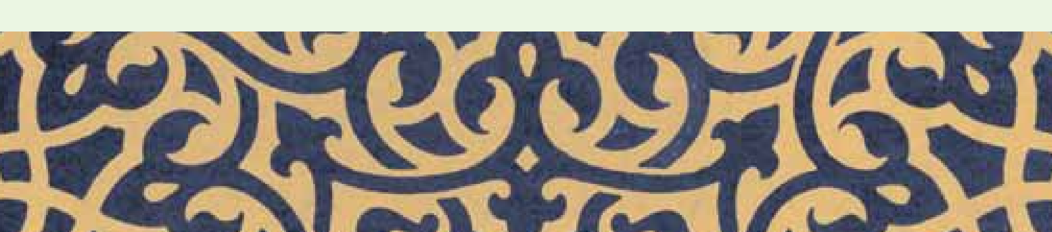
FACTS OF LIFE

YOUTH SEXUALITY AND REPRODUCTIVE HEALTH IN THE MIDDLE EAST AND NORTH AFRICA

BY **FARZANEH ROUDI-FAHIMI** AND **SHEREEN EL FEKI**



This report looks at young people across the MENA region and the challenges they face in their transition to adulthood, specifically their sexual and reproductive health. The report is available at www.prb.org/Reports/2011/facts-of-life.aspx.

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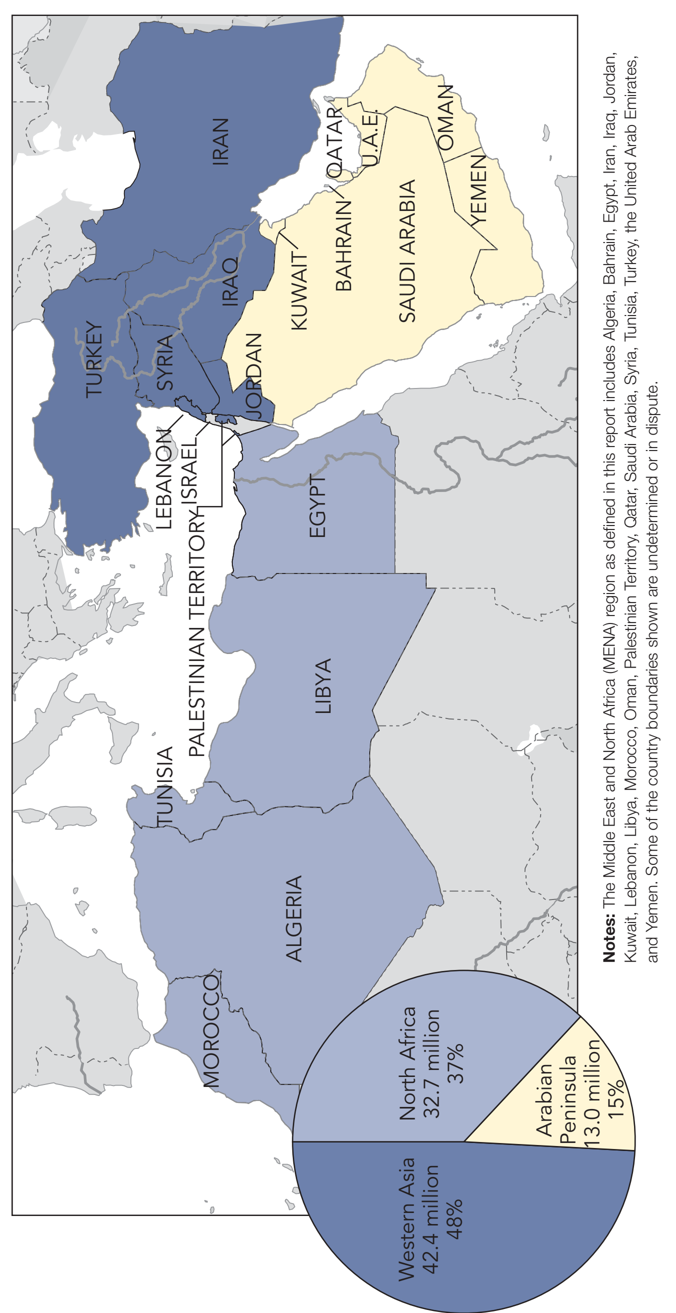


Notes: The Middle East and North Africa (MENA) region as defined in this report includes Algeria, Bahrain, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Palestinian Territory, Qatar, Saudi Arabia, Syria, Tunisia, Turkey, the United Arab Emirates, and Yemen. Some of the country boundaries shown are undetermined or in dispute.

