried young people -– especially females – are reluctant to use these services unless privacy and anonymity can be guaranteed. Young unmarried people tend not to go to health clinics at all unless they are ill. Young men do not want to enter a clinic they consider to be mainly for women, and international literature suggests that men in general are less likely to go to health services than women are.[101]

Furthermore, the use of pharmacies and private doctors demands access to cash, which might limit the population able to access these services, unless some kind of subsidy system were available. Socio-economic status is not always a reliable indicator of access to cash for young people. Young people in general have less access to cash than do the adults from the same families.

All services except for confidential counselling demand that the young person be able to travel to the site. The youth-friendly clinics that have achieved high coverage are in very large cities with financially accessible and high-coverage public transportation systems, where a significant proportion of older young people (20–24) have relative anonymity, some access to cash and freedom of movement.

Married young women have different barriers to access to SRH services related to lack of mobility, low status in the household and family pressure to bear children. **However, in general, the only young people who come in large numbers to clinic-based SRH services are young married women,** usually at the time of their first pregnancy. In these cases, separate services for adolescents are not necessary, and providers do not need the same kind of training as in youth-friendly services, because they are not likely to be judgmental and hostile. However, SRH providers should be trained to recognise the specific risks and constraints of very young wives because of their low status in the household and maternal mortality risks. Health workers can be trained to advocate on their behalf for family support to protect their health, to help them delay or space births and, if possible, to link them with community resources that can provide them with education, livelihood or recreational opportunities.

Benefits: There really is no substitute for SRH services when that is what the young person needs, whether the service be testing and treatment for STIs and RTIs, provision of contraception, access to condoms or diagnosis and treatment of a medical complaint. The services provide opportunities for counselling and health education as well.

Challenges and Solutions: (The challenges are underlined, and possible means of meeting the challenges are in italics)

These are all related to the discussion above on barriers to access to health services for young people, and the recommended service models partially address these barriers to access. In general, the authors do not recommend youth-friendly SRH clinic-based services, since they are often under-utilised and not cost-effective, failing to attract significant numbers of young people, especially in contexts where premarital sex is highly stigmatised.

The psycho-social barriers to use of SRH clinic-based services have been found to be highly significant in numerous studies. More than one study has found that community attitudes are more significant than the youth-friendly training of providers in determining whether young people use a service. For this reason, to date, *no evaluation has shown that increasing the 'youth-friendliness' of a medical health clinic correlates with significantly increased use of services by young people*. "These barriers include health beliefs … as well as perceptions that services such as pregnancy prevention should be only for married adults."[102]

However, once suitable service models are identified, it is essential that the health providers be 'youth-friendly'. Any health service requiring a laboratory test is usually only done in clinical settings, with all of the barriers to usage described above. In these cases, *establishing a youth-friendly network of private doctors is probably the most feasible alternative*.

Media and entertainment education

Using mass media to transmit YPSRH information and messages has been proven effective in many settings.[103] Most of these media strategies use radio or television to reach young people. Using specially designed brands, social marketing programmes use mass media – often including billboards and flyers – to increase usage of a particular service or product, such as condoms.[104] There has been some positive experience with young youth-run newspapers, but these are not strictly mass media. Entertainment education integrates information and positive social norms into entertainment, whether in cultural and artistic performances for specific audiences (such as plays, popular music, cultural fairs or video showings), educational programmes showing videos to stimulate discussion, or in mass media shows, such as soap operas crafted specially to weave information and new social norms into their plot.

For media-based programmes to have any lasting effect, sustained interventions over time are important. **The most sustainable and cost-effective approach is the creation of partnerships with media outlets** in which the owners are committed to integrate health-protective information and norms into their programmes. The potential partners are those outlets or shows most watched by young people in a particular country or region. One of the most striking global examples of such a partnership is 'Staying Alive', the partnership of MTV with numerous agencies to bring HIV/AIDS prevention information and messages to youth around the world.[105]

Segment of the population of young people served: Media programmes and entertainment education can reach a broad, diverse mass audience of young people. In rural areas of some countries, the only mass media available to young people is the radio, and travelling entertainment education programmes (videos plus discussion, theatre) are common in rural areas as well.

Key Resources for this Topic

Centre for Communications Programs, Johns Hopkins Bloomberg School of Public Health, 2000. *Proceedings of the Third International Entertainment-Education Conference for Social Change*. PDF files available from website: http://www.jhuccp.org/pubs/sp/21/pdf.shtml

Piotrow PT; Kincaid DL; Rimon JG 2d; Rinehart W; Samson K. 1997. *Health communication: lessons from family planning and reproductive health*. Westport, Connecticut, Praeger, 1997

Benefits:

- If the mass media space is not too costly (i.e., space available through a government channel) then programmes such as radio shows can be a cost-effective way to reach large numbers of young people.
- Media and entertainment education reinforce programme messages in efforts to promote health-protective norms among both young people and the adults in their lives. Having multiple channels for these behaviour-change messages is recommended; media messages can be an essential part of the mix of interventions in an effective YPSRH programme.
- Entertainment education is an excellent way to break the silence on taboo topics, and to get both young people and adults talking and thinking about them in a different way. This effect is enhanced if the exposure to entertainment education is in a group setting in which discussion can take place, rather than viewed or heard individually in each home.

Challenges and Solutions: (The challenges are underlined, and possible means of meeting the challenges are in italics)

- Television entertainment education can be quite costly to script and film, and then it may be shown only once or twice. *Distributing the video widely to sexuality and life skills education programmes in schools and other venues should expand the benefits* from this investment. The media partnerships recommended above also address this challenge.
- In general, evaluation of impact is a challenge. Few evaluations are able to ascertain whether the short-term effects of exposure to media programmes last once the campaign or programme is over. Embedding health-promoting information and norms within a culture is a long-term effort, requiring constant reinforcement until the new information and norms take hold. *Evaluations can measure exposure to the messages and changed attitudes or increased knowledge arising from this exposure*.

Youth Centres[106]

Beginning in the 1980s, youth centres have been one of the most popular YPSRH programme strategies, and there are many examples in the MENA region and worldwide. Generally, the model consists of a combined recreation and services centre, usually in a building or part of a building that can accommodate a variety of young people's programmes, depending on local needs and preferences. Young people's groups congregate in the centre. Often a centre will have one space that can hold a medium-sized audience for

entertainment education, such as movies or theatre. Generally, the main donor for the centre is interested in one type of programme or service to reach a health or development goal, and the recreational facilities and other programmes are used to attract young people to the centre, or in the case of YPSRH services, to make coming to the centre socially acceptable.

Segment of the young people's population served: Most centres have been found to attract mainly older unmarried male youth, especially in settings where girls' mobility is restricted. Centres that successfully attract both sexes often serve mainly university-age unmarried youth in modern urban centres, such as the Princess Basma Centre in Jordan. In response to this finding from international evidence, many youth centres have devised a variety of strategies to reach girls and young women.

For programmes that aim to serve mainly ages 15–24, male, unmarried young people and have mainly development (as opposed to health) goals, this is a highly appropriate strategy. In some settings, this sector of the youth population is most at risk for sexual and reproductive health problems.

Benefits:

> A youth centre can provide much-needed recreation and development opportunities in dense urban areas where young people are mobile.

> Many centres provide an opportunity for young people's participation; young people often decorate the centre, decide on activities, and turn it into a vital, youth-oriented space that serves as the focal point for a wide variety of activities.

> The space is useful for multiple purposes. Having a building makes certain kinds of activities possible, such as vocational classes that can attract at-risk young people, meetings for youth organizations, and cultural events that can attract large numbers of neighbourhood young people.

Challenges and Solutions: (The challenges are underlined, and possible means of meeting the challenges are in italics)

In recent years, numerous evaluations have pointed out the limitations of the strategy.[107]

1. Coverage tends to be low. First, low usage by girls contributes to this. Second, having a fixed location limits usage, since in many cities or towns, transit costs, safety en route, travel time to the centre are all a barrier to use. In one evaluation in Lomé, Togo, "while awareness of the youth centre increased from 6 per cent in 1998 to 42 per cent in 2000, actual use only rose moderately from 3 per cent in 1998 to 8 per cent in 2000 and 10 per cent in 2001."[108]

2. A certain social network of young men from the immediate neighbourhood tends to 'take over' the centre, especially when sports are offered, so that other young people's social networks in the community or city do not use it.
3. International experience has shown that the young people mainly use the centre for development or recreation programmes, and that any SRH services provided at these centres tend to be under-used.
4. Because of the under-utilization of the centre itself, and of the SRH services among the actual users, the cost per number of young people served tends to be prohibitively high compared to other YPSRH programme models. The centre needs to have staffing for both development and health activities and services, and there are high security requirements, since the centres often have sports, computer and other equipment. MEXFAM (the IPPF affiliate in Mexico) experimented with using peer educators to increase usage of their youth centre. However, using peer educators alone was found to be more cost-effective; the youth centres were closed down and entirely replaced by the peer education component.[109]

Several programmes supported by the IPPF affiliates, Save the Children, and UNICEF in the MENA Region have experimented with variations in the basic centre model to correct for these disadvantages, such as having centres only for girls, and having some hours for boys and others for girls. The centres supported by the IPPF affiliates often locate YPSRH health services at the centre, but also *transform the original model considerably, using the youth centre as a base from which to conduct community outreach by peer educators.*

Given the discouraging international evidence, this ***review recommends that the existing youth centres in the MENA Region be evaluated closely*** *for level of usage, for the profile of users, for the cost per young person served as compared to other models, and for other types of positive impact on YPSRH issues in the communities where they are located.* For those centres that are found to be successful by these criteria, lessons learned on the strategies that led to their success should be disseminated widely. **This review does NOT recommend establishing any new centres until these evaluation results are available.**

Conclusion

The goal of this chapter was to provide an overview of important considerations in YPSRH programming. The tables and checklists that are the final annexes to this section are tools to help planners think about all these aspects of YPSRH programme design. These considerations may help programme designers avoid common errors in the field of young people's sexual and reproductive health programmes, or to improve their programmes' effectiveness.

This review of international effective practices in YPSRH programmes is necessarily a partial and idiosyncratic document, since each topic in the review has overviews, studies and literature giving guidance to the practitioner. Faced with the need to produce a useful document that is not overly lengthy, the author has emphasised certain points in particular – those that may help practitioners understand the rationale behind the recommendations in chapter four. The review then directs the reader to helpful resources in the field.

Perhaps the most important design point is that each context is unique. Among countries, and sometimes in states/provinces within countries, the law and policy environment may differ dramatically, making some programme strategies more feasible than others. In general, this review recommends decentralised and participatory approaches that involve young people, their families and communities in the programme design. Generation gaps and conflicting values in societies can make this process difficult at times, but we hope that the approaches recommended in this review minimise these difficulties, as they protect the health and promote the development of young people.

TABLE 3.3

Examples of monitoring and evaluation indicators

This table illustrates types of indicators that could be measured using the monitoring systems and pedagogical testing normally used by a Ministry of Education and by in-school courses. Behavioural and health outcome objectives requiring more sophisticated evaluation designs – such as condom use during sexual activity and reduced incidence of STIs – are not included in this table.

Elements of successful promotion of young people's sexual and reproductive health[110]	Examples of specific objectives in a national school-based programme 2004–2009
Young people acquire accurate information on sexual and reproductive health	By the end of 2006, 90% of secondary schools will have implemented a life skills and health education programme including SRH topics. By the end of 2007, 50% of primary schools will have implemented a life skills and health education programme including SRH topics in the oldest two grade levels. By the end of 2009, 75% of students in secondary schools will correctly identify the woman's fertile period during a knowledge test in their 2nd year. By the end of 2009, 95% of secondary students will correctly name three main methods of prevention of HIV/AIDS and other STIs during a knowledge test in their 2nd year.
Young people acquire life skills and learn to apply them to situations related to sexual and reproductive health	By the end of 2006, 75% of students participating in the life skills curriculum in the 1st year of secondary school will demonstrate their ability to apply decision-making, communications and negotiation skills in at least four role-play exercises related to common situations that put them at risk for sexual and reproductive health problems, receiving an average score of at least 80% in observation checklists filled out by teachers and peer educators.

continued

(Table 3.3, continued)

Examples of monitoring and evaluation indicators

Young people have access to counselling (especially during crises) and basic health services, including those for sexual and reproductive health	By the end of 2006, 50% of urban school districts, and 25% of rural school districts will have developed partnerships with health and social service agencies to implement programmes providing access to counselling and SRH services for young people, within or nearby the secondary school, with young people's participation in the design, implementation and evaluation of the programmes.
Young people live in a safe, supportive environment; adults support their right to information and services; young people are not subject to violence or abuse; social and political context supports health-protective social norms and policies.	By the end of 2006, physical and sexual violence prevention programmes are following Ministry technical guidelines and one of the four approved curricula is being implemented in 50% of all secondary schools. By the end of 2006, 50% of secondary schools will have implemented education programmes for parents and community leaders on YPSRH issues and on gender issues, with three goals: 1) increasing parents' knowledge and acceptance of the content of the life skills and health programme; 2) decreasing discrimination against girls within families, and 3) preventing physical and sexual violence in homes and communities.
Young people have opportunities for participating meaningfully in their communities, and in programmes that promote their health.	By the end of 2006, 90% of secondary schools will have elected student councils with by-laws and specified roles and responsibilities in school programmes and policies. By the end of 2006, 90% of secondary schools will have included male and female student council elected delegates in the design and evaluation of the life skills and health education programme.
Young people have access to opportunities for livelihoods.	By the end of 2006, 50% of urban secondary schools and 35% of rural secondary schools will have developed partnerships with public and private sector employers that provide internships to male and female students during their last two years of schooling.

Table 3.4

Sectors of government and civil society best suited to serve segments of the young people's population

Sectoral Channel	Health	Education	Media	Community Organizations & Municipal Agencies	Labour	Sports & Recreation	Police & Judiciary	Military
Segment of young people population best suited to reach:	Married young pregnant women, with efforts to involve their husbands. The health sector usually only reaches unmarried young people if they run community-based education programmes, or produce health education materials that are disseminated through channels outside of clinics.	In-school young people, or working young people in night schools. Sexuality education should start in late primary school to reach 10- to 14-year-olds; advocacy is needed to address political sensitivities.	General population with access to the media channel. Radio is often the main media available in rural areas.	Sector includes grassroots community associations, religious groups, and NGOs. Most flexible sector, able to reach out-of-school young people, both married and unmarried young people, rural young people, and other harder-to-reach young people such as IDUs and CSWs. Youth organizations such as Scouts and Girl Guides are able to reach ages 10-14 .	Young people in workplaces and government vocational training programmes. Apt for reaching young adults 18-24[111], married or unmarried. Reaches mainly men where female workforce participation is low.	Most often reaches boys and young men, in and out of school, but more resources should be invested in girls' sports programmes.	Young people at risk: street children and 'delinquents'. These sectors come into contact with CSWs and IDUs, and often are the first contact with victims of physical or sexual abuse.	Young men, usually 18- to 25-years-old. Mainly unmarried. Socio-Economic class depends on whether the military is recruited with incentives (in which case lower Socio-Economic classes represented), whether there is universal conscription, and, if so, what exceptions are allowed.

Table 3.5

Sectors of government and civil society best suited to each essential programme component

The items in the x axis are some sectoral 'duty bearers', and the items in the y axis are the pillars of YPSRH strategies. This table does not pretend to be an exhaustive list. It is adapted to the author's understanding of the social context of the MENA region and not meant to be applied universally.[112] The Xs are a rough guide to which sectors are best suited for direct provision of programmes; anything can be provided in any one programme through referrals and partnerships.

Sectoral Channel Programme Component	**Health**	**Education**	**Media**	**Community Organizations & Municipal Agencies**	**Labour**	**Sports & Recreation**	**Police & Judiciary**	**Military**
Information (on SRH and gender) including messages with social norms promoting SRH.	X	X	X	X	X	X	X (materials)	X
SKILLS: Through both education and training in life skills. Latter involves intensive and multiple group sessions that are not compatible with structure of many sectors.		X with a special focus on making education more accessible and gender equitable for girls and young women, through family oriented advocacy and incentives.		X		X	X facilities should be provided in prisons and juvenile detention and rehabilitation centres for young people convicted of crimes.	X especially in respect for human rights, non-violent conflict resolution.
Medical and counselling services (actual provision or referrals).	X (including clinic-based and alternate services such as hotlines).	X School nurses, where they exist, can provide services, including SRH.	X Internet chat-based counselling now possible, and call-in shows on radio.	X Both adult and peer education approaches possible for information provision, counselling and referrals.	X Some workplaces can provide health education and services for employees.	X Sports coaches can be trained as counsellors and refer to services.	X Should be trained to refer to services.	X Military services should have a full array of STI prevention, care, and treatment.
Safe and Supportive environments	X Youth-friendly' services, & training in detection, counseling and treatment for victims of physical and sexual abuse.	X Focus on promoting SRH and gender-equality norms among teachers, parents, and students. Work with males to dis-courage violence among them, and against females.	X Young people's programmes and media can promote healthy SRH and gender norms. Use of celebrities or respected leaders can be effective.	X A wide variety of actors can be engaged, including important community and religious leaders.	X Labour ministries should promote policies for gender equity and against sexual harassment. They can fund workplace-based SRH education.	X Sports figures can be engaged to transmit positive messages. Sports teams can provide gender and SRH education for young people.	X Firm policies and laws should be in place against all forms of sexual violence and coercion, besides health promotion for young people in trouble with the law and in prison.	X Firm policies and laws should be enforced against all forms of sexual violence and coercion. SRH education and services should be provided to all recruits.
Young people's Participation	X	X	X	X	X	X	X Poses challenges in hierarchical settings.	X Poses challenges in hierarchical settings.
Access to livelihoods		X		X	X		X (vocational training in prisons).	X

Table 3.6

Checklist for young people's sexual and reproductive health and rights projects

Instructions: Place an "X" in the appropriate column

UNWEIGHTED SCORING**: No = 0; Partial = 2; Yes = 4

Potential to Produce Positive Health Outcomes among Young People	1. No	2. Partial	3. Yes	Comments
1. Improved health outcomes through reductions in: RTIs, STIs including HIV, unsafe abortions, unwanted pregnancies, gender-based violence, maternal mortality.				
2. Reduction in risky behavior or increases in health-seeking behavior e.g. increased use of condoms, contraception, and/or health services; decreases in substance abuse, numbers of sexual partners.				
3. Increased social inclusion & protective factors, e.g. school attendance, employment, relationships with sympathetic adults, opportunities for youth participation, health-protective social norms among peers and in community re: gender equity and YPSRH, increased community acceptance of SRH education and services for youth, increased access for youth to SRH education, protection methods (condoms and contraception), and services.				
Other possible impact in the political environment, in other organizations, in the implementing organizations, and in the YSRH field				
4. Potential for the evaluation results to contribute to the state of knowledge on effective programmes in YPSRH field.				
5. Potential for building capacity for leveraging funds and other resources for YPSRH				
6. Potential to stimulate similar YPSRH programmes in other national and international organizations				
7. Potential for broad coverage or for scale-up to a broader population (organization that might scale up must be meaningfully involved in the project)				
8. Potential to increase support for YPSRH programmes and policies by conducting advocacy as needed at appropriate levels (depending on context, community through national or regional)				
9. Increased organizational capacity to work with youth in a human rights–based approach on sexual and reproductive health and rights, including youth participation, attention to highly vulnerable sectors, and strategies to provide a full range of services and education				
Attention to key principles of YPSRH programme design				
10. Has a strategic results framework for the programme strategy, with intermediate and long-term indicators, (in accordance with theories of behavior change when applicable)				

continued

(Table 3.6 continued)

Checklist for YPSRH and rights projects

Instructions: Place an "X" in the appropriate column; UNWEIGHTED SCORING**: No = 0; Partial = 2; Yes = 4

	1. No	2. Partial	3. Yes	Comments
Attention to key principles of YPSRH programme design (continued)				
11. Collection of information on needs, preferences and risks of clearly defined segments of the youth population (segmented by age, sex, marital status, schooling, etc.) with strategies and sectoral involvement appropriate to that segment.				
12. Design takes into account state of art knowledge on good practices for the sector of youth and the programme model chosen.				
13. Design process includes input or data collection from youth from the same segments that the project will serve.				
14. Has sound plan for monitoring for quality and evaluation for impact, with evidence of institutional capacity to do so. If possible, quasi-experimental design for impact evaluation when model not tested.				
15. Plans for dissemination of results increase chances of broad impact in the country, the region, and the field.				
16. YPSRH advocacy efforts take advantage of the international human rights system and country reporting process.				
a) Participatory and rights-based approaches to young people				
17. Youth representing populations served have significant input into decisions in the programme, including setting priorities, review of materials, design of activities, and evaluation.				
18. Includes practical implementation of attention to women's rights, to sexual and reproductive rights as applied to youth, and attention to vulnerable sectors of young people.				
19. YPSRH advocacy efforts involve young people, not just adults. Advocacy includes young people in policy-setting processes.				
20. Education and training materials and methods designed for increasing knowledge, building life skills, and promoting healthy attitudes and behaviours through participatory educational methods, with young people's input on design and content.				
21. Service providers and educators trained in youth-friendly approaches.				
b) Community and parental involvement				
22. Involvement of the important adult gatekeepers and duty-bearers in the community and political environment of the programme in programme design and implementation, including religious leaders.				

continued

(Table 3.6 continued)

Checklist for YPSRH and rights projects

Instructions: Place an "X" in the appropriate column; UNWEIGHTED SCORING**: No = 0; Partial = 2; Yes = 4

	1. No	2. Partial	3. Yes	Comments
Attention to key principles of YPSRH programme design (continued)				
c) Use of comprehensive multisectoral strategies for behavior change				
23. Promotion of health-protective social norms among community leaders and organizations, families, and other social actors (politicians, teachers, religious leaders, etc.)				
24. Organisation(s) uses its special expertise and resources efficiently by forming partnerships, coordinating with other sectors, and through media strategies				
25. Adequate coordination mechanisms for involving multiple sectors (such as health, education, agriculture, sports)				
d) Attention to gender issues				
26. Evidence of commitment to gender equality in goals and activities, such as promotion of increased mobility and opportunities for young women, reduction of gender-based violence				
27. Evidence of knowledge of how gender issues affect health among youth, and access to services				
28. Trained staff in gender issues, or training as part of programme, with follow-up technical assistance				
29. IEC materials show gender approach				
30. Programme impact indicators include gender equality issues				
Technical and Managerial Criteria				
31. Systematic and ongoing training and supervision of staff that includes issues related to YPSRH and commitment to gender equality.				
32. Valid strategies for technical capacity-building and financial sustainability of programme in local institutions and communities once support ends.				
33. Organization shows strategic planning capacity with iterative cycle of planning, monitoring and evaluation, with systems to adjust programme as indicated.				
34. Has a feasible quality assurance system as the programme scales up.				
TOTALS	_____	_____	_____	

This checklist has been adapted by Bonnie Shepard from a checklist originally developed by Bonnie Shepard, José García-Nuñez, and Saul Helfenbein under a contract from the Bill and Melinda Gates Foundation in 2001.

Planners can decide which categories are most important to them, and assign those a higher scoring system, e.g. impact,gender issues, community participation, and youth participation sections, could be scored No= -1, Partial = 2, Yes = 5

A planner could also simplify this task by scoring only the evaluation-related and impact sections first, to decide whether the project has a potential for impact and for showing whether there was impact. If the answer is "no," the project should be rejected, or substantially revised using the full checklist

1 Bonnie L. Shepard is the author of this section.

2 Comment from Sofia Gruskin, Director of the International Health and Human Rights Program, François-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health

3 See a much more complete discussion of this point in Population Council 2002, Judith Bruce, "Steps in Building Evidence-Based Programs for Adolescents".