Source: United Nations Population Division, *World Population Prospects: The 2010 Revision* (New York: United Nations, 2011).

1 BREAKING THE SILENCE ON YOUTH SEXUALITY

KEY POINTS

- Youth are physically ready to initiate sexual activity but often lack the information and services needed to protect their sexual and reproductive health.
- International agreements provide frameworks for defining and addressing young people's sexual and reproductive health needs.
- The extent to which youth achieve their full potential depends on how well governments and civil societies adapt to meet young people's needs, including their sexual and reproductive health.

One in five people living in the Middle East and North Africa (MENA) region, or nearly 90 million in 2010, is between the ages of 15 and 24, a demographic group called "youth" (see map, page 2). No longer children, but not yet independent adults, these young people are at a crucial juncture in their lives. The vast majority are physically ready to initiate sexual activity, making it critical to reach them with accurate information and accessible services to protect their sexual and reproductive health (see Box 1, page 4). All too often, however, young people's sexual and reproductive health is excluded from countries' health and development agendas, particularly in the MENA region.

Young people's lives in MENA today differ dramatically from those of their parents. In the past, the transition from childhood to adulthood took place abruptly through early marriage and childbearing. Today, however, young women and men are staying in school longer and marrying later. With puberty starting earlier, largely because of better nutrition, youth now reach sexual maturity long before they are able to act on it in a socially acceptable manner—that is, through officially sanctioned marriage. During this extended period of adolescence, young people may have sexual relationships before marriage, putting them at risk of sexually transmitted infections, unintended pregnancies, unsafe abortions, and other problems that result from largely hidden activity.

At the other end of the spectrum, a significant number of girls in some countries and communities are still marrying at a young age. These relationships, though

BOX 1

Defining Sexual and Reproductive Health and Rights

The International Conference on Population and Development (ICPD), held in Cairo in 1994, broke new ground in developing a common understanding of reproductive health. The ICPD Programme of Action defined reproductive health as: "A state of complete physical, mental and social well-being in all matters related to reproduction, including sexual health. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so." (paragraph 7.2)

Consistent with this definition, reproductive health care was defined to include:

- Family planning information and services.
- Safe pregnancy and delivery services.
- Post-abortion care.
- Abortion where it is not against the law.
- Prevention and treatment of sexually transmitted infections, including HIV.
- Treatment of reproductive tract infections.
- Information and counseling on sexuality, reproductive health, and responsible parenthood.

The Programme also called for the elimination of harmful practices such as female genital cutting and forced marriage. It also called for greater attention to men as partners in reproductive health—for men to respect women's self-determination and to share responsibility in matters of sexuality and reproduction.

While the ICPD touched on "reproductive rights," neither the Cairo meeting nor its follow-up meetings explicitly defined "sexual rights." In 2002, a technical consultation supported by the World Health Organization and the World Association of Sexology broached this sensitive topic, declaring that:

> "Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:
>
> - The highest attainable standard of sexual health, including access to sexual and reproductive health care services.
> - Seek, receive and impart information related to sexuality.
> - Sexuality education.
> - Respect for bodily integrity.
> - Choose their partner.
> - Decide to be sexually active or not.
> - Consensual sexual relations.
> - Consensual marriage.
> - Decide whether or not and when to have children.
> - Pursue a satisfying, safe, and pleasurable sexual life.
>
> The responsible exercise of human rights requires that all persons respect the rights of others."

Sources: United Nations, *Programme of Action Adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994* (New York: UNFPA, 1995); and World Health Organization, *Defining Sexual Health: Report of a Technical Consultation on Sexual Health, 28-31 January 2002 Geneva* (Geneva: World Health Organization, 2006).

out in the open, also pose significant risks to the health and well-being of young women, both at the time of marriage and throughout their lives.

Like any other aspect of life, young people's sexual and reproductive health behavior is shaped by the economic, social, and cultural context in which they are raised, including the powerful forces of religion and tradition, which set gender roles and define taboos. Parents and families strongly influence children's behavior by enforcing these social norms. At the same time, however, globalization is bringing a new dimension into people's lives, particularly those of young people, who have an enormous capacity to learn about and embrace new trends and technologies. At the click of a button, for better or worse, the Internet and satellite television expose users to a world of ideas and information beyond their immediate communities. Today's youth must now navigate two worlds—local and global—simultaneously, which they often find in conflict.

Young people's ability to produce and consume new media was amply demonstrated in the uprisings that swept the Arab world in 2011—political upheavals catalyzed by youth and the power of information technologies. Given the failure of governments in several countries to curtail access to the Internet during these events to suppress opposition, MENA countries would do better to empower youth to use new information technologies in positive ways, particularly when it comes to safeguarding their health.

Moreover, the prospect of democracy and increased participation of civil society in many countries in the region enables this generation of youth more than ever before to take part in local and national decisionmaking. MENA countries have an opportunity to involve youth—boys and girls—in development planning and programs, and allow them to articulate their needs and concerns. Such involvement of youth is particularly important when it comes to issues surrounding their sexual and reproductive health.

Investing in young people to ensure they are healthy and productive will boost nations' ability to prosper and achieve their development goals. The extent to which the region's largest youth population in history will achieve its full potential depends on how well governments and civil societies adapt to meet young people's needs. Educational systems need to give students a quality education to prepare them for the global economy; labor markets must expand to provide jobs for their new entrants; housing markets must meet the demands of couples wanting to marry; and health services must adapt to the needs of a constituency they have largely overlooked.

Such demands lay at the heart of uprisings across the region—failure to substantively address them will perpetuate further political, economic, and social instability. Sexual and reproductive rights are integral to social development, and must be included in any systematic program of reform. MENA's population, however expanding from Morocco to Iran, is diverse across and within countries in so many ways—socially, economically, and politically—that young people's sexual

and reproductive health needs must be addressed within the context in which they live.

This report looks at young people across the MENA region and the challenges they face in their transition to adulthood, specifically their sexual and reproductive health—a culturally sensitive topic for societies in MENA. The report highlights the urgency of acknowledging and addressing the needs of young people for sexual and reproductive health information and services. A few countries in the region are rising to this challenge, but many are still struggling. Failure to do so is not only a loss for today's youth, but for society as a whole for generations to come.

2 MENA'S YOUTH MOSAIC

KEY POINTS

- MENA's youth population is both large and diverse, making it essential to understand the unique needs and challenges facing youth in different communities.
- Young people stay in school longer, but many face limited job prospects and a high cost of living, which drives up age at first marriage.
- Gender inequality is deeply entrenched across the region, limiting girls' choices and opportunities.

With half the population of the region under age 25, MENA has the second youngest population among world regions, after sub-Saharan Africa. Within the MENA region, countries are diverse in terms of numbers of youth and their social and economic well-being. In Iraq, Palestine, and Yemen, where fertility (births per woman) remains relatively high, half the population is below age 20 (see Figure 1, page 8). The median age is higher in countries where fertility is lower, such as Iran, Lebanon, and Tunisia. In the Gulf countries, the median age is higher in part because of the large number of foreign nationals living there.