4 About 80 per cent of this section is directly quoted from WHO 2002a, p. 12, with some additions and changes by the author.

5 See the conclusions section of Population Action International 2002 for a fuller discussion of relevant policy issues.

6 Chapter one of King 1999 – "Theories and models of behavioural change" – provides an excellent summary of the range of behaviour change theories, focusing both on individual and social processes.

7 King, 1999, p.4 References within quote: Kalichman S, Rompa D, Coley B. "Lack of positive outcomes from a cognitive-behavioral HIV and AIDS prevention intervention for inner-city men: lessons from a controlled pilot study." *AIDS Education and Prevention* 1997, 9 (4): 299-313; and Sweat, M, Denison J. "Reducing HIV incidence in developing countries with structural and environmental interventions." AIDS 1995, 9 (suppl. A): S251-S257.

8 Kirby, 1999

9 Bond, 2004

10 Bond, 2004, p. 17, quoting Kirby, 1999

11 The field of program evaluation has produced a rich literature on evaluations based on program theory. See Weiss 1998 for an excellent discussion of how to construct the theory.

12 See Kirby 2002 for a useful guide on constructing logic models

13 UNAIDS, 1999, 8.

14 Abstinence-only programs consistently inflate the failure rates of contraceptive methods, especially condoms. See Congressional Report prepared for US Rep. Henry Waxman: "The Content of Federally Funded Abstinence-Only Education Programs" December 2004. Accessed July 2005 at: http://www.democrats.reform.house.gov/Documents/20041201102153-50247.pdf. A BBC television special, Panorama, on October 12, 2003, showed several interviews giving evidence that the Vatican and Catholic-run programs have started to give the message consistently that condoms have tiny holes in them through which the HIV virus passes. WHO and many other authorities have dismissed this statement, which has no basis in scientific fact.

15 Iowa Collaboration for Youth Development, accessed at: http://www.icyd.org/Definition_&_Philosophy.asp

16 Search Institute, *40 Developmental Assets,* accessed January 5, 2005: http://www.search-institute.org/assets/40Assets.pdf. There are many other excellent resources on the Search Institute website.

17 Bond, 2003, 2004

18 Kirby, 2001

19 Unless otherwise specified, these protective and risk factors pertain to all three health issues analyzed in the publication: early sexual initiation, depression, and substance abuse.

20 Physically or mentally harmful and/or dependence-causing substance use.

21 A common lament from most writings in the field. See Senderowitz, 2000; Bond, 2003; Speizer, 2003. Most of the evidence from YPSRH programs comes from North America or Europe. Recently, the Horizons Program has produced some evidence from international programs, and the YouthNet website publishes recent program evaluations as well.

22 Speizer 2003,14.

23 Quoted from Shepard, Nunez and Helfenbein, 2001. Executive Summary, page 4.

24 Rugh, 2002. The "gold standard" in evaluations is experimental design, in which evaluators randomly assign subjects either to the program or to the control group. However, in practice, this design is complicated to implement and there are few examples in the literature from developing countries. In quasi-experimental designs, the control group usually consists of young people from schools or communities as similar to the intervention group as possible.

25 Bamburger et al, 2004, Weiss, 1997, and Rugh, 2002.

26 UNICEF designated these human rights instruments as the key references for programming. All countries in this review have signed the CRC, and see annex IV of this review for complete list of which countries in the MENA region have signed CEDAW. The country sections have useful information on reservations expressed, and on observations by the Committees for these treaties.

27 Female genital mutilation is also referred to as "female genital cutting" (FGC) and "female circumcision," although there is general agreement that the latter term is misleading.

28 For a full discussion of this approach, see Patel 2001, WHO 2002b, and all the papers from the UNICEF Global Consultation on Human Rights Approach to Programming, Tanzania, August 5–8, 2002. A CD is available from UNICEF's human rights officer with all of the materials from the conference.

29 Shepard et al, 2001 and Focus on Young Adults 2001.

30 See Greene et. al. 2002 and Bond 2004 for a full discussion of policy advocacy for YPSRH.

31 The box is copied from a paper by Fabio Sabatini of UNICEF Zimbabwe, "Programming with a Human Rights Approach. An Experience in Operational Practice: UNICEF Zimbabwe 1998-2003" presented at the UNICEF Global Consultation on the Human Rights Approach to Programming, Dar Es Salaam, Tanzania, 4–8 August 2002.

32 A basic reference for situation analyses using a human rights lens begins on page 20 of "A Human Rights Approach to UNICEF Programming for Children and Women: What it is, and Some Changes it will Bring." CF/EXD/1998-04 of 21 April 1998. Accessed July 2005 at URL: http://coe-dmha.org/Unicef/HPT_IntroReading01.htm.

33 See explanations of these principles on UNICEF's website for a much more complete discussion of the state obligations arising from these general principles. See links under "guiding principles" on the following page: http://www.unicef.org/crc/crc.htm

34 Bahrain, Oman, Qatar, Saudi Arabia, and UAE are not parties to this treaty. However, Bahrain is a party to the CRC and CEDAW without reservations--treaties that are based on principles in the ICESCR and the International Covenant on Civil and Political Rights (ICCPR).

35 Search by country at the following URL: http://www.unhchr.ch/tbs/doc.nsf and see annex III for references up to 2003.

36 UNICEF, 2002c, 290ff.

37 Ibid.

38 Ibid.

39 According to most definitions, 'youth' covers the age group 15–24, so this report uses the term 'young people' whenever possible, to include the 10–24 age group. However, certain terms such as 'youth-friendly' or 'adolescent-friendly' are commonly used in the literature, and are used in this report, with the understanding that the age range of any program's intended audience should be decided through needs assessments.

40 These elements (the lead phrases in italics) are inspired by the questions and answers in WHO 2002b, 16–17.

41 See Population Council 2003, chapter 5, for a fuller discussion. Erulkar, Anabel. "Examining the Gender Dimensions of Popular Adolescent Programming Concepts."

42 There is extensive literature on the subject that is beyond the scope of this paper.

43 Speizer 2003. Quote from summary of Speizer's conclusions in Issues in Brief, "The Role of Reproductive Health Providers in Preventing HIV." Alan Guttmacher Institute and UNAIDS, 2004. Accessed July 2005: http://www.agi-usa.org/pubs/ib2004no5.pdf

44 Employment programs for adolescents need to respect ILO standards protecting them against child labour.

45 See Mensch, Bruce and Green, 1998; chapter 9 in Population Council 2003, by Nicole Haberland, "The Neglected Majority: Married Adolescents"; Population Council 2000, and UNICEF Innocenti Research Centre 2001 for full discussion of this important point.

46 Interview, Jane Ferguson, WHO, Division of Child and Adolescent Health.

47 The following comments are based on the author's interview with Bruce Dick, WHO.

48 From interview with the coordinator David Harrison, fall 2000, during the author's work on an evaluation of young people programs for the Bill and Melinda Gates Foundation.

49 In the MENA Region, these ministries are most often called Youth and Sports.

50 For an excellent discussion of the challenges, see: Population Council and Overseas Development Council, 1998. "What Can Be Done to Foster Multisectoral Population Policies?" Seminar Report. http://www.popcouncil.org/multisectoral/multisectoral.html

51 Interviews by the author with several experts during the process of this review, and during an evaluation of the Bill and Melinda Gates' Foundations adolescent reproductive health programs in 2000–2001. (See Shepard et al, 2001)

52 Interview by author with Bruce Dick, WHO.

53 Drawn mainly from the author's experiences. See also Population Council 1998 op. cit.

54 Gender equality is the ultimate goal of women's empowerment programs, and means that women's rights, responsibilities and opportunities will be equal to men's, and will not depend on whether they are born male or female. Gender equity means fairness of treatment for women and men, according to their respective needs and situations, and is a strategy needed to achieve gender equality. In the development context, a gender equity goal often requires built-in measures to compensate for the historical and social disadvantages of women. Adapted from INSTRAW's glossary of gender-related terms and concepts. Accessed 29 July 2005 at http://www.un-instraw.org/en/index.php?option=content&task=view&id=37&Itemid=76

55 Although several countries from various regions expressed reservations to certain sections. See annex III with the table of country reservations.

56 There is copious literature on this subject. See Rivers, Kim and Peter Aggleton. 1999. "Adolescent Sexuality, Gender and the HIV Epidemic" and WHO. 2001. Transforming Health Systems: Gender and Rights in Reproductive Health.

57 These points are adapted from Shepard 2003.

58 The term refers to societies where men wield power and authority over women's lives and actions, so that women are under their control within families, communities, in the public and private sectors, and in the elected bodies of government. It is not an absolute concept, as there are varying degrees of patriarchy in any given setting.

59 Senderowitz, 2000, 13.

60 "Sex and young people: contextual factors affecting risk for HIV/AIDS — A Comparative analysis of multi-site studies in developing countries" (UNAIDS: Geneva, 1999, cited in Senderowtiz, 2000, 12).

61 There are many forms of discrimination against women not listed here, embodied in civil codes on property rights or control over financial assets, for example; this list concentrates on those aspects of gender issues most apt to affect girls and young women.

62 Brady, Martha 1998." Laying the Foundation for Girls' Healthy Futures: Can Sports Play a Role?" in Studies in Family Planning, Vol. 29, No. 1. (March 1998), pp. 79–82

63 See Greig et al 2002 for a comprehensive discussion of gender issues related to masculinity.

64 Rajani, 2001,1

65 Association Tunisians de Lute contra Les Maladies Sexuellement Transmissible et le Sida (ATL MST SIDA)

66 Field notes by Iman Mortagy from 31 July 2003 interview with Alia Shukri, Representative of Standing Committee on Reproductive health including HIV/AIDS International Federation for Medical Students Association, and Lassaad Souza, Volunteer for ATL MST SIDA and later communication via email from Lassaad Souza.

67 The following paragraphs are based on Rajani & UNICEF, 2001

68 Shah et al 1999

69 Hart 1997 adds this note regarding levels of participation: "The ladder of children's participation: while the upper levels of the ladder express increasing degrees of initiation by children, they are not meant to imply that a child should always be attempting to operate at the highest level of their competence. The figure is rather meant for adult facilitators to establish the conditions that enable groups of children to work at whatever levels they choose. A child may elect to work at different levels on different projects or during different phases of the same project. Also, some children may not be initiators but are excellent collaborators. The important principle is to avoid working at the three lowest levels, the rungs of non-participation".

70 Rajani, 2001.17. Figure 3.

71 This version on the checklist comes from the pre-publication draft, given to the author in 2000. See annex four in Rajani 2001 for the current version. The author has made small changes in the original.

72 There is no evaluation information on whether the Youth Parliament has improved the effectiveness of their youth programs, or made them more responsive. IPPF/Youth 1998

73 B. Shepard, June 2000, table originally developed for SADC Report, with small changes for this publication.

74 See Shah et al 1999 for discussion

75 Grunseit, A. *Impact of HIV and Sexual Health Education on the Sexual Behavior of Young People: A Review Update*. UNAIDS Best Practice Collection. Geneva: UNAIDS (1997). PDF file available at www.unaids.org/publications/documents/children/schools/grunskme.pdf.; Kirby, D. "Sexuality and sex education at home and school." *Adolescent Medicine: State of the Art Reviews* 10(2):195–209 (June 1999). Cited in RHO, "Adolescent Reproductive Health, Key Issues, School-Based sexuality education."

76 The many sources on this topic are mostly based on studies in the USA. The following are just a sampling: Jemmott, J, Jemmott, L, Fong, G. (1998). "Abstinence and safer sex HIV risk-reduction interventions for African American adolescents: A randomized controlled trial." JAMA, May 20, 1998, vol 279, No. 19, pp1529–1536, and Kirby, D. (2001). *Emerging Answers: Research Findings on programs to reduce teen pregnancy*. The National Campaign to Prevent Teen Pregnancy. USA, quoted in UNICEF, 2003, "Lessons Learned…." ; C. Collins, P. Alagiri, T. Summers, S. Morin. UCSF AIDS Research Institute, March 2002. "Abstinence Only vs. Comprehensive Sex Education: What Are the Arguments? What Is the Evidence?" available at website: http://hivinsite.ucsf.edu/pdf/sex_education.pdf .

77 See Waxman Report, US House of Representatives, December 2004.

78 Bond 2003, Section 3.2.

79 co-author of this publication.

80 DeJong 2003, 109. An explosion strategy is "implementing a large-scale intervention suddenly to achieve maximum coverage in a short amount of time."

81 See a detailed case study of such a scenario in an unpublished manuscript available from the author (Bonnie Shepard) on the history of a sex education program in Chile.

82 Shepard et al, 2001, 9. Most were large-scale multi-site programs, funded by the Bill and Melinda Gates Foundation, and implemented in 36 countries.

83 Ibid.

84 Ibid.

85 Interview notes with Angel Foster of Ibis Reproductive Health, Foster 2002, and email survey answers from several countries pointing out risks for university students.

86 Paragraph based on Reproductive Health Outlook, "Adolescent Reproductive Health, Key Issues, School-Based sexuality education."

87 See a literature review of school-family partnerships by the North Central Regional Education Laboratory in the United States. From the website: http://www.ncrel.org/sdrs/pidata/pi0ltrev.htm "At the middle and high school levels, parent involvement practices decline (Lucas & Lusthaus, 1978).

88 Amin 1998 and 2003

89 Sabo, Donald F., Kathleen E. Miller, Michael P. Farrell, Merrill J. Melnick and Grace M. Barnes, 1999. "High school athletic participation, sexual behavior and adolescent pregnancy: a regional study," in *Journal of Adolescent Health,* Volume 25, Issue 3, September 1999, Pages 207–216.

90 The Lebanese Family Planning Association suspected, when the number of callers fell, that this was because the line had been too busy and not all people were able to get through. Interview with Rana Jawad, research assistant.

91 See very informative article on the hot line in India by Bishakha Datta and Elizabeth Coleman, "Hot Lines are Lifelines" in *Ford Foundation Report,* Winter 1999. Available at the website: http://www.fordfound.org/publications/ff_report/view_ff_report_detail.cfm?report_index=130

92 Communication from Dr. E.M. Rafique in the International Policymakers Conference on HIV/AIDS, "Focusing on Young Adults. http://health.groups.yahoo.com/group/saathii/message/545

93 See McIntyre 2002 for a comprehensive overview.

94 Herdman, 1999.

95 AIDSCAP/FHI 2001, 10-14.

96 Finding from a survey by MEXFAM's Gente Joven Program. Also, focus group research among participants in the Gente Joven program in Mexico and another program for Latino young people in Cambridge Massachusetts found that most young people did not really care about the age of the person providing information or counseling; they cared about being able to trust them. Hasselberg, E.L. 2003. "The Disconnect between Preferences and Programs: An Analysis of the Opinions of Latino Young people in Mexico City and Cambridge, Massachusetts, on Sexual and Reproductive Health Programs." Unpublished M.P.H. thesis, Harvard School of Public Health.

97 Erulkar, Annabel. "Examining the Gender Dimensions of Popular Adolescent Programming Concepts" in Population Council, 2003. Full report, pp. 101–102.

98 FOCUS on Young Adults, 2001, 48-52; Speizer et al., 2003, 10–11.

99 Foster, 2002.

100 As mentioned earlier, this paper uses the more common term "youth-friendly," but the recommendations include the 10- to 14-year-old age group. See full description of characteristics of youth-friendly services at the conclusion of the "CRC-based programming" section in this chapter.

101 Research has amply supported this observation. See discussion in Shepard 2004,157–58, and Green, Carla A. and Clyde R. Pope. "Gender, psychosocial factors and the use of medical services: a longitudinal analysis," *Social Science and Medicine,* Vol 48, #10, May 1999, 1363–1372.

102 FOCUS on Young Adults 2001, 57–59.

103 See Speizer 2003, 10–14.

104 This review does not discuss social marketing strategies in depth, since much guidance exists in the literature. These strategies, when well-designed, are often effective in increasing condom and contraceptive use, although it is often hard to evaluate what segment of buyers merely switched brands.

105 This partnership was highlighted at the Global Health Council's Conference in June 2004. It is a partnership between MTV Networks International, YouthNet spearheaded by Family Health International, and the Kaiser Family Foundation. Additional partners include USAID, UNAIDS, The World Bank, and other organizations. http://www.staying-alive.org/en/about_us.jhtml

106 Since 'youth centres' rarely serve the 10- to 14-year-old age group, this paper uses the more common label in the literature.

107 See Speizer, 21–22.

108 Cited in Speizer: footnote 79. Kouwonou K, Speizer I. Enquète evaluation du centre des jeunes de l'ATBEF x Lomé (EVACJEUNE3): Analyse de changements d'attitudes et de comportements sexuels des jeunes de Lomé. Lomé, Togo: Unité de Recherche Démographique, New Orleans: FOCUS on Young Adults Program/Tulane University School of Public Health, 2001.

109 Quote from *YouthNet Website*, FAQs, Peer Education. The quote references Marques M. *Gente Joven/Young people: A Dialogue on Sexuality with Adolescents in Mexico*. Quality/Calidad/Qualité. The Population Council. No. 5. 1993. http://www.fhi.org/en/Youth/YouthNet/FAQs/FAQspeered.htm

110 See section on the comprehensive strategies for a fuller explanation of thee components.

111 Age depends on employment structure and laws in each country. Some informal sector workplaces such as markets are often excellent venues for provision of information through distribution of materials, or cultural strategies such as street plays and videos.

112 The idea for this table came from a conversation with Bruce Dick of WHO.

CHAPTER FOUR: POLICY, PROGRAMME, AND RESEARCH RECOMMENDATIONS

These recommendations arise from the authors' consideration of the findings from the regional situation analysis, the international evidence on effective practices in programmes and policies that protect young people's sexual and reproductive health, and on the human rights frameworks in international treaties to which the Arab States and Iran are parties. While recognizing that the region is diverse with different situations among countries as well as within countries, we believe that these recommendations will serve the best interests of young people in these diverse contexts.

Policy Recommendations to Governments

General Recommendation

Increase government investment in policies and programmes promoting the health and development of young people. This investment is best achieved by **integrating initiatives to promote young people's sexual and reproductive health into a broader framework of building their capacity** – formulating policies that address the different needs of married and unmarried young people holistically by strengthening protective factors.

Discussion

This review urges governments to make these investments in order to achieve Millennium Development Goals (MDG) and to fulfil their obligations under major human rights treaties.

These investments are in line with the current recommendations of the Committees responsible for monitoring government compliance with the Convention for the Rights of the Child (CRC) and Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). General Comment 3 on "HIV/AIDS and the Rights of the Child" from the Committee on the Rights of the Child[1] and General Comment 4 on "Adolescent health and development..."[2] both help to further clarify the obligations of governments for adolescent sexual and reproductive health.

Investing in young people's health and development will contribute to raising low-income young people out of poverty – benefiting their present and future families, and thereby helping countries meet the following Millennium Development Goals (MDG): (1) eradicating extreme poverty and hunger, (2) achieving universal primary education, (3) pro-

moting gender equality, with the target of reducing gender inequalities in education, (5) improving maternal health, (6) combating HIV/AIDS.

Since there is much political and cultural resistance to implementing policies and programmes that promote YPSRH, advocacy will play a central role in policy change and increased investments in this area. Much fruitful policy dialogue can be conducted among different stakeholders within government agencies. International donor agencies and civil society organizations have a key role to play, providing evidence and arguments in favour of programmes and policies that will protect the health of young people.

Legal recommendations

Review status of country's ratification of and reservations to major human rights treaties: CRC, CEDAW, ICESCR, ICCPR.[3]

> Sign and ratify unsigned treaties.

> Review any reservations to CRC and other treaties for implications for the health and development of young people.

Encourage multisectoral involvement in the treaty body reporting process.

> Encourage reporting on YPSRH and gender issues that encompasses political and socio-economic factors.

> Use the treaty body recommendations as guidance to improve sexual and reproductive health policies and programmes for young people.

Review existing civil and customary law from human rights and gender equality perspectives. Use the CEDAW and CRC country reporting documents to identify key human rights issues for young people. (See the comments by country from treaty bodies in annexed policy sheets in this report, annex III).

> Establish legal mechanism for **young people's participation** in policy discussions, education, and in 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 **female genital mutilation/cutting (FGM/C)** in the four countries where it is practised, and establish enforcement mechanisms to **eradicate** the practice.

- **Reform laws on physical and sexual violence against girls and women** as well as on **child abuse,** to better protect the rights of victims.
- **Review age of consent laws** to ensure that young people have access to confidential medical services, including SRH services.
- **Address abortion laws.** At a minimum, governments that have not already done so are urged to **consider legalizing abortion for medical reasons** to save the life and health of the mother, in cases of rape or incest, and in case of foetal impairment.
  - Access to SRH education and services is the most effective way to lower abortion rates and maternal mortality. Since legal prohibitions do not lower abortion rates, and unsafe illegal abortions are a major factor in maternal mortality, consider **eliminating criminal penalties** for the provision and receipt of services of safe abortion services.

Social investment recommendations in accordance with Millennium Development Goals

Provide free education through secondary school and **eliminate all gender discrimination relating to access to education** (with particular attention to married and pregnant young girls). (MDGs 2 and 3)

- Increase coverage for both sexes in countries with gross secondary enrolment ratios below 80 per cent: Yemen, Djibouti, Iraq, Kuwait, Morocco, Oman, Saudi Arabia, Sudan and Syria.
- Eliminate discrimination against girls in levels of secondary enrolment in Yemen, Iraq, Morocco and Saudi Arabia.
- Establish closer links between the education system and the labour market.

Provide sexual and reproductive health (SRH) education and services to young people to prevent HIV/AIDS and STIs, RTIs, unwanted pregnancies, maternal mortality, infertility, and unsafe abortions. (MDGs 5 and 6)

- Invest more resources in **building the capacity of National AIDS Programmes and youth ministries in multisectoral health and youth development programming** that includes SRH education and services.
- **Invest in SRH education in the school system** with age-appropriate

information in each grade beginning at age 10. While encouraging abstinence until marriage and monogamy within marriage, education should provide scientifically valid information on all methods of contraception and means of preventing HIV infection.

- **Institutionalise mechanisms for young people's participation** in these programmes and institutions
  - Consult diverse groups of young people on preferred education and service channels before designing programmes, and enable participation in implementation.
  - **Involve young people living with HIV** in the development and implementation of these programmes.
- Provide accessible and anonymous **voluntary counselling and testing for all STIs and RTIs** (including HIV/AIDS), and **treatment** as necessary, through confidential services in primary and secondary care health facilities.
- **Provide widespread access to emergency contraception**. Emergency contraception (EC) is particularly useful to young people, whose sexual activity is often unplanned. Access to EC is essential in cases of rape and coerced sex. Numerous medical studies have confirmed that this method prevents pregnancy, and is not a method of abortion.[4] It is recommended that public education and advocacy correct misconceptions about this method and that it be made widely available.
- **Reduce the incidence of abortion and reduce mortality and morbidity from clandestine unsafe abortion.**
  - Promote universal access to contraception for those who are already sexually active to prevent unwanted pregnancies.
  - Institute humane post-abortion care and safe legal services.

Programme Recommendations for Governments, Donor Agencies and NGOs/Civil Society Organizations

These recommendations are concerned with how programmes are designed and carried out, with the audience of programme designers and managers in mind. As in the policy recommendations, these recommendations take into account both the regional situation analysis, and international evidence on effective programme strategies. (See the preceding two chapters for more information.)

General Recommendation

Coordinate and integrate YPSRH and youth development programmes. It is recommended that both government and NGO/civil society programmes serving young people **use a comprehensive youth development approach, coordinating with each other in sustainable health and development interventions that integrate YPSRH,** giving high priority to:

- **Populations:**
  - Young people in pockets of high poverty
  - Marginalised and vulnerable young people, including: labour migrants, refugees, children who live and work on the street, prisoners, sex workers, men who have sex with men, intravenous drug users. The needs of these populations need to be met in ways that respect their rights in a supportive environment.[5]
  - All young people out of school, with special efforts to reach young women – married and unmarried.[6]
- **SRH education, skills-building and referrals**
  - Where young people are congregated in large numbers, including parallel education programmes for parents
  - In mass media and entertainment education through sustainable partnerships with media outlets and producers
- **Promoting gender equity** in all programmes and policies
  - Conduct education and advocacy to prevent gender-based violence and discrimination in all programmes, at every opportunity
- **Decentralised YPSRH counselling and service networks**
  - Hotlines, Internet, premarital counselling
  - Private doctors and pharmacies

Discussion

The focus of the programme in each setting should be determined by a **general health and development needs assessment** that includes SRH and gender issues, and disaggregates data by relevant dimensions such as age, schooling, urban/rural location, marital status, and socio-economic status. Ideally, the assessment should use both confidential survey techniques and involvement of young people and adult stakeholders in separate, and then joint, discussions of needs. The involvement of adult stakeholders in the needs assessment

helps to reduce resistance to YPSRH programmes, and facilitates their future involvement in the programme.

It is essential to **enable evidence-informed programming by investing in adequate evaluation designs**. The collection of disaggregated baseline data should be the first activity. Evaluations designed and begun at mid-term or at the end of a programme rarely produce reliable information on the programme's impact on health, or health-related behaviour, attitudes and knowledge.

Specific Recommendations on Programme Strategies

Focus on SRH and gender equity information, skills-building and education in settings where large numbers of young people are concentrated. Civil society organizations can play a leading role, especially in youth organizations and youth development programmes, and they can also be involved in training and providing technical assistance.

- Develop age-appropriate SRH, health and life skills education for students **in the education sector** beginning at age 10 and continuing at primary, secondary, and university levels.
  - Enlist teachers who are comfortable with discussing the subject matter.
  - Train teachers in content and participatory teaching methods, and provide continual support.
  - Involve parents and key family members in parallel education programmes.
- Integrate YPSRH issues into **youth development programmes,** such as those providing sports and recreation, cultural activities, training and resources for livelihoods, agricultural extension, and literacy programmes. All of these programmes may require special efforts to involve girls. Religious education programmes are widespread in the region and present important opportunities for involvement.
- Offer YPSRH education and health services **in the military** among young recruits.
- Integrate YPSRH education and service referrals with the activities of **youth organizations**.
- **Develop peer education programmes in any of these settings,** when assessments indicate that young people prefer this strategy. Preferences may differ by gender and level of vulnerability, topic, or

programme component (information, counselling, life skills, contraceptive provision, etc). (See International Evidence chapter for technical notes on peer education strategies.)

Support **confidential, private counselling and service delivery mechanisms for young people to prevent unwanted pregnancies and STIs, including HIV.**

- **Counselling:** Explore all possibilities for introducing confidential counselling on SRH and gender issues. Examples include **premarital education and counselling** in Iran, and **telephone hotlines** in Egypt and other countries. **Internet-based counselling** in countries where free, uncensored access is available to large numbers of young people could be experimented with, when confidentiality is guaranteed.[7]
  - **Premarital counselling** programmes can serve multiple purposes and achieve high coverage. Counsellors can intervene positively in cases of legal early marriage, working with the husband and family to delay age of first birth and to allow the young bride to continue her education. In these sessions, couples can receive counselling and education on RTI and STI prevention, sexual health and pleasure, contraception, fertility awareness, and gender-based violence. Ideally, private medical exams would accompany the counselling, so that STI testing could be offered, particularly for the man.
  - **Telephone hotlines** are probably the most cost-effective and confidential way to offer SRH counselling to a general population of unmarried and married young people with telephone access. This model needs adequate investment in marketing, specifically in promoting awareness of programme accessibility and confidentiality in the development of telephone line and counsellor capacity. (See sidebar in Situation Analysis for regional experiences.)
- **SRH Services:**
  - **Pharmacies:** Make condoms and other contraceptives accessible through pharmacies whose staff is trained to be youth friendly.
  - Provide services through **private doctors' offices,** which are often named as young peoples' service channel of choice in surveys, along with pharmacies. It is recommended that programmes in the region experiment with providing services through this channel: training interested doctors in youth-friendly SRH services in diverse neighbourhoods in urban settings,

involving young people in evaluating the services, and publicizing the service network. Subsidy strategies for low-income youth could be explored.

- Enhance or create **peer education programmes,** especially among highly vulnerable populations of young people. These programmes can provide referrals to services.
- **Integrate education and programmes into primary care health services,** where large numbers of young people attend, such as:
  - Universities (as in Tunisia).
  - The military (as in Morocco).
- To prevent HIV, explore the acceptability of having condoms available discreetly in **other venues where young people congregate.**
- **Service strategies with limitations – not highly recommended** in the MENA Region
  - **Clinic-based 'youth-friendly' SRH services are usually under-utilised** when their main intended clients are unmarried young people. For young women, the perceived level of stigma is too high, and young men rarely go to clinics. For this reason, this study only recommends this strategy for SRH services integrated into a primary care clinic in settings like universities and the military.
  - **Youth centres** combining recreation, health and development services rarely attain significant usage of the SRH services, and often find it difficult to involve girls and 10- to 14-year-olds. Such centres **must institute community outreach strategies to make them accessible to the full range of young people** in need by involving parents and other adult stakeholders. They must then be evaluated to see if they have overcome the limitations of the model.[8]

Implement mass media and entertainment education strategies to break the silence on this topic, change social norms and increase access to contraception through social marketing. Throughout the region, the taboo surrounding discussion of sexuality has been described as an important obstacle to advocacy, and to implementation of programmes to protect young people's sexual and reproductive health.

- Develop sustainable **media partnerships** with selected shows or producers (radio stations, TV channels, etc.) to integrate SRH content into ongoing media programmes. One-shot interventions are costly and do not have sustainable results.
- Duplicate and distribute widely all regional media materials already produced that have received favourable evaluations. These **SRH 'entertainment education' programmes** can be used to enhance peer education programmes and community-based dialogue on SRH issues.
- **Invest in social marketing,** which can increase condom and emergency contraception use, and publicise counselling and SRH services.

Complementary Programme Recommendations on some specific SRH Issues

Early marriage.

- Strengthen prevention efforts through opportunities for education and livelihoods, media campaigns, premarital counselling and appropriate changes in laws and regulations.
- Limit the harm caused by early marriage through premarital counselling, efforts to prevent high-risk childbirth and advocacy in favour of young married girls' access to opportunities for education, recreation and livelihoods.

Maternal mortality.

- Raise community awareness about danger signs and improve access to essential quality obstetric care.
- Prevent the malnutrition-related risk factors for maternal mortality (e.g., anaemia and stunting in early childhood).
- Involve women's husbands before and during the first birth through prenatal campaigns.
- Provide post-abortion counselling in hospitals and clinics with provision of contraception

Reproductive morbidity.

- To reduce obstetric morbidity (e.g., prolapse[9], fistula[10]), most measures identified above for reducing maternal mortality will also address this issue.
- Screen women for risk of obstructed labour in countries where FGM/C is practised, particularly infibulation.
- Improve screening and treatment for RTIs in family planning and women's health services
- Raise awareness about RTIs and the importance of genital and menstrual hygiene starting at puberty. Educate the general public about the risk of future infertility from RTIs, to facilitate young girls' access to treatment.

Infertility.

- Increase education and advocacy with policy makers to persuade them of the importance of infertility prevention, and the possibility of reducing future incidence through widespread hygienic education, the availability of RTI and STI testing and treatment, and the promotion of condom use.
- Concentrate public resources on prevention of infertility among men and women, rather than on treatment.
- Promote testing for both male and female infertility factors in treatment programmes.

HIV/AIDS and STIs.

- Focus resources on rights-based approaches that help people to protect themselves. Resource availability is especially important in countries where the epidemic is estimated to be concentrated among highly vulnerable and marginalised populations of young people, such as children who live and work on the streets, men who have sex with men (MSM), commercial sex workers (CSW) and intravenous drug users (IDU). Peer education is often the most effective education and counselling strategy for HIV/AIDS prevention with these young people.
- Strengthen efforts to involve HIV-positive young people in prevention and services.
- Destigmatise HIV-positive young people and populations with high-

risk behaviours, using non-repressive means to improve their access to services.

Substance abuse.[11]

- Expand harm-reduction programmes (as in Iran).
- Use peer educator networks to reach substance abusing populations with services.
- Expand youth development programmes to decrease demand for illicit substances.
- Increase public education in order to reduce stigma.

Female genital mutilation/cutting (FGM/C). Adopt a three-pronged strategy in order to eliminate all forms of FGM/C.

- **Media education to change social norms:** 'Break the silence' surrounding the topic as a first and necessary step through media campaigns against the practice, reaching rural areas and all linguistic groups practicing FGM/C.
  - Raise awareness that FGM/C is not practised universally, which is critical. In Muslim communities, it can be very beneficial to point out that entire countries such as Saudi Arabia do not practise FGM/C while others such as Egypt are actively working to combat the practice.
  - Disassociate the practice from religious justifications, enlisting the support of sympathetic religious leaders.
- Invest in community-based programmes to **change cultural marriageability norms,** building support within communities for eradicating the practice.
- Change laws to **make FGM/C illegal,** with adequate financing and training of personnel for enforcement mechanisms that respect human rights.

Violence against women.

- Make full use of every opportunity to focus on prevention through information and education programmes with both sexes in all YPSRH programmes, especially in mass media.
- Combat all forms of sexual violence and harassment, making special

efforts to educate young men, including those in the military.

> Train police, judges, social services and healthcare workers so that they take appropriate action and full advantage of positive changes in laws on violence against women when dealing with victims and/or perpetrators.

Research Recommendations for Governments, Donor Agencies, and Research Institutions

Improve the support for and dissemination of SRH research.

> Strengthen political and institutional support for SRH researchers.

> Improve dissemination of this research in the respective national languages – Arabic, Farsi and French.

> Facilitate ability of researchers to publish in international literature through translation into the language of most relevant journals and dissemination of these journals.

> Conduct advocacy so that all data already collected on YPSRH is released and disseminated.

Conduct rigorous process and impact evaluations.

> Support programme evaluation. All agencies implementing YPSRH programmes are encouraged to support more evaluation of current programme models in the region.

Expand the range of issues addressed in nationally representative health and development **surveys on young people.**

> Conduct research on YPSRH. Donors collaborating with national governments and regional bodies can play a positive role in pointing out the importance of conducting research on YPSRH in particular, and the full range of health and development issues for young people in general.

Legitimise and support inter-disciplinary research on SRH issues and young people.

> Employ complementary research methods. YPSRH data gaps demand triangulation of quantitative and qualitative methods, particularly on

the social protective and risk factors, and SRH-related knowledge, social norms, and behaviour.

Encourage disaggregation by age and sex and other relevant dimensions in primary research on SRH topics.

> Conduct secondary analysis of existing data-sets that include young people; this is a cost-effective and immediately feasible strategy.

Support inter-disciplinary research to fill specific knowledge gaps.

> Encourage qualitative research on **young people's perceptions of SRH service needs and quality**

> Document trends in age at marriage, arranged marriage, and non-conventional forms of marriage and their SRH effects.

> 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.

> Explore **factors leading to maternal deaths** for the under-19 age group, who are at highest risk.

> Encourage community-based research, using quantitative and qualitative methods, on prevalence, protective and risk factors, and cultural norms regarding **unwanted pregnancy, obstetric and gynaecological morbidity**.

> Conduct research on the contribution of FGM/C to maternal mortality and morbidity, and to HIV infection.

> Conduct rigorous evaluation of FGM/C prevention programmes.

> Encourage epidemiological studies on prevalence of **infertility** and determine factors most relevant to young people's infertility.

> Explore interactions between SRH issues and the **mental health** of young people, including possible links between SRH issues and cases of suicide.

> Encourage country-level research, in collaboration with the legal community, on **laws and policies that affect YPSRH** negatively.

> Conduct triangulated quantitative and qualitative research on **violence against children and women,** including qualitative research on cultural norms regarding various forms of violence.

1 "HIV/AIDS and the Rights of the Child." General Comment 3 (2003) CRC/GC/2003/1

2 "Adolescent health and development in the context of the Convention on the Rights of the Child," General Comment 4 (2003), CRC/GC/2003/4.

3 The International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR)

4 Numerous studies are cited in the Planned Parenthood Fact Sheet on Emergency Contraception, accessed online 20 September 2004 at: http://www.plannedparenthood.org/library/BIRTHCONTROL/EC.html

5 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.

6 Young boys and men out of school tend to congregate in public places and be easier to reach in outreach efforts. Girls and young women out of school tend to be isolated in their homes, and outreach efforts thus need to use different strategies, involving families, using media, etc.

7 Some governments in the region use Internet surveillance, so that privacy of communications would be compromised.

8 Egypt's Ministry of Youth has issued a decree recommending measures to increase access of girls to youth centres in Egypt.

9 Uterine prolapse: A condition in which the uterus protrudes into, and sometimes out of, the vagina. Genital prolapse: A condition in which the vaginal wall or uterus descend below their normal positions; part of the bladder or rectum may protrude from the vagina. From the Glossary at website: www.rho.org.

10 Fistula: An abnormal opening between the vagina and the rectum, which can lead to incontinence (inability to retain urine and/or feces). From the Glossary at website: www.rho.org.

11 This report uses the term 'substance abuse' to refer to harmful and/or dependence-causing substance use.

ANNEX I: LIST OF INTERVIEWS

The following people graciously agreed to be interviewed, and many also provided us with relevant literature. We thank all of them for their time and insights.

For content on International Programs and Policies: Interviews with Bonnie Shepard:

Susan Adamchack, formerly of Horizons Project, Population Council

Shahira Ahmed, UNAIDS Reference Group on Human Rights

Nisreen Alami, UNIFEM

Maria José Alcalá, UNFPA

Lucille Atkin, Margaret Sanger Center International

Fabio Castaño, Margaret Sanger Center International

Shanti Conly, USAID

Mark Connolly, UNICEF

Nazneen Damji, UNIFEM

Bruce Dick, WHO

Jane Ferguson, WHO

Angel Foster, IBIS Reproductive Health

Amaya Gillespie, UNICEF

Kristina Goncalves, UNICEF

Margaret Greene, Consultant

Nicole Haberland, Population Council

Elizabeth Lule, World Bank

Holly Mahler, Youthnet, FYI

Sanyukta Mathur, International Center for Research on Women (ICRW)

Maxwell Marx, Youthnet, FYI,

Joan Mayer, UNICEF

Kerry McQuarrie, International Center for Research on Women (ICRW)

Roeland Monasch, UNICEF

Nancy Murray, Futures Group International

Rushnan Murtaza, UNICEF

Christine Norton, UNICEF

Nazy Roudi-Fahimi, Population Reference Bureau

Dorothy Rozga, UNICEF (NYC)

Monique Sternin, Consultant

Mark Stirling, UNICEF

Amy Weissman, Save the Children

For the Regional Situation Analysis: Interviews with Jocelyn DeJong, Iman Mortagy and Rana Jawad

Interviews and Communications with Jocelyn DeJong:

Ed Abel, Futures Group, USA (re Egypt and Jordan)

Ahmed Abdel Monem, PAPFAM, Cairo, Egypt

Rima Afifi-Soweid, American University of Beirut, Lebanon

Abdel Moneim Abo Nowar, UNFPA, CST, Jordan

Na'ima Al Quseir, formerly UNFPA, now at WHO, Bahrain/Geneva

Zahra Al Quseir, Bahrain Family Planning Association, Bahrain

Izzat Ayoub, Palestinian Family Planning and Protection, Palestine

Yahyia Babily, Yemen Family Care Association , Yemen

Heli Bathijah, WHO-Geneva

Hedia Belhadj-El Ghouayel, UNFPA – NY (Arab States)

Chukri Ben Yahyia, formerly IPPF, Tunisia

Elizabeth Bennour, IPPF-Arab World (Tunis)

Rebecca Cook, University of Toronto, Canada

Siham Dillo, (formerly UNICEF) Minister of Social Affairs, Syria

Rogers Eusulwa, consultant WHO, Yemen

Nazy Farzaneh Roudi-Fahimi, Population Reference Bureau, Washington, D.C. (Iran)

Angel Foster, Ibis Reproductive Health

Jumana Haj Ahmed, UNICEF, Palestine

Barbara Ibrahim, Population Council, Cairo, Egypt

Shireen Jejheebhoy, Population Council (India)

Mayada Kanj, American University of Beirut, Lebanon

Marwan Khawajeh, American Univeristy of Beirut, Lebanon

Pedram Moosavi-Shandi, Director and young people from the Iran Family Planning Association, Iran

Lama Mukawakaa, Syrian Family Planning Association, and Youth Organisations, Syria

Marie-Claire Mutanda, UNICEF-Djibouti

Samia Naggar, Reproductive Health Working Group, Sudan

Rania Salem, Population Council, Cairo, Egypt

Abdallah Sayari, ICD, Yemen

Mohammed Takieldin, National AIDS Program manager, Yemen

Robert Thompson, UNFPA (formerly WHO-EMRO)

Nahid Toubia, RAINBO (London/Sudan)

Soraya Tremayne, Oxford University, UK (Iran)

Shadia Wannous, independent researcher (formerly Ministry of Health, Syria)

Interviews with Iman Mortagy:

Zouari Abdel Aziz, Scouts Movement, Tunisia

Ahmed Abdel Monem, PAPFAM, Arab League, Egypt

Khaled Alouhichi, Arab League, Egypt

Farouk Ben Mansour, Reproductive Health Center, Office National de la Famille et de la Population (ONFP), Tunisia

Shukri Ben Yehyia, ONFP, Tunisia

Aicha Chaherli, Tunisian Family Planning Association, Tunisia

Mawaheb El Mouelhy, Egyptian Family Planning Association, Egypt

Sahar El Tawila, Cairo University, Egypt

Hind Khattab, Egyptian Society for Promotion of Reproductive Health and Rights

Ala'a Saber, Centre for Development Services, Egypt

Lilia Labidi, Tunis University, Tunisia

Pamela McCloud, CEDPA (Egypt)

Ramez Mehrez, World Health Organization (EMRO), Egypt

Ali Mokhtar, Centre for Development Services, Egypt

Mona Mounir, Save the Children Federation – USA, Egypt

Hoda Rashad, Social Research Centre, American University of Cairo, Egypt

Morad Rashem, UNFPA, Tunisia

Aida Seif al Dawla, Ain Shams University, Egypt

Amira Seif El Din, Alexandria Institute for Public Health, Egypt

Alia Shukri, International Federation for Medical Students Association, Tunisia

Lassaoud Soua , Association Tunisienne de Lutte contre Les Maladies Sexuellement Transmissible et le Sida (ATL MST SIDA) Tunisia

Youssef Waheeb, Suez Canal University, Egypt

Interviews/Meetings with Rana Jawad:

Bashir Abu Jammous, UNDP, Jordan

Bassem Abu Ra'ad, Jordan Family Planning Association, Jordan

Dana Dajani, Princess Basma Youth Centre, Jordan

Soliman Farah, Johns Hopkins Program, Jordan

Ms. Hamarneh, Arab Women's Organization , Jordan

Basma Khreisat, Family Health International, Jordan

Sana Nemr, Lebaniese Family Planning Association, Lebanon

Luna Qardan, Johns Hopkins Program, Jordan

ANNEX II: SYNOPTIC TABLE

TABLE A2.1: SYNOPTIC TABLE

Development and health statistics — Arab Countries and Iran

Country	1. % of urban population 2001	2. HDI ranking 2003	3. % of population earning less than $1/day 1999–2000	4. Gender development index ranking 2003	5. Adult literacy rate: male/female % above 15 (2001)		6. Maternal mortality ratio (per 100,000 live births)	7. Total fertility rate per woman 2000–2005	8. % of births delivered by skilled health personnel 1995–2001
					Male	Female			
Algeria	57.7	107	<2	88	77.1	58.3	140	2.8	92
Bahrain	92.5	37	_	40	91.1	83.2	28	2.7	98
Djibouti	84.2	153	_	_	76.1	55.5	730	5.7	_
Egypt	42.7	120	3.1	99	67.2	44.8	84	3.3	61
Iran	64.7	106	<2	86	83.8	70.2	76	2.3	_
Iraq	66	_	_	_	_	45	250	4.95	60
Jordan	78.8	90	<2	75	95.2	85.1	41	3.6	97
Kuwait	96.1	46	_	45	84.3	80.3	5	2.7	98
Lebanon	90	83	_	70	92.4	81	150	2.2	88
Libya	87.9	61	_	_	91.3	69.3	97	3	94
Morocco	56.1	126	<2	102	62.6	37.2	220	2.7	40
Occupied Palestinian Territories	_	98	_	_	_	_	100	5.6	_
Oman	76.5	79	_	71	80.9	63.5	87	5	91
Qatar	92.9	44	_	_	80.8	83.5	7	3.2	_
Saudi Arabia	86.6	73	_	68	83.5	68.2	23	4.5	91
Sudan	37	138	_	116	70	50.6	590	4.4	86
Syria	51.8	110	_	93	88.8	61.6	160	3.8	76
Tunisia	66.1	91	<2	76	82.3	61.9	120	2	90
United Arab Emirates	87.1	48	_	49	79.8	75.2	54	2.8	99
Yemen	25	148	15.7	127	76/1	33.4	570	7	22

continued

Table A2.1: Synoptic Table (continued)

Development and health statistics — Arab Countries and Iran

Country	9. Ages 10–24 as % of population 2002	10. Gross secondary enrolment male 1998–2002	11. Gross secondary enrolment female 1998–2002	12. % Youth in the labor force		13. Age at first sexual relation	14. Median Age (yrs.) at 1st birth (women ages 20–49)	15. Estimated no. of young people living with HIV/AIDS			
				Male	Female			Female		Male	
								low	high	low	high
Algeria	33	69	74	32	2	_	_	_	_	_	_
Bahrain	25	91	99	total= 30.5		_	20.6	_	_	_	_
Djibouti	32	24	15	over 30		16	_	_	_	_	_
Egypt	32	91	85	14.6	6.4	_	21.6	_	_	_	_
Iran	36	79	75	25	6	_	_	550	1100	2200	4600
Iraq	33	47	29	28	2	_	22	_	_	_	_
Jordan	32	85	87	26.8	4.9	_	23.2	_	_	_	_
Kuwait	38	83	88	21	3	_	20.8	_	_	_	_
Lebanon	29	74	81	19	8	_	_	7	25	12	50
Libya	35	102	108	24	2	_	_	_	_	_	_
Morocco	32	45	36	25	6	_	22.7	_	_	_	_
Occupied Palestinian Territories	32	82	88	10–14=3.1 15–19= 34.8 20–24=73.7	10–14= 0.4 15–19=2.2 20–24=13.6	_	20	_	_	_	_
Oman	33	79	78	over 20	_	_	17.5	47 females		156 males	
Qatar	21	88	93	over 20	_	_	20.6	-	-	_	_
Saudi Arabia	32	73	65	26	2	_	18.5	-	-	_	_
Sudan	31	34	30	27	4	_	20.5	13,000	63,000	22,000	46,000
Syria	36	47	42	23	5	_	_	-	_	174	
Tunisia	32	78	81	27	_	_	23.1	-	_	_	_
United Arab Emirates	25	77	82	over 20	_	_	18.6	-	_	_	_
Yemen	35	65	27	10–14=21.08 15–19= 48.35 20–24=85.69	10–14=16.35 15–19=24.91 20–24=30.27						

continued

Table A2.1 Synoptic Table (continued)