In 2010, the MENA region had nearly 90 million young people between the ages of 15 and 24, more than half of whom lived in three countries—Egypt, Iran, and Turkey—according to the United Nations (see Appendix 1, Table 1). The most populous country in the region, Egypt, is home to 16 million people ages 15 to 24.[1] At the other end of the spectrum, Bahrain counts only about 190,000 youth in its population. Bahraini youth are by-and-large highly literate and urban, whereas more than half of those in Egypt live in rural areas, home to most of the country's illiterates.[2] There is also tremendous variation in the economic circumstances of youth in MENA. The most extreme example is that of neighboring states in the Arabian Peninsula: Saudi Arabia's per capita income is 10 times higher than Yemen's—US$22,950 and US$2,210, respectively, in 2008 (see Appendix 1, Table 2).

Religious and ethnic diversity also characterize the region's youth mosaic. Lebanon, for example, is home to more than a half-dozen major religious sects, and several other countries in the region contain a rich mix of Sunni and Shiite Muslims as well as Christian denominations. While MENA's population largely speak Arabic, the two large populations of Iran and Turkey speak Persian and Turkish, respectively.

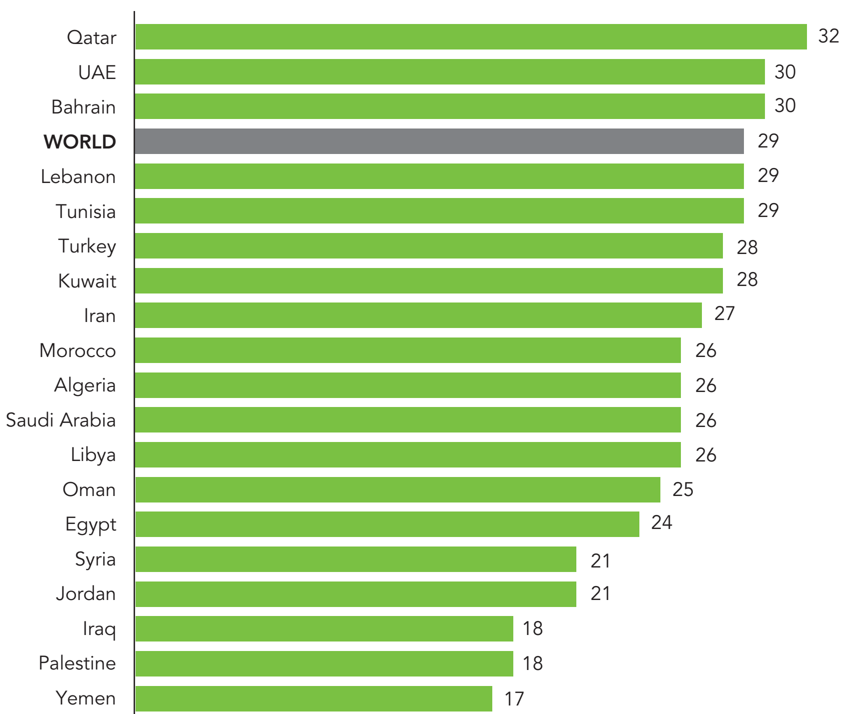
Education

Today's youth are attaining higher levels of education as school enrollment has risen markedly throughout the region. Primary education is now nearly universal, and the gap between boys' and girls' enrollment in secondary school has disappeared in most countries (see Appendix 1, Table 3). In a number of countries, including Lebanon, Libya, and Palestine, more young women than men are enrolled in secondary and tertiary (university) education. However, illiteracy and school dropout rates remain high among youth in some places. There are millions of illiterate youth in the region, three-quarters of whom are in Egypt, Iraq, Morocco, and Yemen. Two-thirds of these illiterate youth are female (see Appendix 1, Table 4).

An increasing number of programs work in underprivileged communities across the region to help girls enroll and stay in school. *Ishraq* ("sunrise" in Arabic) is a well-known program in Egypt, for example, that brings marginalized rural girls into safe learning spaces and seeks to improve their educational, health, and social opportunities. *Ishraq* seeks to delay marriage by encouraging formal school attendance. The program is

FIGURE 1

Median Age in MENA Countries, 2010



Source: United Nations Population Division, *World Population Prospects: The 2010 Revision* (New York: United Nations, 2011).