Development and Health Statistics —Arab Countries and Iran

Country	16. Reported cases of HIV/AIDS 2001						17. % youth who know healthy-looking people can be HIV+	18. % of young people 15–24 who know 3 methods of HIV prevention (methods: abstaining from sex, one faithful uninfected partner, consistent condom use)	19. Adolescent fertility rate ages (per 1,000 women)		20. Contraceptive prevalence rate (ages 15–49)	21. Antenatal care %		
	10–14		15–49		20–24				15–19	20–24		15–19	20–24	Total pop. of ever-married women 15–49
	M	F	M	F	M	F								
Algeria	0	0	0	0	1	0	_	_	20	_	64	_	_	58
Bahrain	0	0	0	0	0	0	_	_	12	106	62	100	99.3	97.2
Djibouti	0 [5-14]	0	1	1	10 [20-29]	10	_	_	65	_	_	_	_	_
Egypt	0	0	1	0	3	1	_	_	53	195	56	_	_	53
Iran	_		_		_		_	_	48	_	73	_	_	77
Iraq	0	0	0	0	1	0	51	_	38	_	14	_	_	78
Jordan	0	0	0	0	1	0	51.9	method not specified (F)= 45%; who know about condoms (F) 15–19=60.4, 20–24=81.3	43	172	53	_	_	96
Kuwait	0	0	0	0	0	1	_	_	19	170	50	100	94.2	95
Lebanon	0 [0-14]	0	1	0	1 [20-29]	0		_	25	_	61	_	_	87
Libya	_		_		_		_	_	53	_	40	_	_	81
Morocco	1 [5-14]	0	0	0	12 [20-29]	19	_	_	35	125	50	_	_	42
Occupied Palestinian Territories	_		_		_		49	one faithful uninfected partner (F) = 54; one faithful uninfected partner + condom use: 32%	77	311	51.4	_	_	96
Oman	1	0	0	0	1	0	_	_	67	251	32	97.2	99.4	98.2
Qatar	0	0	0	0	0	0	_	_	22	143	43	91.2	89.7	91.2
Saudi Arabia	1	0	0	0	4	0	_	_	39	178	32	89.7	90.6	90
Sudan	0	1	3	2	24	20	16	_	69	183	8.3	_	_	75
Syria	0	0	1	0	0	0	_	_	41	_	46.6	_	_	51
Tunisia	0	0	0	0	0	1	_	one faithful uninfected partner: F = 28; M = 41	6.8	62.4	60	_	_	79
United Arab Emirates	_		_		_		_	_	39	193	28	98.9	97.2	96.8
Yemen	1 [0-14]	0	0	0	4 [20-29	3	_	_	100	_	21	_	_	34

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1. % of Population which is urban: UNDP 2003 Human Development Report
   Exceptions: Occupied Palestinian Territory – Projected Urban Population for 2015 is 71.7% and estimated at 59.6% for 1975.
2. HDI Ranking: UNDP 2003
3. % of population earning less than $1/day:UNDP 2003
4. Gender Development Index Ranking: UNDP 2003
5. Adult Literacy Rate: Females as % of Males: UNDP 2003
   Exceptions: Iraq – UNICEF/UNDP 2003 Social Sector Watching Brief, Iraq: Overview Report; Yemen – Arab Human Development Report 2002
6. Maternal Mortality all from UN Statistics Division, Millennium Indicators for 2000. Notes that for 1) Algeria, Djibouti, Iraq, Lebanon, Libya, Palestine, Oman, Sudan, Syria and UAE no national data on maternal mortality available; estimates based on model; 2) For Bahrain, Qatar and Kuwait, data derived from vital registration with good death registration and good attribution for cause of death; 3) for Tunisia, data derived from vital registration with good death registration but uncertain attribution of cause of death; 3) for Iran, data from a household survey or census. 6) For Egypt, Jordan and Saudi Arabia data is based on RAMOS. 5) For Morocco and Yemen, data derived from direct sisterhood method adjusted estimates.
7. Total Fertility Rate: UNDP 2003
   Note: Data refer to medium-variant projections.
   Exception: Iraq – UNICEF/UNDP 2003; Sudan: Total Fertility Rate for the period 1998–2003, Central Bureau of Statistics Data, 2001; Syria – Data on RH from Multi Purpose Survey, 2000, Ministry of Health. The Estimated number of HIV cases for the year 2000 from the National Aids Programme Report, 2003, Ministry of Health
8. Skilled attendant at delivery: UNDP 2003
   Note: Data refer to most recent year available in period specified.
   Exception: Jordan – DHS 1997: 95%; Sudan – Data refer to a year or period other than that specified, differ from standard definition.
9. Ages 10–24 as percent of population: UNICEF/UNAIDS/WHO (2002) Young People and HIV/AIDS: Opportunity in Crisis
   Exception: Iraq – UNICEF website, statistics by country
10. Gross Secondary Enrolment Ratio (males): UNICEF State of the World's Children 2005
11. Gross Secondary Enrolment Ratio (females): UNICEF State of the World's Children 2005
12. % of youth in labour force: UNAIDS
    Exception: OPT – PCBS 2000, cited by UNICEF 2003 Country Fact Sheets for MENA; Yemen – ILO 2000, cited by UNICEF 2003
    Note: Data collected for 1985 except Egypt (1994); Jordan (1993); Occupies Palestine Territories (2000); Saudi Arabia (1986); Yemen (2000)
13. Median age at 1st sexual relations: Source of Data is UNICEF/UNAIDS/WHO 1998–2001.
    Note: Data available only for Djibouti.
14. Median Age (yrs.) at 1st birth (women ages 20–49): Gulf Family Health Surveys(GFHS) (2000) for Bahrain, Qatar, Kuwait, Oman, Saudi Arabia and UAE.

    Egypt, Jordan, Morocco and Sudan: source DHS (dates available for each country is specified below)
    Iraq: the figure shown is the mean age and the gender was not specified.
    Occupied Palestinian Territories: the age group is 25–49, source: Palestinian Central Bureau of Statistics 2001
    Note: Data excludes the age group 15–19 as less than 50% of women in that age group qualified.
    Data only available for 1988: Tunisia
    Data only available for 1990: Sudan
    Data only available for 1995: Bahrain, Morocco, Oman
    Data only available for 1996: Saudi Arabia
    Data only available for 1997: Jordan
    Data only available for 1998: Qatar
    Data only available for 2000: Egypt
    Data only available for 2001: Occupied Palestinian Territories
15. Estimated number of young people living with HIV/AIDS, end-2001: UNICEF/UNAIDS/WHO 2002

16. Reported cases of HIV 2001: UNICEF/UNAIDS/WHO 2002
Exception: Egypt – UNAIDS cites the following figures in 2003: reported cases of HIV+ in 15-24 age group: males= 128 and females=35.
Data only available for 1998: Djibouti, Yemen
Data only available for 1999: Iraq, Tunisia
Data only available for 2000: Saudi Arabia

17. % youth who know healthy-looking people can be HIV+ (1998-2001): UNAIDS/UNICEF/WHO 2002

18. % of young people 15–24 who know 3 methods of HIV prevention source: UNAIDS/UNICEF/WHO 2002
Exception: Jordan – DHS1997

19. Adolescent Fertility Rate:
Source for Bahrain, Kuwait, Oman, Qatar, UAE, Saudi Arabia is the GFHS (2000).
Source for Algeria, Iran, Iraq, Lebanon, Syria and Yemen is the World Bank 1999 (as cited by UNICEF 2003)
Source for Egypt, Jordan, Morocco and Sudan is DHS (Egypt – 2000; Jordan – 1997 Morocco – 1995; Sudan – 1989/90)
Source for Occupied Palestinian Territories is the Palestinian Central Bureau of Statistics (2000)
Source for Tunisia is the National Institute of Statistics (2001)
Source for Djibouti is the UNICEF website
Note: "Adolescent fertility rate" indicates the number of live births for every 1,000 women per age group listed, in this table ages 15–19 and ages 20–24.
The data provided in DHS and GFHS go back 19 years before the year of the current figures shown here.

20. Contraceptive Prevalence Rate (ages 15–49): UNDP 2003
Note: Data refers to most the recent year available during the period specified and applies only to married women. The actual age range may vary.
Exceptions: Iraq – UNAIDS/UNICEF/WHO (2002).The Iraqi Annual Abstract of Statistics (2001) cites 23%
Occupied Palestinian Territories – PCBS Health Survey 2000, Main Findings
Oman – figure for 1995 to 2003 from www.unicef.org/infobycountry/oman-stats.html accessed online 29 August 2005
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Tunisia – ICPD Indicators from UNFPA State of World Population Report 2003.

21. Antenatal care coverage %: UNAIDS/UNICEF/WHO 2002
Gulf countries: GFHS 2000
Note: Data for years 1995–2001, actual age range may vary across countries, data refer to married women and most recent year available during specified period.
Data only available for 1995: United Arab Emirates, Oman, Bahrain
Data only available for 1996: Saudi Arabia
Data available only for 1998: Qatar
Time period of data not specified: Sudan, Syria, Tunisia

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ANNEX THREE: POLICY FRAMEWORKS AND COUNTRY REFERENCE TABLES[1]

This annex is designed as a reference tool for YPSRH advocates in the Arab States and Iran to:

- highlight some basic facts about the human rights frameworks relevant to YPSRH
- provide quotes from human rights documents and benchmarks in UN consensus documents
- list the ratifications and reservations to human rights treaties and consensus agreements made by the Arab States and Iran
- summarise the comments by the treaty bodies to each country.

Arab Countries and Iran: Their International Commitments

The Arab States and Iran have ratified international human rights treaties by which they incurred obligations to promote and protect the survival, development and health of young people, and to eliminate discrimination against women. 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),[2] 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).[3] All Arab countries in this study are parties to the Arab League Charter on Human Rights,[4] 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.

Please see chapter three of this report, the section of CRC-based programming, for a more complete description of how basic principles of the CRC apply to YPSRH. This annex will only discuss how the right to health has been applied to young people's sexual and reproductive health.

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'[5] 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 (CESCR) produced a General Comment on the right to the highest attainable standard of health[6] that includes 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 education 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."[9] 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[7] and General Comment 4 on "Adolescent health and develop-

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.

ment..."[8] 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, from FGM/C; and from 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 school enrolment and achievement, and other instances of discrimination or violence against women and girls.[10] The multisectoral focus of the Committee is evident in their comments and in their General Comment on Adolescent Health and Development, which links social, political, and economic risk and protective factors to adolescent health.

Reservations and Declarations of the Arab States and Iran

See table A3.1 on page 177 for a full list of ratifications and reservations to the treaties and optional protocols to the treaties.

Many of the countries who have signed the international human rights treaties have made qualifying reservations or declarations to them. No country has actually signed all four instruments without making a declaration or reservation to at least one of them. Only 3–4 countries in the region have agreed to be bound by CEDAW and the CRC without qualifying declarations and reservations.[11] Most of these declarations or reservations indicate that Shari'a law[12] and national laws or customs may take precedence in certain situations, particularly regarding the provisions in these treaties that call for 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. Due to differing interpretations of Shari'a, many countries raise objections to freedom of religion clauses in international treaties, particularly the CRC. Muslim countries also show diverse interpretations of the issue of equality of women and men; several countries, such as Tunisia, have made important strides in legislation and programmes to eliminate discrimination against women and girls.

The issue of equality for women in inheritance has been a focus of country reservations to CEDAW and to the Beijing Platform of Action, and of treaty body concerns expressed to

several countries. In Shari'a, inheritance rules are based on the principle of equity given assumed social roles, rather than equality. Thus, for example, a sister inherits half of what her brother inherits on the premise that she is married or will marry and be taken care of by her spouse. Within Islam there are strong normative pressures on men to support their wives economically. However, one could argue that the assumptions about the respective roles of women and men are based on historical conditions rather than current social reality. For example, this premise is difficult in a context where, as shown in the situation analysis, increasing numbers of women in the Arab States and Iran remain unmarried.

The country reference tables in this annex will summarise all reservations and declarations for every country included in this report, including reservations made to non-binding outcome declarations in international conferences such as the International Conference on Population and Development in 1994 and the Fourth World Conference on Women in 1995 (the Beijing Conference).

Consensus Agreements

The International Conference on Population and Development in 1994 (ICPD) provided the first comprehensive analysis of how international human rights laws generate State obligations to respect, protect and fulfil the right to reproductive health and reproductive healthcare. The Programme of Action stated that reproductive rights were based on human rights that are already recognised in national and international law, such as the right to health and the right to non-discrimination regarding gender equality. The ICPD Programme of Action specified that adolescents have a right to information and services that allow them to "understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases, and subsequent risk of infertility."[13]

The Beijing Conference reaffirmed the right to the highest attainable standards of physical and mental health, including reproductive health. It further insisted on the link between reproductive health and women's right to control their own bodies and fertility. For adolescent girls, the Beijing Platform for Action also recommended education in the physiology of reproduction and sexual and reproductive health, as agreed to in the ICPD Programme of Action, including information about family planning and HIV/AIDS prevention.

The attention given by the UN system to HIV/AIDS has increased in recent years as the pandemic has expanded, so that in 2001 there was a Special Session of the General Assembly (UNGASS) focused on HIV/AIDS. The UNGASS called for urgent actions that reflect the commitment to equality of men and women, the link between human rights and development, and concern for the education and participation of adolescents. The ensuing Global Strategy Framework sets up strategies for decreasing the risk of infection to slow the epidemic, with specific strategies for youth protection.[14]

In the year 2002, the General Assembly Special Session on Children (UNGASS) renovated and expanded States' commitments to protection of children. The 10 basic commitments in the consensus outcome document, *A World Fit for Children*,[15] included combating HIV/AIDS.[16] The UNGASS on Children also insisted on the importance of eliminating all forms of discrimination against the girl child, and the promotion of gender equality and equal access to social services including sexual and reproductive healthcare.

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.

Goals set at these consensus meetings are listed below.

Benchmarks and Indicators Concerning YPSRH Set by UN Conferences

Health and Reproductive Health

- Reduce by three-quarters the ratio of **women dying in childbirth** by 2015 (Millennium Development Goals).
- Provide **universal access to the primary healthcare system and to reproductive healthcare** for all individuals of appropriate ages as soon as possible and no later than 2015 (UNGASS Children 2002; Beijing +5; ICPD El Cairo; ICPD + 5).
- Ensure that by 2015 all primary health and planning facilities can provide **family planning** and contraceptive methods, prevention and management of sexually transmitted diseases (60 per cent by 2005, 80 per cent by 2010) (ICPD + 5)
- Increase in **birth with skilled attendants** to 90 per cent of all births by 2015. (ICPD +5)

Healthcare and HIV/AIDS

- By 2015 halt and begin to reverse the **spread of HIV/AIDS** and the incidence of malaria and other major diseases (Millennium Development Goals).
- Ensure that 80 per cent of pregnant women accessing antenatal care have information counselling and other **HIV prevention services** available to them by 2010 (UNGASS Children 2002.)

Young People and HIV/AIDS

- **Access of young men and women to information, education and services to reduce vulnerability to HIV infection**
  - By 2005, "at least 90 per cent and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to information, education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection. Services should include access to preventive methods, such as male and female condoms, voluntary testing, counseling and follow up." (ICPD+5, para. 70)
- Reduction of prevalence in persons ages 15–24
  - "Governments should use as a benchmark indicator (for access of young people to information), HIV infection rates in persons 15 to 24 years of age…" (ICPD +5 and UNGASS Children July 2002)
  - "Global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 per cent and by 25 per cent globally by 2010, and to intensify efforts to achieve these targets as well as to challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys". (UNGASS on Children, para. 46a and similar targets in ICPD+5, para. 70, UNGASS on HIV/AIDS, para. 47).

Children and HIV/AIDS

- By 2003, develop and, by 2005, implement national policies and strategies to provide for **orphans and girls and boys infected and affected by HIV/ AIDS** (UNGASS Children 2002).

Gender Equity

> Eliminate **gender disparity in primary and secondary education** preferably by 2005, and at all levels by 2015 (Millennium Development Goals 3 and Beijing +5).

> **Remove gender discriminatory provisions in the law** as soon as possible, preferably by 2005, and eliminate **legislative gaps** that leave women and girls without protection for their rights. (Beijing +5.)

Right to Education

> Ensure that all boys and girls complete a full course of **primary schooling** (Millennium Development Goal 2).

The following table lists the ratifications and reservations of each country to four major human rights conventions. The next section describes the reports and issues relevant to YPSRH raised by each country to the main human rights treaty bodies, and the comments of the treaty bodies to each country.

TABLE A3.1

Ratifications and reservations by Arab Countries and Iran for the major UN Human Rights Treaties

	ICCPR International Covenant on Civil and Political Rights				ICESCR International Covenant on Economic Social and Cultural Rights			
	Convention		CCPR – OP1 (optional protocol)		Convention			
	Date Signed/ Ratified	Reservation (R) or Declaration (D)	Date Signed/ Ratified	Reservation (R) or Declaration (D)	Date Signed/ Ratified	Reservation(R) or Declaration (D)		
Algeria	12 September 89	D	12 September 89	No	12 September 89	D		
Bahrain	No	No	No	No	No	No		
Djibouti	5 November 02	No	5 November 02	No	5 November 02	No		
Egypt	14 January 82	D	No	No	14 January 82	D		
Iran	24 June 75	No	No	No	24 June 75	No		
Iraq	25 January 71	D	No	No	25 January 71	D		
Jordan	28 May 75	No	No	No	28 May 75	No		
Kuwait	21 May 96	R and D	No	No	21 May 96	D		
Lebanon	3 November 72	No	No	No	3 November 72	No		
Libya	15 May 70	D	16 May 89	No	15 May 70	D		
Morocco	3 May 79	No	No	No	3 May 79	No		
Occupied Palestinian Territory	NA	NA	NA	NA	NA	NA		
Oman	No	No	No	No	No	No		
Qatar	No	No	No	No	No	No		
Saudi Arabia	No	No	No	No	No	No		
Sudan	18 March 76	No	No	No	18 March 86	No		
Syria	21 April 69	D	No	No	21 April 69	D		
Tunisia	18March 69	D	No	No	18 March 69	No		
United Arab Emirates	No	No	No	No	No	No		
Yemen	9 February 87	D	No	No	9 February 87	D		

Several of the optional protocols to human rights treaties allow the treaty bodies to hear individual complaints.

Only three countries (Algeria, Djibouti and Libya) have signed the Optional Protocol to the ICCPR, which allows the Committee to hear individual complaints.

(Table A3.1 continued)

Ratifications and reservations by Arab Countries and Iran for the major UN Human Rights Treaties

	CEDAW Convention on the Elimination of All Forms of Discrimination against Women				**CRC** Convention on the Rights of the Child			
	Convention		**CEDAW – OP (optional protocol)**		**Convention**		**CRC – OPSC (protocol sale of children)**	
(D)	**Date Signed/ Ratified**	**Reservation (R) or Declaration (D)**	**Date Signed/ Ratified**	**Reservation (R) or Declaration (D)**	**Date Signed/ Ratified**	**Reservation(R) or Declaration (D)**	**Date Signed/ Ratified**	**Reservation(R) or Declaration**
Algeria	22 May 96	R	No	No	16 April 93	D	16 April 93	No
Bahrain	18 June 02	R	No	No	13 February 92	No	21 Sep 2004	No
Djibouti	2 December 98	No	No	No	6 December 90	D	No	No
Egypt	18 September 81	R	No	No	6 July 90	R	12 July 02	No
Iran	No	No	No	No	13 July 94	R	No	No
Iraq	13 August 86	R	No	No	15 June 94	R	No	No
Jordan	1 July 92	D	No	No	24 May 91	R and D	6 September 00	No
Kuwait	2 September 94	R	No	No	21 October 91	R	26 August 2004	R
Lebanon	21 April 97	R	No	No	14 May 91	No	8 November 2004	No
Libya	16 May 89	R	18 June 04	No	16 April 93	No	18 June 2004	No
Morocco	22 June 93	R and D	No	No	21 June 93	R	2 October 01	No
Occupied Palestinian Terr.	NA	NA	NA	NA	NA	NA	NA	NA
Oman	No	No	No	No	9 December 96	R	17 Sep 2004	2004
Qatar	No	No	No	No	4 April 95	R	14 December 01	R
Saudi Arabia	8 September 00	R	No	No	26 January 96	R	No	No
Sudan	No	No	No	No	3 August 90	No	2 November 2004	No
Syria	28 March 03	R	No	No	15 July 93	R	15 May 2003	R
Tunisia	20 September 85	R and D	No	No	31 January 92	R and D	13 Sep 02	No
United Arab Emirates	6 October 2004	No	No	No	3 January 97	R	No	No
Yemen	30 May 84	No	No	No	1 May 91	No	No	No

Only Libya has signed the Optional Protocol to the CEDAW, which allows the Committee to hear individual complaints.

Thirteen countries have signed the Second Optional Protocol to the CRC, which addresses rights violations related to the sale, trafficking and prostitution of children.

Algeria

Algeria is party to the main human rights conventions and to the ICPPR first optional protocol. It signed and ratified both the ICCPR and the ICESCR in 1989, and made interpretive declarations to both. The more substantive declaration is the one made to article 23, paragraph 4, of the ICCPR (equal rights and responsibilities of spouses in marriage and in its dissolution). Algeria declared that this provision can not be interpreted as "impairing the essential foundations of the Algerian legal system." Germany sent a communication in the sense that it understands Algeria's declaration is not a restriction on its obligation to ensure equality of spouses. In its recommendations to Algeria in 1998, the ICCPR Committee said it welcomed government manifestations that this declaration would soon become obsolete.[17]

Algeria is also party to the CEDAW (in 1996) and to the CRC (in 1993.) It made several reservations to the CEDAW, most of them on provisions of equality of men and women in marriage, where Algeria said these provisions could not conflict with the Algerian Family Code.[18] Algeria made reservations to the CRC insisting a child will be educated in the religion of his or her father (declaration to article 14) and that the child's right to privacy, freedom of expression and access to information is interpreted taking into account Algerian Penal Code and Information Code. In its comments to Algeria's 1997 country report the Committee on the Rights of the Child stated that Algeria's concerns were reflected in the convention and that retaining these declarations could lead to 'misunderstandings' about State commitment to implement these rights.[19]

In their comments on Algeria's human rights reports, the UN Treaty Bodies expressed concern over similar areas affecting young people's access to reproductive health and the exercise of their reproductive rights.[20] These areas are: prejudicial traditional practices, especially discrimination against women, and a series of legal provisions that sustain discrimination, particularly in the Algerian Family Code. Some examples are: discrimination against children born out of wedlock, no penalty for a rapist who marries his victim even if she is a minor, unequal rights and obligations of men and women in marriage and divorce. They recommended that Algeria change its laws, and particularly the Algerian Family Code, to conform to the international human rights conventions. They urged the State to withdraw its declarations and reservations to the conventions, and to gather additional data on the situation of vulnerable groups in Algeria. The Committee for ESCR additionally urged Algeria to conform its laws, practices and regulations to International HIV/AIDS guidelines.[21] However none of the Committees mention adolescent sexual or reproductive health except the Committee for the Rights of the Child, which does so with some regularity, but only after 2000, and even then not in all cases.

A shadow report to the CEDAW Committee stresses State responsibility for the horrors

committed by fundamentalist groups against young women, particularly their kidnapping, rape and murder; it makes no specific reference to reproductive health.[22] The CEDAW recommendation acknowledged this violence and urged the State to take appropriate measures.[23] Another shadow report to the Human Rights Committee expressed similar concerns.[24]

Algeria has made no reservations to either the Beijing or ICPD Declarations and Action Plans.