located in youth centers as a way of improving girls' access to public spaces and visibility in the community. Its curriculum emphasizes literacy and life skills with special attention to reproductive health, civic engagement, information on livelihoods, and sports. Aware of the cultural sensitivities surrounding their efforts, *Ishraq* leaders work carefully with parents and the community to gain permission for girls to participate. The program mobilizes the entire community and helps set the stage for an environment conducive to social change.[3]

Education is key to girls' and women's well-being and empowerment for a number of reasons. Girls who are enrolled in school are less likely to marry and start childbearing at a young age, and they have the opportunity to socialize and see alternative role models in teachers and peers. Modern education encourages new ways of thinking about social issues and gender norms based on individual rights and equality between men and women. As girls grow up, education also provides opportunities for work outside the home and economic independence. More-educated women generally have fewer children and are also more likely to obtain health care for themselves and for their children.

The School-To-Work Transiton

While enrollment in secondary and higher education has reached unprecedented levels for both girls and boys, it has not translated into higher employment rates and wages for the region's youth. This is in part because educational systems have been ill-resourced and rudimentary and geared toward preparing students to serve in the public sector, which used to be—but is no longer—the primary employer of new graduates. As the region's growing market economies adopt new technologies and become more integrated into the world economy, the demand for modern skills is increasing, making much of the material taught in public school systems in MENA obsolete. Studies of the school-to-work transition in Egypt and Syria show that young people face serious challenges in finding employment because of their lack of appropriate education and the scarcity of jobs relative to new entrants in the job market.[4]

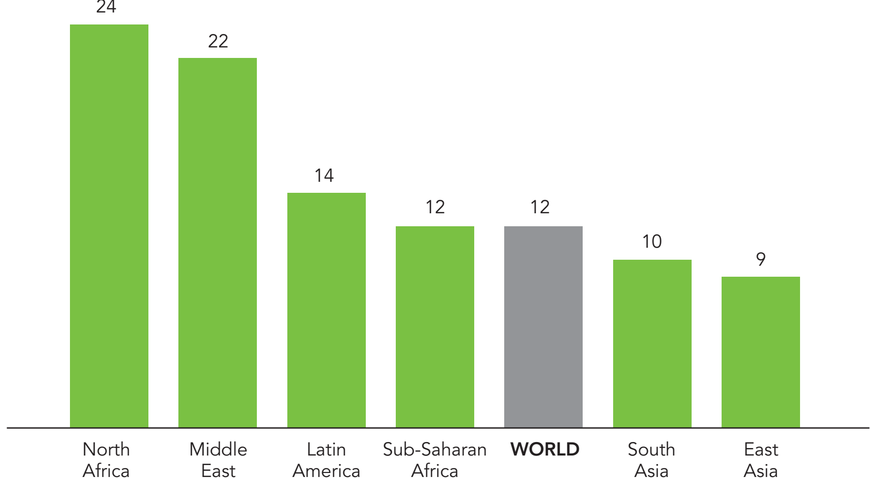
The tough job markets have led MENA's youth to experience the highest rate of unemployment in the world. More than one in five of MENA's youth who were in the labor force in 2008 were looking for a job, twice the world's average (see Figure 2a, page 10). Moreover, youth in MENA have always had the lowest rate of labor force participation in the world (see Figure 2b, page 10), partly due to women's low participation in the labor force and partly due to discouraged youth—both male and female—leaving or not even entering the job market in the first place. On average, only one-third of youth in MENA are in the labor force, compared to half of youth in the world. Job prospects are particularly dim for young women, who are more likely than young men to be unemployed.