Contents of Reservations Made by Algeria to Human Rights Treaties and World Summit Declarations

ICCPR

Party 12 September 98

Declaration.
See declaration to ICESCR.

Declaration
The Government of the Democratic People's Republic of Algeria recognizes the competence of the Human Rights Committee referred to in article 28 of the Covenant to receive and consider communications to the effect that a State Party claims that another State Party is not fulfilling its obligations under the Covenant.

Protocol 1 ICCPR

Party 12 September 98
No reservation or declaration

ICESCR

Party 12 September 98

Interpretative declarations:

1. The Algerian Government interprets article 1, which is common to the two Covenants, as in no case impairing the inalienable right of all peoples to self-determination and to control over their natural wealth and resources.

   It further considers that the maintenance of the State of dependence of certain territories referred to in article 1, paragraph 3, of the two Covenants and in article 14 of the Covenant on Economic, Social and Cultural Rights is contrary to the purposes and principles of the United Nations, to the Charter of the Organization and to the Declaration on the Granting of Independence to Colonial Countries and Peoples [General Assembly resolution 1514 (XV)].

continued

2. The Algerian Government interprets the provisions of article 8 of the Covenant on Economic, Social and Cultural Rights and article 22 of the International Covenant on Civil and Political Rights as making the law the framework for action by the State with respect to the organization and exercise of the right to organize.

3. The Algerian Government considers that the provisions of article 13, paragraphs 3 and 4, of the Covenant on Economic, Social and Cultural Rights can in no case impair its right freely to organize its educational system.

4. The Algerian Government interprets the provisions of article 23, paragraph 4, of the International Covenant on Civil and Political Rights regarding the rights and responsibilities of spouses as to marriage, during marriage and at its dissolution as in no way impairing the essential foundations of the Algerian legal system.

CEDAW

Party 22 May 96

Reservations:

Article 2:

The Government of the People's Democratic Republic of Algeria declares that it is prepared to apply the provisions of this article on condition that they do not conflict with the provisions of the Algerian Family Code.

Article 9, paragraph 2:

The Government of the People's Democratic Republic of Algeria wishes to express its reservations concerning the provisions of article 9, paragraph 2, which are incompatible with the provisions of the Algerian Nationality code and the Algerian Family Code.

The Algerian Nationality code allows a child to take the nationality of the mother only when:

- the father is either unknown or stateless;
- the child is born in Algeria to an Algerian mother and a foreign father who was born in Algeria;
- moreover, a child born in Algeria to an Algerian mother and a foreign father who was not born on Algerian territory may, under article 26 of the Algerian Nationality Code, acquire the nationality of the mother providing the Ministry of Justice does not object.

Article 41 of the Algerian Family Code states that a child is affiliated to its father through legal marriage.

Article 43 of that Code states that `the child is affiliated to its father if it is born in the 10 months following the date of separation or death'.

continued

Article 15, paragraph 4:
The Government of the People's Democratic Republic of Algeria declares that the provisions of article 15, paragraph 4, concerning the right of women to choose their residence and domicile should not be interpreted in such a manner as to contradict the provisions of chapter 4 (art. 37) of the Algerian Family Code.

Article 16:
The Government of the People's Democratic Republic of Algeria declares that the provisions of article 16 concerning equal rights for men and women in all matters relating to marriage, both during marriage and at its dissolution, should not contradict the provisions of the Algerian Family Code.

Article 29:
The Government of the People's Democratic Republic of Algeria does not consider itself bound by article 29, paragraph 1, which states that any dispute between two or more Parties concerning the interpretation or application of the Convention which is not settled by negotiation shall, at the request of one of them, be submitted to arbitration or to the International Court of Justice.
The Government of the People's Democratic Republic of Algeria holds that no such dispute can be submitted to arbitration or to the Court of International Justice except with the consent of all the parties to the dispute.

Protocol CEDAW

Not a party

CRC

Party 16 April 93

Interpretative declarations:
Article 14, paragraphs 1 and 2:
The provisions of paragraphs 1 and 2 of article 14 shall be interpreted by the Algerian Government in compliance with the basic foundations of the Algerian legal system, in particular:

- With the Constitution, which stipulates in its article 2 that Islam is the State religion and in its article 35 that "there shall be no infringement of the inviolability of the freedom of conviction and the inviolability of the freedom of opinion";
- With Law No. 84-11 of 9 June 1984, comprising the Family Code, which stipulates that a child's education is to take place in accordance with the religion of its father.

Articles 13, 16 and 17:
Articles 13, 16 and 17 shall be applied while taking account of the interest of the child and the need to safeguard its physical and mental integrity. In this framework, the Algerian Government shall interpret the provisions of these articles while taking account of:

- The provisions of the Penal Code, in particular those sections relating to breaches of public order, to public decency and to the incitement of minors to immorality and debauchery;
- The provisions of Law No. 90-07 of 3 April 1990, comprising the Information Code, and particularly its article 24 stipulating that "the director of a publication destined

continued

for children must be assisted by an educational advisory body";

> Article 26 of the same Code, which provides that "national and foreign periodicals and specialized publications, whatever their nature or purpose, must not contain any illustration, narrative, information or insertion contrary to Islamic morality, national values or human rights or advocate racism, fanaticism and treason. Further, such publications must contain no publicity or advertising that may promote violence and delinquency."

Protocol CRC

Not a party

Beijing Declaration and Platform for Action

None

ICPD Declaration and Programme of Action

None

Bahrain

Bahrain is party to the CEDAW (18 June 2002), and the CRC (13 February 1992), but not to the ICCPPR or the ICESCR. Bahrain made reservations to several articles of CEDAW: Article 2, 4, 9 (par.2), 15, and 29, paragraph 1. It claimed article 2 conflicted with the Shar'ia and gave no reason for the other reservations. Article 2 concerns the various applications of the principle of equality between men and women; article 4 allows for affirmative action; and article 9, paragraph 2, to equal rights of men and women with respect to the nationality of their children. Article 15 relates to equality of men and women before the law; and article 29, paragraph 1, arbitration between States.

Bahrain made no reservations to the CRC. It presented a report to the Committee on the Rights of the Child in 2002,[25] and all the information in this section comes from that report.

The CRC Committee begins its review of Bahrain's report with a formula it started using in 2000 for several Muslim countries: "the Committee expresses concern over the country's 'narrow interpretation of Islamic texts'. The Committee takes note of two issues that affect young people's sexual and reproductive health and rights. The first is that personal and criminal law is applied by a Shari'a Court system of religious judges without clearly defined laws or safeguards of human rights. The second is the persistence of discrimination against women. The Committee recommends that Bahrain review its legislation to make sure it is in accord to human rights standards.

Although Bahrain has excellent health indicators and is high ranking in the UNDP 2001 Human Development Index, the Committee is also concerned with the lack of information on adolescent health. It recommends that the State formulate adolescent health policies and programmes with full participation of adolescents and ensure adolescents have access to child-sensitive and confidential counselling.

Bahrain has made no reservations to either the Beijing or ICPD Declarations and Action Plans.

Content of Reservations Made by Bahrain to Human Rights Treaties and World Summit Declarations

ICCPR
Not a party

Protocol 1 ICCPR
Not a party

ICESCR
Not a Party

CEDAW
Party 18 June 02

Reservation:

… The Kingdom of Bahrain makes reservations with respect to the following provisions of the Convention:

- Article 2, in order to ensure its implementation within the bounds of the provisions of the Islamic Shari'a;
- Article 9, paragraph 2;
- Article 15, paragraph 4;
- Article 16, in so far as it is incompatible with the provisions of the Islamic Shari'a;
- Article 29, paragraph 1

Protocol CEDAW
Not a party
No reservation or declaration

CRC
Party 13 February. 92
No reservation or declaration

continued

Protocol CRC
Not a party

Beijing Declaration and Platform for Action
None

ICPD Declaration and Programme of Action
None

Djibouti

Djibouti is party to the ICCPR, the ICCPR optional Protocol 1, and the ICESCR. All were signed and ratified in 2002 without any reservations. Djibouti is also party to the CEDAW since 1998 without reservations and to the CRC since 1990 with the following declaration: "(Djibouti) shall not consider itself bound by any provision or articles that are incompatible with its religion and its traditional values." This declaration was objected to by Sweden and Denmark.

In the year 2000, Djibouti presented a report to the Committee for the Rights of the Child.[26] This section is based on that report. The Committee presents several areas of concern for young people's sexual and reproductive health and rights. It begins with the general declaration that it started using in 2000 for several Muslim countries: the Committee expresses concern over the country's "narrow interpretation of Islamic texts." It then describes various areas of concern, including: early marriage (minimum legal age for girls' marriage is 15); persistent discrimination faced by girls and by children born out of wedlock; polygamy; female genital mutilation that persists even if it is prohibited in the new Penal Code; high rates of HIV infection, infant mortality, maternal mortality and malnutrition; high incidence of child prostitution and of children involved in the production and consumption of psychotropic drugs.

The Committee then recommends to Djibouti to review laws and amend legislation to harmonise the law with the CRC, to address discrimination, and to further engage communities to eliminate FGM/C. It also urges the State to address the sexual and reproductive healthcare needs of older children, particularly those who enter into early marriages or who belong to other vulnerable populations.
Djibouti has made no reservations to either the Beijing or ICPD Declarations and Action Plans.

Content of Reservations Made by Djibouti to Human Rights Treaties and World Summit Declarations

ICCPR
Party 5 November 02
No reservation or declaration

Protocol 1 ICCPR
Party 5 November 02
No reservation or declaration

ICESCR
Party 5 November 02
No reservation or declaration

CEDAW
Party 2 December 98
No reservation or declaration

Protocol CEDAW
Not a party

CRC
Party 6 December 90

Declaration:
[The Government of Djibouti] shall not consider itself bound by any provisions or articles that are incompatible with its religion and its traditional values.

Note 13. The Secretary-General received from the Government of Sweden the following communications: on 20 July 1993, with regard to the reservations made upon accession by Thailand concerning articles 7, 22 and 29, upon ratification by Myanmar concerning articles 15 and 37 (see also note 26), upon ratification by Bangladesh concerning article 21, upon ratification by Djibouti concerning the whole Convention, and on 29 March 1994, with regard to the reservation made upon signature by Qatar.

Subsequently, on 11 April 1997, the Government of Thailand notified the Secretary-General that it had decided to withdraw its reservation with regard to article 29.

Note 14. In this regard, on 16 November 1995, the Secretary-General received from the Government of Denmark, the following communication:

"Because of their unlimited scope and undefined character these reservations are incompatible with the object and purpose of the Convention and accordingly inadmissible and without effect under international law. Therefore, the Government of Denmark objects to these reservations. The Convention remains in force in its entirety between Djibouti, the Islamic Republic of Iran, Pakistan, the Syrian Arab Republic respectively and Denmark.

continued

It is the opinion of the Government of Denmark that no time limit applies to objections against reservations, which are inadmissible under international law.

The Government of Denmark recommends the Governments of Djibouti, the Islamic Republic of Iran, Pakistan and the Syrian Arab Republic to reconsider their reservations to the Convention on the Rights of the Child."

See also note 20.

On 3 July 1996, the Secretary-General received from the Government of Denmark a communication regarding the reservations made by Botswana and Qatar, identical in essence, mutatis mutandis, as the one made on 16 November 1995.
Note 20. On 6 February 1995, the Secretary-General received from the Government of the Netherlands the following communication with regard to the reservations made upon ratification by Djibouti, Indonesia, Pakistan and the Syrian Arab Republic:

> [Same text, mutatis mutandis, as the objection made with regard to Iran (Islamic Republic of) under "Objections".]

See also note 14.

Protocol CRC
Not a party

Beijing Declaration and Platform for Action
None

ICPD Declaration and Programme of Action
None

Egypt

Egypt has been party to the ICCPR and the ICESCR since 1982; it made for both a declaration saying that "taking into account the provisions of the Islamic Shari'a and the fact that they do not conflict with the text…we accept, support and ratify it." The Human Rights Committee has called this declaration "ambiguous and general in nature" and insisted that the State should either "clarify its scope or withdraw it."

Egypt has also been party to the CEDAW since 1981. It made reservations to article 9, paragraph 2, because in Egypt, until 2004, the nationality of a child is acquired solely through the father; and to article 16, on equality between men and women in marriage and its dissolution. It gives no reason to do so but it says that this reservation is made "without prejudice to the Shari'a tradition where women and men have 'equivalent' and

'complementary' rights in divorce." It also said it would comply with article 2 (equality of men and women before the law) only insofar as it did not counter Shari'a. Egypt also reserved article 29 concerning the jurisdiction of the International Court of Justice.

At the World Conference on Women in Beijing, Egypt also made a pronouncement about the Beijing Platform for Action similar to its reservations to the CEDAW. It said it understood sexual and reproductive relations to be only those within the framework of the marital bond, and that the mention of inheritance rights in the Platform for Action is not in accordance with Shari'a law and Egyptian law and Constitution.

Egypt made no reservation to the ICPD Declaration and Programme of Action.

Egypt also made a reservation to the Convention on the Rights of the Child, to which it is a party since 1990. It reserved the article on adoption. The committee has pointed out that this reservation as unnecessary, since the convention recognises the alternative of 'kafalah'[27] in Islam. Egypt is also party to the Second CRC Protocol on the Sale, Trafficking and Prostitution of children and has made no reservations or declaration.

In the last decade, Egypt has made two reports to the UN Committees: to the Committee on the Rights of the Child in 2001 and to the Human Rights Committee in 2002.[28] Both committees displayed concern for issues that affect young people's sexual and reproductive health, such as early marriage (16 years for girls); discrimination against women; discrimination against children born out of wedlock; nationality transmitted only through the father; and FGM/C, which was prohibited in 1996 but is still practised. The Committee on the Rights of the Child also mentioned Egypt's "narrow interpretation of Islam" and suggested the State mobilise religious leaders to eliminate discrimination against women. It also said there was insufficient information on adolescent health, giving as an example the inadequacy of data on reproductive health services and HIV prevention.

Both Committees recommended that the State review and adapt its legislation to human rights instruments, and eliminate both discrimination against women and the practice for female genital mutilation. The Committee on the Rights of the Child also recommended that the State undertake "a comprehensive study to understand the nature and extent of adolescent health problems" in order to formulate an adequate policy, with adolescent participation. It recommended that adolescents have access to, and be provided with, reproductive health education.

A shadow report published by a coalition of Egyptian NGOs for children mentions some issues of interest for the advancement of adolescent sexual and reproductive health and rights.[29] It mentions the existence of discrimination against the girl child,

without giving specific examples. It mentions discrimination against women in the transmission of Egyptian nationality to their children; only men transmit the nationality, unless the child's father is unknown, resulting in many stateless children. Recently, this situation was remedied.[30] The NGO report also states that female genital circumcision is still widely spread and that a 1995 survey showed the majority of mothers intended to circumcise their girls. It mentions however that the practice of forced marriage of girls to strangers has declined. The NGO report cites a survey on development and social change in Egypt where most adolescents reported a lack of information about physical maturity (73 per cent of boys and 89 per cent of girls.) Most reported they learn about sexuality by themselves or through observation.

Contents of Reservations Made by Egypt to Human Rights Treaties and World Summit Declarations

ICCPR
Party 14 June 82

Declaration
Same as for the ICESCR.

Protocol 1 ICCPR
Not a party

ICESCR
Party 14 June 82

Declaration:
...Taking into consideration the provisions of the Islamic Shari'a and the fact that they do not conflict with the text annexed to the instrument, we accept, support and ratify it....

CEDAW
Party 18 September 81

Reservations made upon signature and confirmed upon ratification:
In respect of article 9:
Reservation to the text of article 9, paragraph 2, concerning the granting to women of equal rights with men with respect to the nationality of their children, without prejudice to the acquisition by a child born of a marriage of the nationality of his father. This is in order to prevent a child's acquisition of two nationalities where his parents are of different nationalities, since this may be prejudicial to his future. It is clear that the child's acquisition of his father's nationality is the procedure most suitable for the child and that this does not infringe upon the principle of equality between men and women, since it is customary for a woman to agree, upon marrying an alien, that her children shall be of the father's nationality.

continued

In respect of article 16:
Reservation to the text of article 16 concerning the equality of men and women in all matters relating to marriage and family relations during the marriage and upon its dissolution, without prejudice to the Islamic Sharia's provisions whereby women are accorded rights equivalent to those of their spouses so as to ensure a just balance between them. This is out of respect for the sacrosanct nature of the firm religious beliefs which govern marital relations in Egypt and which may not be called in question and in view of the fact that one of the most important bases of these relations is an equivalency of rights and duties so as to ensure complementary which guarantees true equality between the spouses. The provisions of the Shari'a mandate that the husband shall pay bridal money to the wife and maintain her fully and shall also make a payment to her upon divorce, whereas the wife retains full rights over her property and is not obliged to spend anything on her keep. The Shari'a therefore restricts the wife's rights to divorce by making it contingent on a judge's ruling, whereas no such restriction is laid down in the case of the husband.

In respect of article 29:
The Egyptian delegation also maintains the reservation contained in article 29, paragraph 2, concerning the right of a State signatory to the Convention to declare that it does not consider itself bound by paragraph 1 of that article concerning the submission to an arbitral body of any dispute which may arise between States concerning the interpretation or application of the Convention. This is in order to avoid being bound by the system of arbitration in this field.

Reservation made upon ratification:
General reservation on article 2
The Arab Republic of Egypt is willing to comply with the content of this article, provided that such compliance does not run counter to the Islamic Shari'a.

Protocol CEDAW
Not a party

CRC
Party 6 July 90

Reservation made upon signature and confirmed upon ratification:

Since The Islamic Shari'a is one of the fundamental sources of legislation in Egyptian positive law and because the Shari'a, in enjoining the provision of every means of protection and care for children by numerous ways and means, does not include among those ways and means the system of adoption existing in certain other bodies of positive law,

The Government of the Arab Republic of Egypt expresses its reservation with respect to all the clauses and provisions relating to adoption in the said Convention, and in particular with respect to the provisions governing adoption in articles 20 and 21 of the Convention.

Protocol CRC
Party 12 July 02
No reservation or declaration

continued

Beijing Declaration and Platform for Action

The representative of Egypt submitted the following written statement:

The participation of Egypt in the Fourth World Conference on Women reflects its conviction of the importance of women's issues and their promotion. It is an extension of Egypt's participation in the three preceding conferences on women, in addition to its having been host to one of the most important international conferences, the International Conference on Population and Development.

The Egyptian delegation would like to register the fact that its understanding of the texts included in the Platform for Action of the Fourth World Conference on Women that refer to sexual and reproductive relations rests on the basis that these relations are within the framework of a marital bond and that the family is understood to be the basic unit of society. Egypt's compliance with the recommendations contained in the Platform for Action will be conditional on complete respect for the rights of national sovereignty and various moral and religious values and conformity to our Constitution and the precepts of law and with the divine guidance of our true and tolerant religious law.

The Egyptian delegation would also like to register the fact that its reading and understanding of the paragraphs relating to inheritance rights in the Platform for Action, particularly paragraph 274 (d), will be against the background of complete respect for the laws of inheritance in the Islamic Shari'a and in accordance with the provisions of the law and the Constitution.

The Egyptian delegation requests that this statement in its entirety should be included in the official report of the Fourth World Conference on Women.

ICPD Declaration and Programme of Action

None

The Islamic Republic of Iran

Iran has ratified without declaration or reservation the ICCPR and the ICESCR, both in 1975. It has not ratified or signed the CEDAW. It ratified the CRC in 1994, and made a reservation where it said "(Iran) reserves the right not to apply any provisions or articles of the Convention that are incompatible with Islamic Laws." Denmark, Austria and Italy objected to this reservation. In its recommendations to the country report in 2000, the CRC Committee said these reservations were "broad and imprecise" and they "potentially negate" many of the convention's provisions.

Iran presented reports to the ICCPR and to the ICESCR in 1993, after 10 years of silence in the wake of the revolution that ousted the Pahlavi dynasty. In their recommendations to these two reports,[31] the Committees manifested concern over Iran's discrimination against women, both in law and in practice; for example, by public punishment and harassment of women for violating the dress code, their need to obtain permission from their husband to leave home, exclusion from the magistracy,

prohibition to practise sports in public and segregation in public transportation.[32] It is unclear whether these practices and laws persist today as there are no more reports that have come to the authors' attention.

Iran next presented a report in 2000 to the CRC Committee.[33] The Committee manifested concern over several areas that impact young people's sexual and reproductive heath and rights, including a general concern over the "narrow interpretation of Islamic texts." The concerns of the Committee included: the persistence of discrimination against women under the law and stereotypical attitudes about gender roles manifested in early and forced marriages (marriage without consent of the child if the father has given his consent); discrimination against women in marriage in the Civil Code in relation to custody, guardianship and nationality of children; disparity in the enjoyment of rights particularly in the provinces inhabited by ethnic minorities; and the lack of information about adolescent health, including reproductive health services and HIV/AIDS prevention.

The Committee on the Rights of the Child recommended that Iran take measures to prevent and eliminate discrimination in all fields, and that religious leaders should be mobilised to support this. It suggested that the country review legislation to reflect the best interests of the child and that it take all measures to halt early and forced marriages. It also recommended that adolescents have access to, and be provided with, reproductive health education and child-friendly counselling and rehabilitation services.

Iran has made no reservations to either the Beijing or ICPD Declarations and Action Plans.

Contents of Reservations Made by Iran to Human Rights Treaties and World Summit Declarations.

ICCPR
Party 24 June 75
No reservation or declaration

Protocol 1 ICCPR
Not a party

ICESCR
Party 24 June 75
No reservation or declaration

CEDAW
Not a party

continued

Protocol CEDAW
Not a party

CRC
Party 13 July 94

Reservation upon signature:
"The Islamic Republic of Iran is making reservation to the articles and provisions which may be contrary to the Islamic Shari'a, and preserves the right to make such particular declaration, upon its ratification."

Reservation upon ratification:
"The Government of the Islamic Republic of Iran reserves the right not to apply any provisions or articles of the Convention that are incompatible with Islamic Laws and the international legislation in effect."

Protocol CRC
Not a party

Beijing Declaration and Platform for Action
None

ICPD Declaration and Programme of Action
None

Iraq

Iraq is party to the ICCPR and the ICESCR since 1971. Iraq is also a party to the CEDAW since 1986. Iraq also made reservations to several articles in the CEDAW, without giving any reasons; the articles reserved all issues that, according to the reservations of many Muslim States, contradict Shari'a: particularly the mother's transmission of nationality to her children and equal relations of men and women within marriage.[34] To these reservations Iraq added that they were made "without prejudice to the provisions of the Islamic Shari'a according women rights equivalent to the rights of their spouses." The CEDAW Committee has asked Iraq to modify or withdraw its reservations as soon as possible.[35] Iraq is also party to the CRC (1994) and made a reservation of article 14, paragraph 1, stating that allowing a child to change his or her religion is against Shari'a.

At the Fourth World Conference on Women, Iraq also made a reservation to the Platform for Action, claiming that the paragraph 96 (right of women to control their own

sexuality and reproduction including family planning) was incompatible with its social and religious values and that paragraph 274d (no discrimination of girls in inheritance) was accepted only on the understanding there was no conflict with Shari'a.

Iraq made no reservation to the ICPD Declaration and Programme of Action.