Without a steady income, many young men lack the capital to marry and support a family, which puts the only socially accepted context for sexual and reproductive life out of reach. Even employed youth rarely earn enough to be economically

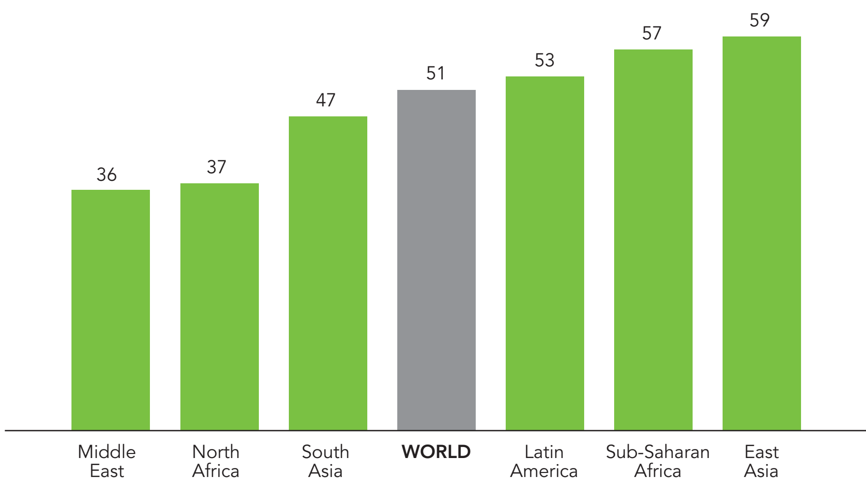
FIGURE 2

Youth Unemployment and Labor Force Participation Rates in Selected World Regions

2a Percent of Youth Ages 15-24 in the Labor Force Who Were Looking for a Job, 2008



2b Percent of Youth Ages 15-24 Who Were Participating in the Labor Force* in 2008



*Youth who either have a job or are looking for one.

Note: As defined by the ILO, the North Africa region includes Algeria, Egypt, Libya, Morocco, Sudan, and Tunisia; and the Middle East region includes Bahrain, Iran, Iraq, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Syria, the United Arab Emirates, and Yemen.

Source: International Labour Organization, *Global Employment Trends: January 2010* (Geneva: ILO, 2010): tables A3 and A9.

self-sufficient because of low wages, thereby perpetuating their dependence on families and further constraining their sexual development and exploration.[5] This financial dependence is pronounced in the case of young women: One nationally representative study of Tunisian youth ages 15 to 24, for example, found that almost three-fourths of women, and more than one-third of men, relied on their parents for pocket money.[6]

Changing Marriage Patterns

Early marriage is no longer universal, as more women are marrying later and some may not marry at all. Changing marriage patterns reflect broader social and economic changes taking place throughout the region. More people are living in urban areas and adopting modern lifestyles, young people are staying in school longer, and young women are more likely to work outside the home in paid jobs. The age at first marriage has increased most markedly in Libya and Tunisia, where today only 1 percent of young women ages 15 to 19 are married (see Appendix 1, Table 5). In Tunisia, on average, women marry at age 27 and men at age 32.

Despite the overall trend toward later marriage, early marriage is still common among some groups. Traditional values about protecting girls' virginity and family honor, as well as household economics, play a major role in some families' decisions to arrange marriages for their daughters at young ages. Early marriage is most prevalent in Egypt, Iraq, Iran, Morocco, Syria, and Yemen. The 2009 Survey of Young People in Egypt showed that 12 percent of young Egyptian women ages 15 to 17 were engaged and an additional 2 percent were already married. Also, 38 percent of women ages 18 to 24 were married and 14 percent were engaged.[7] A change in the law in Egypt in 2008 made it illegal to marry before age 18. In Yemen, where child marriage—marriages below age 18—is prevalent, human rights and women activists are still pushing Parliament to pass such a law.[8]

In general, early marriage leads to early childbearing, as culture and tradition encourage newly wed women to become pregnant as soon as possible. According to the 2008 Egypt Demographic and Health Survey, 24 percent of 19-year-old Egyptian women have begun childbearing—that is, they are either pregnant or have already given birth. This percentage is lower in Morocco and Jordan, where 15 percent and 10 percent of 19-year-olds, respectively, have begun childbearing. But these national averages mask the extent of early childbearing among some groups. In Egypt, young women age 15 to 19 in the poorest fifth of the population are more than twice as likely as those in the richest fifth to have begun childbearing (see Figure 3, page 12). Early childbearing poses serious risks to the health and welfare of mothers and children alike.