All of the UN human rights committees in the recommendations to Iraq shared areas of concern that are directly related to sexual and reproductive health and rights of adolescents.[36] One key area was different aspects of discrimination against women. The CEDAW Committee focused on harmful traditional and cultural practices such as polygamy, honour killings and violence against women, as well as discrimination in legislative provisions (no specification). The CESCR also manifested concern about discrimination against women in law and practice, especially in inheritance rights, freedom of movement, family law, equal remuneration for equal work and access to employment, and pointed out the rapid increase in illiteracy among Iraqis, especially women. The CRC stated concerns about the deteriorating health of children, and the lack of data on adolescent health. All the Committees recommended that Iraq review its domestic legislation to eliminate remaining discriminatory legal provisions and adopt policies to achieve equality between men and women. The CRC Committee furthermore recommended a study of adolescent health problems, as well as efforts to develop and provide appropriate healthcare for adolescents, including strengthening of reproductive health education and counselling services.

Contents of Reservations Made by Iraq to Human Rights Treaties and World Summit Declarations

ICCPR
25 June 71

Declaration
See declaration for ICESCR

Protocol 1 ICCPR
Not a party

ICESCR
Party 25 June 71

Declaration
Upon signature and confirmed upon ratification:
"The entry of the Republic of Iraq as a party to the International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights shall in no way signify recognition of Israel nor shall it entail any obligation towards Israel under the said two Covenants."

continued

"The entry of the Republic of Iraq as a party to the above two Covenants shall not constitute entry by it as a party to the Optional Protocol to the International Covenant on Civil and Political Rights."

Upon ratification:

"Ratification by Iraq ... shall in no way signify recognition of Israel nor shall it be conducive to entry with her into such dealings as are regulated by the said [Covenant]."

CEDAW

Party 13 August 86

Reservations:

1. Approval of and accession to this Convention shall not mean that the Republic of Iraq is bound by the provisions of article 2, paragraphs (f) and (g), of article 9, paragraphs 1 and 2, nor of article 16 of the Convention. The reservation to this last-mentioned article shall be without prejudice to the provisions of the Islamic Shari'a according women rights equivalent to the rights of their spouses so as to ensure a just balance between them. Iraq also enters a reservation to article 29, paragraph 1, of this Convention with regard to the principle of international arbitration in connection with the interpretation or application of this Convention.
2. This approval in no way implies recognition of or entry into any relations with Israel.

Protocol CEDAW

Not a party

CRC

Party 15 June 94

Reservation:

The Government of Iraq has seen fit to accept [the Convention] ... subject to a reservation in respect to article 14, paragraph 1, concerning the child's freedom of religion, as allowing a child to change his or her religion runs counter to the provisions of the Islamic Shari'a.

Protocol CRC

Not a party

Beijing Declaration and Platform for Action

The representative of Iraq submitted the following written statement:

The delegation of Iraq has reservations with regard to paragraph 96 of the Platform for Action because it is incompatible with our social and religious values. Our reservation also applies to paragraph 232 (f) because of its allusion to paragraph 96.

The delegation of Iraq accepts the text of paragraph 274 (d) on the basis of its understanding that this does not conflict with the Islamic Shari'a.

ICPD Declaration and Programme of Action

None

Jordan

Jordan is party to the ICCPR and the ICESCR since 1975; it made no reservations or declaration on accession. It is also party to the CEDAW (1992), the CRC (1991) and the Second CRC Protocol (2000) and made declarations to the CEDAW and a reservation to the CRC. Its declarations to the CEDAW are more like a reservation than a declaration, because they say Jordan is not bound by some articles in the Convention.[37] Jordan gives no explanation; the articles reserved are about transmission of the mother's nationality to her child, freedom of residence and domicile for women, and equal rights of men and women in marriage. Jordan's reservation to the CRC is to the articles that establish freedom of religion and the possibility of adoption, stating that these are contrary to Shari'a law. The CRC Committee said the reservation on adoption was superfluous in view of the existence of the kafalah system in Islam and raised questions on State commitment to the Convention.[38]

Jordan also expressed a reservation on the ICPD Programme of Action, whereby chapters IV, V, VI and VII – on gender equality, the family, population growth and reproductive health and rights – "will be applied within the framework of Shari'a and our own ethical values, as well as laws that shape our behaviour." It also said it understood the reference to individuals and couples to mean only married couples.

Jordan made no reservation to the Beijing Declaration and Platform for Action.

In the last decade, Jordan has presented reports to the Committees for the ICCPR, ICESCR, CEDAW and the CRC. The Committees have expressed concerns and made recommendations relevant to young people's reproductive health and rights.[39] Most of these concerns address different aspects of discrimination against women, both in law and in practice, such as status within the family, inheritance rights, right to leave the country, ability to travel alone or choose place of residency without permission; acquisition of nationality; access to participation in public life; honour crimes that go unpunished; marital rape not being considered a crime; polygamy being legal; women's inability to make contracts in their own names, and early and forced marriages. All the Committees recommend that Jordan take measures to prevent and eliminate discrimination against women both in law and in practice, overcoming the "weight of custom and tradition." For the CEDAW Committee, recommended measures include amendments of the Personal Status Code (eliminate polygamy and recognise equality of men and women in marriage and family) and the Penal Code (punish honour killings and marital rape, and allow abortion for victims of rape or incest.)

Additionally the CRC states that Jordan's narrow interpretation of Islamic texts is a threat to human rights and also that there is insufficient information and attention to adolescent

issues including reproductive health concerns. It recommends a study of adolescent health problems, as well as access to reproductive health services including HIV/AIDS prevention programmes.

Contents of Reservations Made by Jordan to Human Rights Treaties and World Summit Declarations

ICCPR
Party 28 May 75
No reservation or declaration

Protocol 1 ICCPR
Not a party

ICESCR
Party 28 May 75
No reservation or declaration

CEDAW
Party 1 July 92

Declaration made upon signature and confirmed upon ratification:
Jordan does not consider itself bound by the following provisions:

1. Article 9, paragraph 2;
2. Article 15, paragraph 4 (a wife's residence is with her husband);
3. Article 16, paragraph (1) (c), relating to the rights arising upon the dissolution of marriage with regard to maintenance and compensation;
4. Article 16, paragraph (1) (d) and (g).

Protocol CEDAW
Not a party

CRC
Party 24 May 91

Reservation:

The Hashemite Kingdom of Jordan expresses its reservation and does not consider itself bound by articles 14, 20 and 21 of the Convention, which grant the child the right to freedom of choice of religion and concern the question of adoption, since they are at variance with the precepts of the tolerant Islamic Shari'a.

continued

Protocol CRC

Party 6 September 00
No reservation or declaration

Beijing Declaration and Platform for Action

None

ICPD Declaration and Programme of Action

The representative of Jordan stated the following:

> *"The delegation of Jordan, in its deliberations and discussions with all delegations and in a very serious and responsible manner, always wanted to join the consensus on the Programme of Action. While deeply appreciating the great efforts deployed by the Main Committee and the working groups, which have worked for long hours with the aim of achieving consensus on the language, and in full respect of the values of all countries, the delegation of Jordan has reached some compromises regarding the language on all issues.*
> *"We fully believe that the international community respects our national legislation, our religious beliefs and the sovereign right of each country to apply population policies in accordance with its legislation. The delegation of Jordan understands that the final document, particularly chapters IV, V, VI and VII, will be applied within the framework of Islamic Shari'a and our ethical values, as well as the laws that shape our behaviour. We will deal with the paragraphs of this document accordingly. Therefore, we interpret the word 'individuals' to mean couples, a married couple. I hope that you will put these comments on record."*

Kuwait

Kuwait is party to all four treaties – ICCPR (1996); ICESCR (1996); CEDAW (1994) and CRC (1991) – and has made reservations or declarations to all of them, consistently claiming exceptions based on Kuwaiti law. Concerning the ICCPR, it declared that article 2, paragraph 1 (non-discrimination), and article 3 (equal rights of man and women) must be exercised "within limits set by Kuwaiti law." It also made a declaration concerning article 23 (equal rights in marriage), declaring that the matters addressed by this article were governed by personal status law based on Islamic law, and that whenever the provisions of this article conflicted with Kuwaiti law, Kuwait would apply its national law. It also made a reservation to article 25(b) (universal suffrage) because this article conflicted with Kuwaiti electoral law where only males can vote.[40] In its 2000 recommendations to the Kuwaiti report, the ICCPR Committee urged Kuwait to withdraw these reservations, since they "raise the issue of compliance with the purpose and object of the covenant," which cannot be subject to Kuwaiti law.

Kuwait made a declaration to the ICESCR, to article 2, paragraph 2 (non-discrimination), and article 3 (equal rights of men and women), insisting that these principles would be applied within the limits of Kuwaiti law. It also made a declaration to article 9 (right to social security), because social security provisions apply only to Kuwaitis and to article 8, paragraph 1(d) (right to strike), without any further comment.

Kuwait's reservations to the CEDAW and the CRC also subject key aspects of these treaties to Kuwaiti law. Kuwait made a reservation to article 7(a) of CEDAW, because in Kuwait women can't vote; to article 9, paragraph 2, because in Kuwait a child's nationality is solely determined by the nationality of the father, and to article 16(f) (equal rights for women with regard to trusteeship, guardianship and adoption of children) because it conflicts with Shari'a. It also stated it was not bound by article 29 (4) (arbitration and jurisdiction of the International Court of Justice).

As to the CRC, Kuwait made interpretive declarations to article 7, relating to nationality, and article 21 to adoption, based on Shari'a law, which determines that the child's nationality is only given by the father, and does not approve adoption. It also made a general reservation that reads: "Kuwait expresses reservations on all provisions of the covenant that are incompatible with the laws of the Islamic Shari'a and the local statutes in effect."

Kuwait has presented State reports to the Committee for Civil and Political Rights and the Committee for the Rights of the Child.[41] Both Committees shared concerns on the lack of equality between men and women, several aspects of which impact on young people's reproductive and sexual health and rights. They mentioned in particular the following issues: early marriage for girls, non-transmission of Kuwaiti nationality from mother to child, legal polygamy, exemption of punishment for so-called honour crimes, unequal rights in inheritance law, and the fact that women can't vote or be elected to office. They also mention general concerns over lack of data and indicators and general concern about Personal Status laws. According to the CRC recommendations, another area of concern that might impact adolescent health and rights is that only 34 per cent of the population is Kuwaiti, while many rights and services supplied by the government are limited to persons of Kuwaiti nationality.

The Committees recommended the State take measures, including legal measures, to change attitudes to prevent and combat discrimination against women and in particular early marriage, inequality before the law and polygamy. They also asked the State to provide data disaggregated by gender.

Kuwait's delegation to the Beijing Conference said that it attached great importance to the Platform for Action, but registered a reservation to "anything which constitutes a contravention of the Islamic Shariah and the customs and practices of our Islamic society,

particularly paragraphs 232 (f), 106 (k) and 94 to 96." These paragraphs refer to reproductive health and rights of women.

Kuwait expressed a general reservation at ICPD. Without specifying any particular articles, it said that its commitment to the objectives of the Programme of Action was subject to their not being in contradiction with Shari'a, Kuwaiti customs and traditions, or the State Constitution.

Contents of Reservations Made by Kuwait to Human Rights Treaties and World Summit Declarations

ICCPR

Party 21 May 96

Interpretative declaration regarding article 2, paragraph 1, and article 3:
Although the Government of Kuwait endorses the worthy principles embodied in these two articles as consistent with the provisions of the Kuwait Constitution in general and of its article 29 in particular, the rights to which the articles refer must be exercised within the limits set by Kuwaiti law.

Interpretative declaration regarding article 23:
The Government of Kuwait declares that the matters addressed by article 23 are governed by personal-status law, which is based on Islamic law. Where the provisions of that article conflict with Kuwaiti law, Kuwait will apply its national law.

Reservations concerning article 25 (b):
The Government of Kuwait wishes to formulate a reservation with regard to article 25(b). The provisions of this paragraph conflict with the Kuwaiti electoral law, which restricts the right to stand and vote in elections to males.

It further declares that the provisions of the article shall not apply to members of the armed forces or the police.

Protocol 1 ICCPR

Not a party

ICESCR

Party 21 May 96

Interpretative declaration regarding article 2, paragraph 2, and article 3:
Although the Government of Kuwait endorses the worthy principles embodied in article 2, paragraph 2, and article 3 as consistent with the provisions of the Kuwait Constitution in general and of its article 29 in particular, it declares that the rights to which the articles refer must be exercised within the limits set by Kuwaiti law.

Interpretative declaration regarding article 9:
The Government of Kuwait declares that while Kuwaiti legislation safeguards the rights of all Kuwaiti and non-Kuwaiti workers, social security provisions apply only to Kuwaitis.

continued

Reservation concerning article 8, paragraph 1 (d):
The Government of Kuwait reserves the right not to apply the provisions of article 8, paragraph 1 (d).

CEDAW

Party 2 September 94

Reservations:

1. Article 7 (a)
   The Government of Kuwait enters a reservation regarding article 7 (a), inasmuch as the provision contained in that paragraph conflicts with the Kuwaiti Electoral Act, under which the right to be eligible for election and to vote is restricted to males.

2. Article 9, paragraph 2
   The Government of Kuwait reserves its right not to implement the provision contained in article 9, paragraph 2, of the Convention, inasmuch as it runs counter to the Kuwaiti Nationality Act, which stipulates that a child's nationality shall be determined by that of his father.

3. Article 16 (f)
   The Government of the State of Kuwait declares that it does not consider itself bound by the provision contained in article 16 (f) inasmuch as it conflicts with the provisions of the Islamic Shari'a , Islam being the official religion of the State.

4. The Government of Kuwait declares that it is not bound by the provision contained in article 29, paragraph 1.

Note 32. Several Governments notified the Secretary-General that they consider the reservations made by the Government of Kuwait concerning article 7 (a) and article 16 (f) as "incompatible with the object and purpose of the said Convention and, therefore, as prohibited by virtue of its article 28 paragraph 2" on the dates indicated hereinafter:

Protocol CEDAW

Not a party

CRC

Party 21 October 91

Upon signature:
Reservation:
"[Kuwait expresses] reservations on all provisions of the Convention that are incompatible with the laws of Islamic Shari'a and the local statutes in effect."

Upon ratification:
Declarations:
Article 7:
The State of Kuwait understands the concepts of this article to signify the right of the child who was born in Kuwait and whose parents are unknown (parentless) to be granted the Kuwaiti nationality as stipulated

continued

by the Kuwaiti Nationality Laws.

Article 21:
The State of Kuwait, as it adheres to the provisions of the Islamic Shari'a as the main source of legislation, strictly bans abandoning the Islamic religion and does not therefore approve adoption.

Second Optional Protocol CRC

Not a party

.....with a reservation in respect of paragraph 5 of article 3 of the second protocol.

Beijing Declaration and Platform for Action

The representative of Kuwait submitted the following written statement:

> My country's delegation attaches great importance to the Platform for Action adopted by this Conference and believes in its significant contribution to the advancement of women. However, at the same time, it would like to register a reservation to anything which constitutes a contravention of the Islamic Shari'a and the customs and practices of our Islamic society, particularly paragraphs 232 (f), 106 (k) and 94 to 96.

The delegation of Kuwait would like to have its reservation recorded in the report of the Conference.

ICPD Declaration and Programme of Action

The representative of Kuwait stated the following:

> "The delegation of Kuwait would like to express its support for the Programme of Action, including all its positive points for the benefit of humankind. At the same time, we would like to put on record that our commitment to any objectives on population policies is subject to their not being in contradiction with Islamic Shari'a or with the customs and traditions of Kuwaiti society and the Constitution of the State."

Lebanon

Lebanon became party to the ICCPR and the ICESCR in 1972, without making any reservation or declarations to the treaties. It became party to the CRC in 1991 and to the Protocol on Sale of Children, Child Prostitution and Child Pornography in 2001 without any reservations or declarations. It also signed and ratified the CEDAW in 1997 and made reservations to articles 9, paragraph 2 (equal rights of women and men with respect to the nationality of their children), article 16 (1c, 1d, 1d, 1f and 1g: equality of men and women in family relations), and to the jurisdiction of the International Court of Justice (article 29 (1)).

In 1997, Lebanon presented a State report to the ICCPR[42] and, in 2002, to the CRC.[43]

Both Committees in their recommendations addressed issues that affect young people's sexual and reproductive health and rights, with a focus on the discrimination against women in law and in practice. Specifically, some of these issues are: discrimination in transmitting nationality to children; low age of marriage for girls; discrimination in rights relating to custody, guardianship, inheritance, and reduced sentences for 'honour crimes'. The Committee on the Rights of the Child also expressed concern for the lack of indicators on the status of children and on sexual exploitation of children, as well as the discrimination against Palestinian children refugees. Both Committees recommended that the State review its laws and undertake measures to ensure the equality of men and women. The CRC also recommended the State develop child-related indicators, raise minimum age for marriage and awareness among confessional groups about the negative consequences of early marriage, eliminate the provision that gives honour crimes a reduced sentence, and improve healthcare for children.

There is one shadow report available on the Internet for the Lebanese 2001 report to the CRC, and it concentrates on the situation of the Palestinian refugee children in Lebanon.[44] According to this report, the situation of these children and adolescents is critical as they cannot benefit from Lebanese health services or social security and must depend on the UNRWA[45] and NGOs for the provision of services. This situation must surely impact adolescent sexual and reproductive health.

Lebanon did not express any reservation to the ICPD Programme of Action or the Beijing Declaration and Platform for Action.

Contents of Reservations Made by Lebanon to Human Rights Treaties and World Summit Declarations

ICCPR
Party 3 November 72
No reservation or declaration

Protocol 1 ICCPR
Not a party

ICESCR
Party 3 November 72
No reservation or declaration

CEDAW
Party 21 April 97

continued

Reservations:
The Government of the Lebanese Republic enters reservations regarding article 9 (2), and article 16 (1) (c) (d) (f) and (g) (regarding the right to choose a family name).

In accordance with paragraph 2 of article 29, the Government of the Lebanese Republic declares that it does not consider itself bound by the provisions of paragraph 1 of that article.

Note 34. On 26 June 1998, the Secretary-General received from the Government of Denmark the following communication with regard to the reservation made by Lebanon upon accession in respect of article 9, paragraph 2, and article 16, paragraph 1 (c), (d), (f) and (g). in as much as the last paragraph deals with the right to choose a family name.

The Government of Denmark is of the view that the reservations made by the Government of Lebanon raise doubts as to the commitment of Lebanon to the object and purpose of the Convention and would recall that, according to article 28, paragraph 2 of the Convention, a reservation incompatible with the object and purpose of the present Convention shall not be permitted. For this reason, the Government of Denmark objects to the said reservations made by the Government of Lebanon.

The Government of Denmark recommends the Government of Lebanon to reconsider their reservations to [the Covenant].

Protocol CEDAW
Not a party

CRC
Party 14 May 91
No reservation or declaration

Protocol CRC
No reservation or declaration

ICPD and Beijing Declaration and Platform for Action
None

Libya

Libya became party to the ICCPR and the ICESCR in 1970; and to the ICCPR First Protocol in 1989.

Libya is also party to the CEDAW (1989) and the CRC (1993). It is the only Arab country to have signed the Optional Protocol to CEDAW. It made no reservation to the CRC, but did to the CEDAW. On accession, Libya made reservations to article 2 and article 16, paragraphs (c) and (d) of the CEDAW. About article 2, it said that article would be implemented "with due regard for the peremptory norms of the Islamic

Shari'a" about inheritance. As to article 16, paragraphs (c) and (d), it said they would be implemented "without prejudice to any of the rights guaranteed to women by the Islamic Shari'a." However, in 1995 Libya reformulated the reservation to the Convention with a general reservation to all of the CEDAW in the sense that accession to the treaty "cannot conflict with personal status derived from the Islamic Shari'a."

At the ICPD, the representative from Libya stated a reservation on "all the terms in the document that are in contravention of the Islamic Shari'a" and especially to paragraph 4.17 (promotion of girl children and equal inheritance rights), to chapter 2 (principles) in relation to inheritance, to paragraph 8.31 in relation to extramarital activities and sexual behaviour, and paragraph 8.25 in reference to unwanted pregnancies and abortion based on the illegality of abortion in Libya unless the mother's health is in danger. It expressed a reservation to the word 'individual' in the term "basic rights of couples and individuals," not recognizing the word 'individuals'.

At the Fourth World Conference on Women in Beijing, Libya also expressed reservations. It made a general statement saying that Libya's application of the whole outcome document (or Platform for Action) would rest within the limits of "what is permitted by our beliefs and the laws and tradition which shape our behaviour as a society." It then made express reservations to the following phrases: "sexual relations and sexual behaviour" when understood outside of marriage, "sexual education and reproductive health" when used outside of marriage and parental supervision; as well as the term 'individuals' when understood as individuals' right to decide on number of children, and not only the right of couples. It also made a reservation to the following paragraphs: 96 (women's control over their own reproduction and sexuality); 232 (f) (same as 96); 106 (k) (mentions abortion); 106 (j) (also refers to abortion) and 274 (d) (equality of rights of girls and boys, including inheritance). The motivation for all these reservations was that they are inconsistent with local laws and Shari'a.

Libya presented a report to the Committee on Economic and Social rights in 1996, and to the Committee on the Rights of the Child and the Human Rights Committee in 1998.[46] The Committees were concerned with the lack of data in the reports as well as with other aspects that have an impact on the reproductive health and rights of young people. They particularly focused on discrimination against women in: inheritance rights, transmission of the nationality of the mother to the child and the absence of penalty for marital rape. The CRC was also concerned with discrimination against children born out of wedlock. The ICESCR expressed concern that the State party delegation had said that HIV was a problem of foreign workers and not of Libyans, and that, in its presentation the State had advanced arguments against the equality of men and women on the basis of Shari'a. The Committees recommended that the State

review its legislation and amend it in accordance with the existing human rights international instruments, and that it end all aspects of discrimination against women.

Content of Reservations Made by Libya to Human Rights Treaties and World Summit Declarations

ICCPR
Party 15 May 70

Declaration
Same as ICESCR

Protocol 1 ICCPR
Party 16 May 89
No reservation or declaration

ICESCR
Party 15 May 70

Declaration
Libyan Arab Jamahiriya ICESCR

> *"The acceptance and the accession to this Covenant by the Libyan Arab Republic shall in no way signify a recognition of Israel or be conducive to entry by the Libyan Arab Republic into such dealings with Israel as are regulated by the Covenant."*

CEDAW
Party 16 May 89

Reservation:

1. Article 2 of the Convention shall be implemented with due regard for the peremptory norms of the Islamic Shari'a relating to determination of the inheritance portions of the estate of a deceased person, whether female or male.
2. The implementation of paragraph 16 (c) and (d) of the Convention shall be without prejudice to any of the rights guaranteed to women by the Islamic Shari'a.

Note 35. On 5 July 1995, the Government of the Socialist People's Libyan Arab Republic notified the Secretary-General of the "new formulation of its reservation to the Convention, which replaces the formulation contained in the instrument of accession" which read as follows:

[Accession] is subject to the general reservation that such accession cannot conflict with the laws on personal status derived from the Islamic Shari'a.

Protocol CEDAW
Party 18 June 04
No reservation or declaration

continued

CRC

Party 16 April 93
No reservation or declaration

Protocol CRC

Not a party
No reservation or declaration

Beijing Declaration and Platform for Action

The representative of the Libyan Arab Jamahiriya submitted the following written statement:

> *My delegation greatly appreciates the efforts made by the Main Committee and working groups of the Conference towards producing formulas which represent the common positions of the participating delegations and respect the beliefs of different societies and their private affairs. In this context, the Libyan delegation has made every possible effort in its discussions with all the working groups and in meetings to join in the global consensus towards which this Platform for Action is directed.*
>
> *In view of our belief in the importance of the dialogue between the different cultures and civilizations of the peoples of the world for the achievement of universal social peace, we do not accept the right of any nation or civilization to impose its culture or political, economic or social orientations on any other nation or people. In view also of our belief in the sovereign right of every State to draw up domestic policies in keeping with its religious beliefs, local laws and priorities for social and economic development, it is our understanding that the terms and expressions which appear in this document and their application will be within the limits of what is permitted by our beliefs and the laws and traditions which shape our behaviour as a society. On this basis, our country's delegation would like to express reservations with regard to the following:*
>
> *(a) The expression "sexual relations and sexual behaviour" between men and women, adult or otherwise, outside of a lawful marital relationship, which has appeared in a number of articles;*
>
> *(b) The expression "sexual education and reproductive health" used with reference to the unmarried and outside the ambit of parental responsibility, supervision and care;*
>
> *(c) The term "individuals" linked with the basic right of all couples to decide freely and responsibly the number, spacing and timing of their children. This right is not accorded in our society outside the framework of a lawful marital relationship. This expression appears in paragraphs 95 and 223;*
>
> *(d) The entire text of paragraph 96 because it is inconsistent with our social and cultural values. The same applies to paragraph 232 (f);*
>
> *(e) Everything included in and intended by the text appearing in paragraph 106 (k), since it is contrary to local laws based on the Islamic Shari'a. The same applies to the text appearing in*

continued

paragraph 106 (j) regarding abortion, since local laws do not permit the performance of abortion except to save the mother's life;

(f) The text of paragraph 274 (d), which will be interpreted and implemented in accordance with the Islamic Shari'a, which guarantees females the right of inheritance.

We hope that this statement and these reservations will be included in the official report of the Conference.

ICPD Declaration and Programme of Action

The representative of the Libyan Arab Jamahiriya stated the following:

"The delegation of the Libyan Arab Jamahiriya wishes to express a reservation on all terms in the document that are in contravention of Islamic Shari'a, such as we see in paragraph 4.17 and in chapter II of the document, in relation to inheritance and extramarital sexual activities, and the references to sexual behaviour, as in paragraph 8.31.

"I wish to express a reservation, despite the discussion that took place in the Main Committee regarding the basic rights of couples and individuals. We express a reservation regarding the word 'individuals'.

"The Jamahiriya reconfirms, as part of Arab civilization, the importance of a dialogue among all religions, cultures and peoples in order to achieve world peace; yet no country, no civilization has the right to impose its political, economic and social orientations on any other people.

"I also want to express a reservation on the words 'unwanted pregnancies' in paragraph 8.25, because our written Constitution does not allow the State to undertake abortions unless the mother's health is in danger."

Morocco

Morocco is party to the ICCPR and the ICESCR since 1979. It did not make any reservations or declarations. Morocco is also party to the CEDAW and the CRC since 1993, and made reservations to both, and declarations to the CEDAW. It is also party to the Second Optional Protocol to the CRC and made no reservation or declaration.

On accession to the CEDAW, Morocco declared that article 2 (eliminating discrimination against women in laws and policies) would be applied provided it did not conflict with the requirements for succession to the throne or with the Islamic Shari'a and the Moroccan Code of Personal Status particularly regarding women's and men's different rights in marriage. It also declared that the provisions of article 15, paragraph 4, were only binding on Morocco insofar as they are not incompatible with the Moroccan Code

of Personal Status, particularly with reference to the right of women to choose their residence and domiciles. Morocco made reservations to article 9, paragraph 2, and to article 16 because they conflict with local laws; in the Law of Moroccan Nationality, the child bears the nationality of the father. Morocco's reservation to Article 16, which covers equality of men and women in marriage, was made on the grounds of its incompatibility with Shari'a, which gives different rights and duties to each. Morocco also made a reservation to article 29 (1) on the jurisdiction of the International Court of Justice.

Morocco also made a reservation to article 14 of the CRC, which accords freedom of religion to children, "in view of the fact that Islam is the State religion."

It expressed no reservation to the ICPD Programme of Action, but it made a reservation on the articles of the Beijing Platform for Action, which it considered to be in contradiction with the precepts of Islam, and not in conformity with its spiritual values and cultural traditions. These were paragraphs 96 (women's sexual rights); 232 (f), which asks Governments to take action on 96; 106 (k), which deals with addressing unsafe abortion and reviewing criminal penalties for abortion; and 274 (d), which talks of equality in inheritance rights.

The Committee on Economic Social and Cultural Rights and the Human Rights Committee both recently made recommendations to Morocco's State reports on its observation of these conventions.[47] Some of the concerns expressed by the Committees as well as their recommendations are relevant to young people's reproductive health and rights. The Committees were concerned about discrimination against women, particularly traditional practices and attitudes towards women and children; discrimination in family and personal status law and in inheritance; discrimination against children born out of wedlock; and the existence of the honour defence for murders. There is also concern for high maternal and infant mortality and the lack of guarantees for the exercise of freedom of religion. The Committees urge Morocco to amend legislation and take protective measures to guarantee women's rights and overcome all forms of discrimination against women, including guarantee of full and equal access to family planning. Most recently, it is reported that the King, as religious authority of the country, has authorised a substantial revision of personal status law, which includes raising the age of marriage to 18 and making it easier for women to obtain a divorce.[48]

Contents of Reservations Made by Morocco to Human Rights Treaties and World Summit Declarations

ICCPR
Party 3 May 79
No reservation or declaration

Protocol 1 ICCPR
Not a party

ICESCR
Party 3 May 79
No reservation or declaration

CEDAW
Party 22 June 93

Declarations:

1. With regard to article 2:
   The Government of the Kingdom of Morocco express its readiness to apply the provisions of this article provided that:
   - They are without prejudice to the constitutional requirement that regulate the rules of succession to the throne of the Kingdom of Morocco;
   - They do not conflict with the provisions of the Islamic Shari'a. It should be noted that certain of the provisions contained in the Moroccan Code of Personal Status according women rights that differ from the rights conferred on men may not be infringed upon or abrogated because they derive primarily from the Islamic Shari'a, which strives, among its other objectives, to strike a balance between the spouses in order to preserve the coherence of family life.
2. With regard to article 15, paragraph 4:
   The Government of the Kingdom of Morocco declares that it can only be bound by the provisions of this paragraph, in particular those relating to the right of women to choose their residence and domicile, to the extent that they are not incompatible with articles 34 and 36 of the Moroccan Code of Personal Status.

Reservation:
With regard to article 9, paragraph 2:
The Government of the Kingdom of Morocco makes a reservation with regard to this article in view of the fact that the Law of Moroccan Nationality permits a child to bear the nationality of its mother only in the cases where it is born to an unknown father, regardless of place of birth, or to a stateless father, when born in Morocco, and it does so in order to guarantee to each child its right to a nationality. Further, a child born

continued

in Morocco of a Moroccan mother and a foreign father may acquire the nationality of its mother by declaring, within two years of reaching the age of majority, its desire to acquire that nationality, provided that, on making such declaration, its customary and regular residence is in Morocco.

With regard to article 16:
The Government of the Kingdom of Morocco makes a reservation with regard to the provisions of this article, particularly those relating to the equality of men and women, in respect of rights and responsibilities on entry into and at dissolution of marriage. Equality of this kind is considered incompatible with the Islamic Shari'a, which guarantees to each of the spouses rights and responsibilities within a framework of equilibrium and complementary in order to preserve the sacred bond of matrimony.

The provisions of the Islamic Shari'a oblige the husband to provide a nuptial gift upon marriage and to support his family, while the wife is not required by law to support the family.

Further, at dissolution of marriage, the husband is obliged to pay maintenance. In contrast, the wife enjoys complete freedom of disposition of her property during the marriage and upon its dissolution without supervision by the husband, the husband having no jurisdiction over his wife's property.
For these reasons, the Islamic Shari'a confers the right of divorce on a woman only by decision of a Shari'a judge.

With regard to article 29:
The Government of the Kingdom of Morocco does not consider itself bound by the first paragraph of this article, which provides that `Any dispute between two or more States Parties concerning the interpretation or application of the present Convention which is not settled by negotiation shall, at the request of one of them, be submitted to arbitration.

The Government of the Kingdom of Morocco is of the view that any dispute of this kind can only be referred to arbitration by agreement of all the parties to the dispute.

Protocol CEDAW
Not a party

CRC
Party 21 June 93

Reservation:
The Kingdom of Morocco, whose Constitution guarantees to all the freedom to pursue his religious affairs, makes a reservation to the provisions of article 14, which accords children freedom of religion, in view of the fact that Islam is the State religion.

Protocol CRC
Party 2 October 01
No reservation or declaration

continued

Beijing Declaration and Platform for Action

The representative of Morocco submitted the following written statement:
The delegation of Morocco reserves its position on paragraphs 96 and 106 (k) of the Platform for Action, whose content is in contradiction with the precepts of Islam and is not in conformity with its spiritual values and cultural traditions. Morocco also expresses its reservations on paragraph 232 (f), which refers to paragraph 96, and on paragraph 274 (d). The delegation of the Kingdom of Morocco requests that its reservations be included in the report of the Conference.

ICPD Declaration and Programme of Action

None

Occupied Palestinian Territories

No reports directly on the Occupied Palestinian Territories since they do not have country status within the UN system.

Oman

Oman is not party to the ICCPR, the CEDAW or the ICESCR. It is party to the CRC since 1996, and it made a reservation on all the provisions that "do not accord with Islamic law or the legislation in force in the Sultanate," in particular to the provisions in relation to article 14 (the child's right to choose religion), article 21 (adoption), and article 30 (allowing a child belonging to a religious minority to profess his or her religion). Its reservation to article 7 related to the nationality of a child born in Oman of unknown parents. The reservation stated that this would be determined as stipulated in the Omani Nationality Law. Six European countries objected to the reservations.

In 2001, Oman presented a report to the Committee on the Rights of the Child, and the Committee made recommendations.[49] Some of the areas of concern and recommendations of the Committee are of relevance for young people's sexual and reproductive rights and health. The Committee stated that although there are significant achievements in improving the status of women, discrimination persists. The Committee is also concerned over discrimination of children born out of wedlock and children who are not Omani, and about traditional attitudes that pose obstacles to taking children's views into account. There is insufficient information on adolescent health, including access to reproductive health services. The Committee recommends that Oman take all possible measures to reconcile fundamental human rights with Islamic teachings and with the country's legislation, changing and creating laws to prevent and eliminate discrimination and launching education campaigns. It also says the State should continue to promote

and facilitate respect for children's views and participation, strengthen efforts for data collection about adolescents, and ensure access to adolescent health education on all adolescent health issues, including reproductive health.

Oman made no reservation to the Beijing Platform for Action or to the ICPD Programme of Action.

Contents of Reservations Made by Oman to Human Rights Treaties and World Summit Declarations

ICCPR
Not a party

Protocol 1 ICCPR
Not a party

ICESCR
Not a party

CEDAW
Not a party

Protocol CEDAW
Not a party

CRC
Party 9 December 96

Reservations:

1. The words "or to public safety" should be added in article 9 [, paragraph 4,] after the words "unless the provision of the information would be detrimental to the well-being of the child.
2. A reservation is entered to all the provisions of the Convention that do not accord with Islamic law or the legislation in force in the Sultanate and, in particular, to the provisions relating to adoption set forth in its article 21.
3. The provisions of the Convention should be applied within the limits imposed by the material resources available.
4. The Sultanate considers that article 7 of the Convention as it relates to the nationality of a child shall be understood to mean that a child born in the Sultanate of unknown parents shall acquire Oman nationality, as stipulated in the Sultanate's Nationality Law.

continued

5. The Sultanate does not consider itself to be bound by those provisions of article 14 of the Convention that accord a child the right to choose his or her religion or those of its article 30 that allow a child belonging to a religious minority to profess his or her own religion.

Protocol CRC
Party, Royal Decree 41/2004

Beijing Declaration and Platform for Action
None

ICPD Declaration and Programme of Action
None

Qatar

Qatar is not party to the ICCPR, the CEDAW or the ICESCR. It is party to the CRC since 1995, and it made a general reservation to "provisions incompatible with Islamic Law." It is also party to the CRC Optional Protocol since 2001, and to this protocol it made a general reservation to "any provision" incompatible with Islamic law. In its observations to the State report, the Committee on the Rights of the Child said it welcomes information that the State was re-examining this reservation, whose general and imprecise nature potentially negates many CRC provisions and "raises concerns on incompatibility with object and purpose."[50] Qatar is also party to the CRC Optional Protocol 2 On the Involvement of Children in Armed Conflict since 2001. Upon accession it made a "general reservation concerning any provisions in the protocol that are in conflict with the Islamic Shari'a."

In 2001, Qatar presented a report to the Committee on the Rights of the Child and the Committee published its concluding observations. The Committee is concerned that the "narrow interpretation" of Islamic texts in Qatar, "particularly in areas relating to personal status laws" may impede full enjoyment of the rights guaranteed in the Covenant. Some of the Committee's observations are relevant to adolescent reproductive health and rights. The Committee is concerned with persisting discrimination against women; traditional attitudes toward children that may limit respect for their views; women's inability to transmit their nationality to their children; discrimination against children born out of wedlock; insufficient information regarding adolescent health; and inadequate access by adolescents to reproductive healthcare and mental health counselling.

The Committee recommended that Qatar review domestic laws to ensure they conform to international human rights standards and that it take measures, including changing

laws, to eliminate discrimination based on sex and birth. It should also undertake all possible measures to reconcile fundamental human rights with Islamic texts. It also recommended that Qatar ensure adolescents have access to, and are provided with, adolescent health education and care, including reproductive health.

Qatar has not expressed any reservations to the Beijing Platform for Action and the ICPD Programme of Action.

Contents of Reservations Made by Qatar to Human Rights Treaties and World Summit Declarations

ICCPR
Not a party

Protocol 1 ICCPR
Not a party

ICESCR
Not a party

CEDAW
Not a party

Protocol CEDAW
Not a party

CRC
Party 4 April 95

Reservation made upon signature and confirmed upon ratification:
[The State of Qatar] enter(s) a general reservation by the State of Qatar concerning provisions incompatible with Islamic Law.

Protocol CRC
Party 14 December 01

Reservation:
.....subject to a general reservation concerning any provisions in the protocol that are in conflict with the Islamic Shari'a

Beijing Declaration and Platform for Action
None

ICPD Declaration and Programme of Action
None

Saudi Arabia

Saudi Arabia is not party to the ICCPR or to the ICESCR. It is party to the CRC since 1996, and made a general reservation to "all such articles as are in conflict with the provisions of Islamic law." It is also party to the CEDAW since 2000, and made a reservation. It expressed that if there were to be any contradiction between the convention and Islamic law, they were not bound to apply the convention, and also that it did not consider itself bound by article 9, paragraph 2 (equal rights of women and men in respect to the nationality of their children), and article 29, paragraph 1 (jurisdiction of the ICJ). The Committee for the CRC considered this reservation to be broad and imprecise and that it potentially negates many of the Convention's provisions and raises concerns about its compatibility with the object and purpose of the convention.

In 2001, Saudi Arabia reported to the Committee on the Rights of the Child, which then published its concluding observations.[51] Many of the areas of concern and recommendations of the Committee are relevant for adolescent sexual and reproductive health and rights, such as discrimination against women, children born out of wedlock, non-Muslims, and girls in education. Some of the given examples of discrimination against women are lack of identity cards for females and unequal rights in inheritance, custody and guardianship. There were also reports that members of the Committee for the Propagation of Virtue and the Prevention of Vice routinely harass and assault persons under 18 – for example, for infractions of the dress code. Furthermore, respect for the views of the child remains limited. The Committee was also concerned with insufficient information about adolescent health. It recommended that Saudi Arabia collect data about the situation of children and adolescents; that the State take effective measures to prevent and eliminate discrimination on the grounds of sex and birth; and that the State codify law to make sure they are in accordance with Human Rights law. The Committee also urged the State to undertake a study of adolescent heath problems with the full participation of adolescents, and formulate health policies and programmes based on this study. Finally, the Committee recommended that adolescents have access to, and be provided with, education about reproductive health and child-friendly counselling and rehabilitation.

Saudi Arabia made no reservation to either the Beijing Platform For Action or the ICPD Programme of Action.

Contents of Reservations Made by Saudi Arabia to Human Rights Treaties and World Summit Declarations

ICCPR
Not a party

Protocol 1 ICCPR
Not a party

ICESCR
Not a party

CEDAW
Party 8 September 00

Reservations:

"1. In case of contradiction between any term of the Convention and the norms of Islamic law, the Kingdom is not under obligation to observe the contradictory terms of the Convention.

2. The Kingdom does not consider itself bound by paragraph 2 of article 9 of the Convention and paragraph 1 of article 29 of the Convention."

Protocol CEDAW
Not a party

CRC
Party 26 January 96

Reservation:
[The Government of Saudi Arabia enters] reservations with respect to all such articles as are in conflict with the provisions of Islamic law.
Note 16. On 20 March 1997, the Secretary-General received from the Government of Finland communication with regard to reservations made by Brunei Darussalam and Saudi Arabia upon accession:

[Same text, mutatis mutandis, as the objection made with regard to Singapore under "Objections".

Protocol CRC
Not a party

Beijing Declaration and Platform for Action
None

ICPD Declaration and Programme of Action
None

Sudan

Sudan is party to the ICCPR since 1976. It is also party to the ICESCR since 1986 and to the CRC since 1990, making no reservations or declarations to either. It is not party to the CEDAW.

Sudan has reported recently to all three Committees of the treaties of which it is a party. They have passed concluding observations about the State reports.[52] The Committees raised multiple human rights issues, and many of the areas of concern have an impact on adolescent reproductive health and rights. Some of the concerns are related to civil strife and its consequences on development and human rights, for example, the absence of safe drinking water; the lack of basic immunization of children; the considerable number of internally displaced persons, many of whom are women and children; the increasing number of refugee children, children who live and work on the street and sexually exploited children; and large-scale abductions of women and children by different tribes. HIV/AIDS is increasing and there are no affordable medications. Some of the Committees' concerns are based on discrimination against women, which is reflected in high maternal mortality rates (some of which may be a consequence of early marriage), clandestine abortions, and female genital mutilation/cutting. Inequality of women is present both in traditional customs and practices and in the laws that establish an unequal status of men and women in family and criminal law regarding marital relations; for example, marital consent is given by a woman's father and not of her own will. Flagellation or lashing of women for dress code violations or for breaking the curfew is allowed according to the Public Order Act of 1996. The ICESCR also expressed concern that Sudan's lack of clarity on the status of Shari'a law might lead to violations of human rights as contradictions arise between narrow interpretations of it and human rights instruments.
The Committees have recommended a series of amendments to national laws in order to ensure observation of the rights guaranteed in the covenants. They include measures such as: repealing all legal provisions that discriminate against women; reconsidering the Public Order Act to eliminate discrimination against women; and continuing efforts to eradicate FGM/C and early marriage. The CRC also recommended that Sudan integrate into its policies and practices the HIV/AIDS and human rights guidelines in General Comments 3 and 4.

An NGO shadow report for the 2002 Sudan report to the Committee on the Rights of the Child does not include specific issues that are relevant for the sexual and reproductive rights of adolescents, but does report on the general distress and critical Human Rights situation of the country.[53]

Sudan made no reservation to either the Beijing Platform For Action or the ICPD Programme of Action.

Contents of Reservations Made by Sudan to Human Rights Treaties and World Summit Declarations

ICCPR
Party 18 March 76

Protocol 1 ICCPR
Not a party

ICESCR
Party 18 March 86
No reservation or declaration

CEDAW
Not a party

Protocol CEDAW
Not a party

CRC
Party 3 August 90
No reservation or declaration

Protocol CRC
Not a party

Beijing Declaration and Platform for Action
None

ICPD Declaration and Programme of Action
None

Syria

Syria is party to the ICCPR and the ICESCR since 1969. It is also party to the CEDAW since March 2003. It made reservations to article 2, (non-discrimination on the basis of sex); article 9, paragraph 2 (transmission of a woman's nationality to her children); article 15, paragraph 4 (freedom of movement and of residence and domicile); article 16, paragraph 1 (c), (d), (f) and (g) (equal rights between men and women in marriage and parenthood); article 16, paragraph 2 (legal effect of marriage). Syria only gave a reason for this last reservation saying this provision "is incompatible with the provisions of the Islamic

Shari'a ." It also made a reservation to article 29, paragraph 1, on arbitration between nations in case of dispute.

Syria is also party to the CRC since 1993, and it made the following reservation: "The Syrian Arab Republic has reservations on the Convention's provisions which are not in conformity with the Syrian Arab legislation and with the Islamic Shari'a's principles, in particular the content of article (14) related to the Right of the Child to the freedom of religion, and articles 2 and 21 concerning adoption." The Committee on the Rights of the Child has asked Syria to reconsider this reservation since its broad nature might lead to misunderstandings about the nature of the State's commitment to implementing the rights in the treaty.

Since 1997 Syria has presented reports to the CRC (1997) the CCPR (2001) and the ICESCR (2001).[54] Several areas of concern and recommendations of the Committees to these reports are relevant for young people's reproductive heath and rights. A principal area of concern is the status of women, since the Personal Status Act N. 34 of 1975 has discriminatory provisions about the spouses' obligations and rights in marriage and its dissolution. Women are also discriminated by the low legal age for marriage of girls, more severe punishment for women for adultery, exoneration of honour crimes, and unequal treatment of men and women in personal property and social security laws. There is also no legislation against domestic violence and no law against spousal rape. Finally, the situation of refugee and Kurdish persons is an area of concern since they are not given the Syrian nationality and remain Stateless.

The Committees recommended that Syria prevent and combat discrimination against women and girls by amending its legislation, passing new laws, and taking other measures. The Human Rights Committee specifically recommended increasing the minimum age for marriage (currently 13 for girls and 15 for boys, with a judge's permission), and taking measures against discrimination against refugees and Kurds.

Syria made no reservation to the Beijing Platform For Action. At the ICPD the Syrian delegate stated that Syria "will deal with the Programme of Action in accordance with Chapter 2 (Principles) and in accordance with the ethical, cultural and religious concepts and convictions of our society."

Contents of Reservations Made by Syria to Human Rights Treaties and World Summit Declarations

ICCPR
Party 21 April 69

Declaration. See ICESCR Declaration.

Protocol 1 ICCPR
Not a party

ICESCR
Party 21 April 69

Declaration

1. The accession of the Syrian Arab Republic to these two Covenants shall in no way signify recognition of Israel or entry into a relationship with it regarding any matter regulated by the said two Covenants.
2. The Syrian Arab Republic considers that paragraph 1 of article 26 of the Covenant on Economic, Social and Cultural Rights and paragraph 1 of article 48 of the International Covenant on Civil and Political Rights are incompatible with the purposes and objectives of the said Covenants, inasmuch as they do not allow all States, without distinction or discrimination, the opportunity to become parties to the said Covenants.

CEDAW
Party 28 March 03

Reservation:
.....subject to reservations to article 2; article 9, paragraph 2, concerning the grant of a woman's nationality to her children; article 15, paragraph 4, concerning freedom of movement and of residence and domicile; article 16, paragraph 1 (c), (d), (f) and (g), concerning equal rights and responsibilities during marriage and at its dissolution with regard to guardianship, the right to choose a family name, maintenance and adoption; article 16, paragraph 2, concerning the legal effect of the betrothal and the marriage of a child, inasmuch as this provision is incompatible with the provisions of the Islamic Shari'a; and article 29, paragraph 1, concerning arbitration between States in the event of a dispute.

Protocol CEDAW
Not a party

CRC
Party 15 July 93

Reservations:
The Syrian Arab Republic has reservations on the Convention's provisions that are not in conformity with

continued

the Syrian Arab legislations and with the Islamic Shari'a's principles, in particular the content of article (14) related to the Right of the Child to the freedom of religion, and articles 2 and 21 concerning the adoption.

Second Optional Protocol CRC

Acceded May 15, 2003
"A reservation is entered to the provisions set forth in article 3, paragraph 5, and article 3, paragraph 1 (a) (ii) of the Optional Protocol on the sale of children, child prostitution and child pornography, which relate to adoption.

Beijing Declaration and Platform for Action

None

ICPD Declaration and Programme of Action

The representative of the Syrian Arab Republic stated the following:
"I should like to put on record that the Syrian Arab Republic will deal with and address the concepts contained in the Programme of Action in accordance with chapter II and in full accordance with the ethical, cultural and religious concepts and convictions of our society in order to serve the unit of the family, which is the nucleus of society, and in order to enhance prosperity in our societies."

Tunisia

Tunisia is party to the ICCPR and the ICESCR since 1969. It declared, upon accession to the ICCPR that only countries who had acceded to the competence of the Committee could submit communications to the Committee regarding Tunisia.

It is also party to the CEDAW since 1985, and it made the following reservations and declarations: a general declaration stating that the government would not take any decision to implement this convention that would go against article 1 of the Tunisian Constitution.[55] It also declared that paragraphs (g) and (h) of article 16 would not be interpreted to conflict with the provisions of the Personal Status Code on the granting of family names to children and the provision of inheritance. It also made a declaration on article 15, paragraph 4, that the part relating to the right of women to choose their own residence and domicile must not be interpreted to conflict with the Provisions of the Personal Status Code. Tunisia also made reservations to article 9, paragraph 2, because it conflicted with the Tunisian Family Code, and to article 16, paragraphs (c), (d) and (f) (equal rights of men and women in marriage and its dissolution), without any explanation. It also made a reservation to article 29, paragraph 1, regarding the jurisdiction of the ICJ. In 1995, when the Committee for the CEDAW expressed concern about these reservations, the representative said they "would surely be withdrawn before too long."[56]

Tunisia is party to the CRC since 1992. Upon accession it declared that the convention would not be implemented in conflict with the Tunisian constitution and that it should not be interpreted to conflict with Tunisian legislation on abortion.[57] It made reservations to article 2 and 7 of the convention, which means that marriage, inheritance rights and nationality remain subject only to national laws. Tunisia had also made other reservations to this Convention, which it withdrew in 2002 (see boxed information). It is also party to the Second Optional Protocol of the CRC since 2002, without any declarations or reservations.

In spite of these reservations Tunisia stands out among the Muslim States for its interpretation of Islamic teachings regarding women's rights. In 1995 the CEDAW Committee called Tunisia a "shining example for other countries because of its progressive and programmatic interpretation of Islam."[58] Certainly a review of Tunisia's reports to the committees for the CEDAW, the CRC, the CESR and the ICCPR differ from the rest of the region.[59] There is less urgency in the areas of concern and recommendations, at least in matters that are relevant to adolescent sexual and reproductive heath and rights. For example, there is no mention of FGM/C, polygamy, early and forced marriage or dress codes. The Committees are concerned that, in spite of significant progress, discrimination against women remains with regard to positions of responsibility, remuneration and laws of inheritance, parental and custodial rights and the transmission of nationality. There is still a disparity of one year in the minimum age for marriage (17 for girls). The Committees recommended that this legislation be reviewed and amended. CRC also recommended that Tunisia reinforce the capacity of the national health services to address the specific needs of adolescents.

At the Fourth World Conference on Women in Beijing, Tunisia made a statement saying Tunisia would interpret paragraphs 96, 232 (f) and 274 (d) (all on reproductive rights of women) of the Platform for Action "within its fundamental laws and texts."

Tunisia made no reservation to the ICPD Programme of Action.

Contents of Reservations Made by Tunisia to Human Rights Treaties and World Summit Declarations

ICCPR
Party 18 March 69

Declaration
24 June 1993

The Government of the Republic of Tunisia declares that it recognizes the competence of the Human Rights Committee established under article 28 of the [said Covenant] ..., to receive and consider communications to the effect that a State Party claims that the Republic of Tunisia is not fulfilling its obligations under the Covenant.

The State Party submitting such communications to the Committee must have made a declaration recognizing in regard to itself the competence of the Committee under article 41 of the [said Covenant].

Protocol 1 ICCPR
Not a party

ICESCR
Party 18 March 69
No reservation or declaration

CEDAW
Party 20 September 85

1. General declaration:
   The Tunisian Government declares that it shall not take any organizational or legislative decision in conformity with the requirements of this Convention where such a decision would conflict with the provisions of chapter I of the Tunisian Constitution.

Reservations

2. Reservation concerning article 9, paragraph 2:
   The Tunisian Government expresses its reservation with regard to the provisions in article 9, paragraph 2 of the Convention, which must not conflict with the provisions of chapter VI of the Tunisian Nationality Code.

3. Reservation concerning article 16, paragraphs (c), (d), (f), (g) and (h):
   The Tunisian Government considers itself not bound by article 16, paragraphs (c), (d) and (f) of the Convention and declares that paragraphs (g) and (h) of that article must not conflict with the provisions of the Personal Status Code concerning the granting of family names to children and the acquisition of property through inheritance.

continued

4. Reservation concerning article 29, paragraph 1:
The Tunisian Government declares, in conformity with the requirements of article 29, paragraph 2 of the Convention, that it shall not be bound by the provisions of paragraph 1 of that article which specify that any dispute between two or more States Parties concerning the interpretation or application of the present Convention which is not settled by negotiation shall be referred to the International Court of Justice at the request of any one of those parties.

The Tunisian Government considers that such disputes should be submitted for arbitration or consideration by the International Court of Justice only with the consent of all parties to the dispute.

5. Declaration concerning article 15, paragraph 4:
In accordance with the provisions of the Vienna Convention on the Law of Treaties, dated 23 May 1969, the Tunisian Government emphasizes that the requirements of article 15, paragraph 4, of the Convention on the Elimination of All forms of Discrimination against Women, and particularly that part relating to the right of women to choose their residence and domicile, must not be interpreted in a manner which conflicts with the provisions of the Personal Status Code on this subject, as set forth in chapters 23 and 61 of the Code.

Protocol CEDAW

Not a party

CRC

Party 31 January 92

Declarations:

1. The Government of the Republic of Tunisia declares that it shall not, in implementation of this Convention, adopt any legislative or statutory decision that conflicts with the Tunisian Constitution.
...

2. The Government of the Republic of Tunisia declares that the Preamble to and the provisions of the Convention, in particular article 6, shall not be interpreted in such a way as to impede the application of Tunisian legislation concerning voluntary termination of pregnancy.

Reservations:

1. The Government of the Republic of Tunisia enters a reservation with regard to the provisions of article 2 of the convention, which may not impede implementation of the provisions of its national legislation concerning personal status, particularly in relation to marriage and inheritance rights.
...

3. The Government of the Republic of Tunisia considers that article 7 of the Convention cannot be interpreted as prohibiting implementation of the provisions of national legislation relating to nationality and, in particular, to cases in which it is forfeited.

continued

Note 33. On 1 March 2002, the Government of Tunisia informed the Secretary-General that it had decided to withdraw the following declaration and reservation made upon ratification:

Declaration:

2. The Government of the Republic of Tunisia declares that its undertaking to implement the provisions of this Convention shall be limited by the means at its disposal.

Reservation:

2. The Government of the Republic of Tunisia regards the provisions of article 40, paragraph 2 (b) (v), as representing a general principle to which exceptions may be made under national legislation, as is the case for some offences on which final judgment is rendered by cantonal or criminal courts without prejudice to the right of appeal in their regard to the Court of Cassation entrusted with ensuring the implementation of the law.

Protocol CRC

Party 13 September 02
No reservation or declaration

Beijing Declaration and Platform for Action

The representative of Tunisia submitted the following written statement:

The Tunisian delegation, by virtue of the powers vested in it, has the honour to confirm that Tunisia will interpret paragraphs 96, 232 (f) and 274 (d) of the Platform for Action within its fundamental laws and texts.

The foregoing was stated at the meetings of the Main Committee held on 13 and 14 September 1995. Tunisia will reject any provision that is contrary to its fundamental laws and texts. The delegation of Tunisia requests that this reservation be included in the documents of the Conference.

ICPD Declaration and Programme of Action

None

United Arab Emirates

The United Arab Emirates is not party to the ICPPR or the ICESCR, but became a party to CEDAW in 2004 with no reservations or declarations. It is party to the CRC since 1997, having made reservations to article 7 (nationality), article 14 (freedom of religion), article 17 (access to information), and article 21 (adoption). However, in 2002, the Concluding Observations of the CRC Committee report that the State will withdraw reservation to article 21.[60] The Committee was concerned about the other reservations,

which would not be withdrawn, in particular to article 7 and 17, and their subjection to domestic law. The Committee was also concerned that the broad and imprecise nature of the reservation to article 14 would result in the violation of freedoms of thought and religion.

The UAE also made a declaration at the ICPD conference, saying that it did not consider abortion as a means of family planning and also adhered to Islamic law in matters of inheritance. It made a general reservation to the Programme of Action saying "we wish to express reservation on everything that contravenes the principles and precepts of our religion Islam, a tolerant religion and our laws." However, the UAE made no reservation to the Beijing Platform for Action.

In 2002, the United Arab Emirates presented its report to the CRC and received recommendations and observations.[61] The Committee expressed concern over the way Shari'a judges take decisions regarding personal status, especially because the law remains uncodified and federal laws remain a secondary source. The Committee was also concerned about persistent discrimination under the existing personal status laws against girls, women, and children born out of marriage. It recommended the State review its domestic laws, including customary law, to ensure they conform to international law standards. It also recommended the State take effective measures including enacting or rescinding legislation to eliminate discrimination based on birth and sex. Likewise, it recommended the State take all possible measures to "reconcile the interpretation of Islam with fundamental Human Rights." All of these concerns and recommendations are relevant to young people's sexual and reproductive health and rights.

Contents of Reservations Made by United Arab Emirates to Human Rights Treaties and World Summit Declarations

ICCPR
Not a party

Protocol 1 ICCPR
Not a party

ICESCR
Not a party

CEDAW
Party 6 October 2004 with no declarations or reservations

continued

Protocol CEDAW
Not a party

CRC
Party 3 January 97

Reservations:
Article 7:
The United Arab Emirates is of the view that the acquisition of nationality is an internal matter and one that is regulated and whose terms and conditions are established by national legislation.

Article 14:
The United Arab Emirates shall be bound by the tenor of this article to the extent that it does not conflict with the principles and provisions of Islamic law.

Article 17:
While the United Arab Emirates appreciates and respects the functions assigned to the mass media by the article, it shall be bound by its provisions in the light of the requirements of domestic statues and laws and, in accordance with the recognition accorded them in the preamble to the Convention, such a manner that the country's traditions and cultural values are not violated.

Article 21:
Since, given its commitment to the principles of Islamic law, the United Arab Emirates does not permit the system of adoption; it has reservations with respect to this article and does not deem it necessary to be bound by its provisions.

Protocol CRC
Not a party

Beijing Declaration and Platform for Action
None

ICPD Declaration and Programme of Action

The representative of the United Arab Emirates stated the following:

> *"The delegation of the United Arab Emirates believes in protecting man and promoting his welfare and in enhancing his role in the family and in the State and at the international level. We consider also that man is the central object and the means for attaining sustainable development. We do not consider abortion as a means of family planning, and we adhere to the principles of Islamic law also in matters of inheritance.*
>
> *"We wish to express reservations on everything that contravenes the principles and precepts of our religion Islam, a tolerant religion, and our laws. We would like the secretariat of the Conference to put on record the position we have expressed among the reservations that have been mentioned by other States on the final document."*

Yemen

Yemen is party to the CEDAW since 1984; to the ICCPR and the ICESCR since 1987 and to the CRC since 1991. It did not make any reservations or declarations to the CRC. When acceding to CEDAW it declared that it would not be bound by article 29.1 (ICJ arbitration)

In 2002, Yemen presented reports to the Human Rights Committee, and the Committees for CEDAW and the CRC. In 2003, the CEDAW Committee[62] expressed concern about early and forced marriage (legal age is 15), vesico-vaginal fistulae (VVF), inadequate laws and judicial practice regarding rape, and access of young married girls to education and employment opportunities.

The areas of concern and recommendations of the Human Rights Committee are also relevant for young people's sexual and reproductive health and rights. The Committee is concerned with the persistence of both female genital mutilation/cutting and domestic violence despite legislation to the contrary. It is also concerned abut discrimination against women in personal status legislation that establishes rules for marriage and its dissolution as well as the rights and duties of spouses. Some examples of these discriminatory provisions are that, by law, married women may not leave their home without the authorization of their husbands; polygamy and early marriage are legal; and nationality is only acquired through the father. The Committee also comments that women who have served a jail sentence remain detained because of social and family rejection. The Committee recommended Yemen review its legislation to establish the equality of women and men both in law and in fact, abolish polygamy and protect girls against early marriage, as well as address the other areas of concern mentioned.

Yemen made no reservation to the Beijing Declaration and Platform for Action. However, the government made reservations to ICPD, in particular to certain terms in chapter 7 on Reproductive Health, and to paragraphs 8.24 (to delete 'sexual activity'), 8.25 (objection to term 'unsafe abortion', and to paragraph 8.35 on 'responsible sexual behaviour'.

Contents of Reservations Made by Yemen to Human Rights Treaties and World Summit Declarations

ICCPR
Party 9 February 87

Declaration
See Declaration for the ICESCR.
Note 10. The formality was effected by Democratic Yemen.

Protocol 1 ICCPR
Not a party

ICESCR
Party 9 February 87

Declaration
The accession of the People's Democratic Republic of Yemen to this Covenant shall in no way signify recognition of Israel or serve as grounds for the establishment of relations of any sort with Israel.

Note 11. The formality was effected by the Yemen Arab Republic.

CEDAW
Party 30 May 84
No reservation or declaration

The Government of the People's Democratic Republic of Yemen declares that it does not consider itself bound by article 29, paragraph 1, of the said Convention, relating to the settlement of disputes which may arise concerning the application or interpretation of the Convention.

Note 14. The formality was effected by Democratic Yemen.

Protocol CEDAW
Not a party

CRC
Party 1 May 91
No reservation or declaration

Protocol CRC
Not a party

Beijing Declaration and Platform for Action
None

continued

ICPD Declaration and Programme of Action

The representative of Yemen stated the following:

> *"The delegation of Yemen believes that chapter VII includes certain terminology that is in contradiction with Islamic Shari'a. Consequently, Yemen expresses reservations on every term and all terminology that is in contradiction with Islamic Shari'a.*
>
> *"In chapter VIII, we have some observations to make, particularly relating to paragraph 8.24. Actually, we wanted to delete the words 'sexual activity'. And, if we cannot delete them, then we wish to express our reservations. In paragraph 8.25, concerning 'unsafe abortion', we find that the definition is unclear and is not in accordance with our religious beliefs. In Islamic Shari'a, there are certain clear-cut provisions on when abortion should be undertaken. We object to the expression 'unsafe abortion'. We wish to express our reservations on paragraph 8.35, relating to 'responsible sexual behaviour'.*

1 Julieta LeMaitre is co-author of this annex, and conducted all the research and writing of the country tables.

2 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.

3 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.

4 The Charter was adopted by the Council of the League of Arab States by its resolution 5437 (102nd regular session) on 15 September 1994.

5 '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.

6 "The right to the highest attainable standard of health." E/C.12/2000/4, CESCR General Comment 14 (2000).

7 "HIV/AIDS and the Rights of the Child." General Comment 3 (2003) CRC/GC/2003/1

8 "Adolescent health and development in the context of the Convention on the Rights of the Child," General Comment 4 (2003), CRC/GC/2003/4.

9 Op. cit., paragraph 30.

10 Details on the range of concluding comments for all of the countries in the study follow in this annex.

11 Bahrain, Djibouti, Syria, and Yemen made no declarations of reservations to the CRC, and Bahrain, Djibouti and Yemen made no reservations to the CEDAW.

12 Shari'a Law is based on the Qur'an and its commentaries the Sunna. Shari'a is not a formally enacted legal code but rather a large group of commentaries where jurists interpret the Qur'an and the Sunna. Therefore, there is significant diversity among schools of thought on Shari'a law, and among different scholars of each school. The legal systems of many Muslim countries primarily retain only the family law and inheritance clauses or stipulations of Shari'a law. Some Muslim fundamentalist groups advocate the reintroduction of the most conservative interpretations of Shar'ia into the legal system, as the sole or primary law of the land. Based on Abdullahi Ahmed An-na'im, *Human Rights in the Muslim World* 3 Harv.Hum. Rts. J. 13 (1990)

13 International Conference for Population and Development Programme of Action, Henceforth ICPD Programme of Action Paragraph 7.41 Section E. A/CONF.171/13: Report of the ICPD (1994).

14 UNAIDS. Global Strategy Framework on HIV AIDS. Available at: http://www.unaids.org/publications/documents/care/general/JC637-GlobalFramew-E.pdf

15 UNGASS on Children General Assembly Resolution S 27/19 May 2002, Henceforth UNGASS on Children. Available at

http://www.unicef.org/specialsession/documentation/documents/A-S27-19-Rev1E-annex.pdf

16 These Commitments were: "1. Put children first; 2. Eradicate poverty by investing in children; 3. Leave no child behind (no discrimination); 4. Care for every child [nutrition, health]; 5. Educate every child; 6. Protect children form harm and exploitation; 7. Protect children from war; 8. Combat HIV AIDS; 9. Listen to children and ensure their participation; 10. Protect the earth for children"

17 ICCPR/C/79/Add.95 (18 August 1998) paragraph13.

18 Algeria made reservations to article 2 of the CEDAW (equality of men and women before the law); article 9 (equality in nationality and nationality of children); article 15 (equality in choosing residence and nationality; article 16 (equal rights and responsibilities in marriage.) It added it did not consider itself bound by article 29 on jurisdiction of the International Court of Justice.

19 CRC/C/15/ Add. 76 (18 June 1997) par.11.

20 CRC/C/15/ Add. 76 (18 June 1997) ; ICCPR/C/79/Add.95 (18 August 1998); CEDAW A/54/38, paragraphs 41–94 (21, 26 January 1999); CESCR E/C.12/1/Add.71 (30 November 2001).

21 E/C.12/1/Add.71 (30 November 2001) paragraph 39

22 Shadow Report on Algeria to The Committee on the Elimination of Discrimination Against Women Submitted by: International Women's Human Rights Law Clinic and Women Living Under Muslim Laws January 1999. available at: http://www.nodo50.org/mujeresred/argelia-shadowreport.html

23 A/54/38, paras 41-94 (January 21, 26 1999) par. 66.

24 Shadow Report On Algeria Submitted To The United Nations Human Rights Committee By The International Women's Human Rights Law Clinic, The Centre For Constitutional Rights, And The International League For Human Rights available at http://www.ilhr.org/ilhr/reports/shadow/

25 CRC/C/15/Add.175 (7 February 2002)

26 CRC/15/Add.131 (28 June 2000)

27 'Kafalah' in this context is a sort of foster care or guardianship system. Summary Record of 679th meeting, CRC/C/SR.679, 30 January 2002. Paragraph 7: "As Sharia contained a number of rules to ensure, through the kafalah system, the protection of children deprived of a family environment, the general opinion [of lawyers in Egypt] was that Egypt's reservations were not inconsistent with the objectives of the Convention."

28 CRC/C/15/Add.145 (21 February 2001); ICCPR/CO/76/EGY (28 November 2002)

29 NGO Coalition on the Rights of the Child. NGO report on the rights of the Child in Egypt, 2000. Available in http://www.crin.org/docs/resources/treaties/CRC.26/egypt_ngo_report.pdf

30 Rana Salem, Population Council personal communication with Jocelyn DeJong, November 2003.

31 ICCPR/C/79/Add.25 (3 August 1993) and E/C.12/1993/7 (9 June 1993).

32 Op. cit., paragraph 13

33 CRC/C/15/Add.123 (28 June 2000).

34 CEDAW article 2, paragraphs (f) and (g); article 9, paragraphs 1 and 2, and article 16

35 CEDAW A/55/38, paragraphs 166–210 (12–30 June 2000) paragraph 188.

36 ICCPR/C/79/Add.84 (19 November 1997); E/C.12/1/Add.17 (12 December 1997); CRC/C/15/Add.94 (26 October 1998); CEDAW A/55/38, paragraphs 166–210 (12–30 June 2000).

37 Articles 9, paragraph 2; 15, paragraph 4; 16 paragraph 1(c), (d) and (g).

38 CRC/C/15/Add.125 (2 June 2000)

39 ICCPR/C/79/Add.35;A/49/40, paragraphs 226–244. (10 August 1994); ESCR E/C.12/1/Add.46 (1 September 2000); CEDAW A/55/38, paragraphs 139–193 (17 January – 4 February 2000); CRC/C/15/Add.125 (2 June 2000).

40 A proposal by the Emir to grant Kuwaiti women suffrage was rejected by the Kuwaiti Parliament in December 1999.

41 CRC/C/15/Add.96 (26 October 1998); ICCPR/CO/69/KWT; A55/40, paragraphs 452–497 (27 July 2000).

42 ICCPR/C/79/Add.78 (1 April 1997)

43 CRC/C/15/Add.169 (21 March 2002)

44 Second Supplementary Report on the Rights of the Palestinian Child in Lebanon The Coordination Forum of NGOs working in

the Palestinian Community May 2001 http://www.crin.org/resources/infoDetail.asp?ID=189

45 UNRWA United Nations Relief and Works Agency for Palestine Refugees in the Near East

46 CRC/C/15/Add.84 (4 February 1998);E/C.12/1/Add.15 (16 May 1997); ICCPR/C/79/Add.101 (6 November 1998).

47 ICCPR/C/79/Add.113 (1 November 1999); E/C.12/1/Add.55 (1December 2000)

48 *Guardian* 13/10/03

49 CRC/C/15/Add.161 (6 November 2001)

50 CRC/C/15/Add.163 (6 November 2001)

51 CRC/C/15/Add.148 (22 February 1001)

52 ICCPR/C/79/Add.85 (19 November 1997); E/C.12/1/Add.48 (1 September 2000); CRC/C/15/Add.190 (9 October 2002)

53 The Status of Implementation of the Child Rights Convention In the Sudan; An alternative report Prepared by National NGOs Friends of Children Society (AMAL) June 2002.
http://www.crin.org/docs/resources/treaties/crc.31/Sudan_ngo_report_English.pdf

54 CRC/C/15/Add.70 (17 January 1997); ICCPR/CO/71/SYR (24 April 2001); E/C.12/1/Add.63 (24 September 2001)

55 Article 1 [State] Tunisia is a free State, independent and sovereign; its religion is Islam, its language is Arabic, and its form is the Republic.

56 CEDAW A/50/38 paragraphs 218–277 (31 May 1995). paragraph 222

57 Abortion is legal in Tunisia.

58 CEDAW A/50/38 paragraphs 218–277 (31 May 1995). paragraph 222.

59 ICCPR/C/79/Add.43 (10 November 1994); CEDAW A/50/38 paragraphs 218–277 (31 May 1995);E/C.12/1/Add.36; CRC/C/15/Add.181 (13 June 2002).

60 CRC CRC/C/118 (2002)

61 CRC/C/15/Add. 183 (13 June 2002)

62 CEDAW/C/SR.581 (13 January 2003)

ANNEX IV: BIBLIOGRAPHY OF INTERNATIONAL LITERATURE ON YPSRH, AND REGIONAL/COUNTRY LITERATURE FROM THE ARAB STATES AND IRAN

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