ALTERNATIVE FORMS OF MARRIAGE

As an increasing number of young men and women delay marriage, new sexual norms and forms of marriage are emerging, such as *urfi* marriage in Egypt and other parts of the region. These marriages are undertaken to avoid the difficul-

ties of a standard marriage and to give sexual relationships some Islamic legitimacy. However, the young people involved in such marriages are often at odds with their families and society at large, because of the secrecy surrounding their relationships. Also, because these marriages take place in secret, no one knows the extent to which young men and women are having sexual relations outside of conventional marriages. Anecdotal evidence suggests that such relationships, while a minority practice, may well be on the rise.[9]

Generation in Waiting

In MENA, marriage is the gateway to adulthood and greater independence from parents because, in most communities, it is socially unacceptable for young people—particularly young women—to live on their own before marriage. Therefore, matrimony and starting a family are key steps on the road to full social inclusion. But an increasing number of young people today remain unmarried throughout their 20s and well into their 30s. Societies have yet to adapt to the needs for sexual and reproductive health information and services for this growing group of young people.

FIGURE 3

Percent of Young Women Ages 15-19 Who Are Pregnant or Already Have Given Birth, by Wealth Quintile in Selected Countries

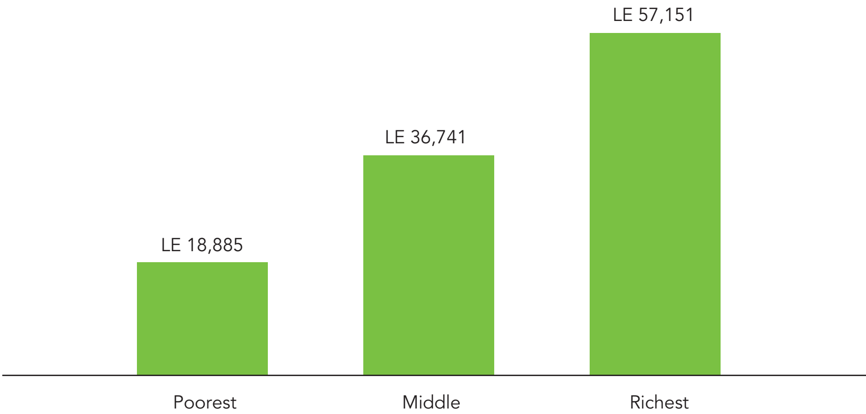
Note: Wealth quintiles (five groups of equal size) were created using an index of household assets. The first, third, and fifth quintiles are shown here.
Sources: Fatma El-Zanaty and Ann Way, *Egypt Demographic and Health Survey 2008* (Cairo: Ministry of Health, El-Zanaty and Associates, and ICF Macro, 2009); Ministere de la Sante DPRF/DPE/SEIS, ORC Macro, and Project PAPFAM, *Morocco Demographic and Health Survey 2003-04, Final Report* (in French) (Rabat, Morocco: Ministere de la Sante DPRF/DPE/SEIS, 2005); and Jordan Department of Statistics and ICF Macro, *Jordan Population and Family Health Survey 2009* (Calverton, MD: ICF Macro, 2010).

The high costs of marriage and housing, along with high rates of unemployment, are often cited as reasons for the rising age of marriage in the MENA region. In countries such as Egypt and the oil-rich Gulf states, marriage is a considerable economic burden on families, as they need to finance costly celebrations, dowries, jewelry, housing, and furniture. The most comprehensive analysis of the cost of marriage and its impact on the timing of marriage comes from Egypt. The latest youth survey in Egypt shows that the average cost of marriage for those who married over the past decade or so was around LE 35,000 (about US$6,400 in 2009), excluding housing, which typically is the most significant part of marriage costs.[10] The survey also shows that, on average, the richest families spend three times the amount that the poorest spend on marriage (see Figure 4).

Nearly all young people in Egypt live with their parents until marriage, and parents are expected to feed, clothe, and house their children until they marry. Parents are also expected to pay for the bulk of marriage costs. In a typical marriage in Egypt, the families of the bride and groom, and the groom himself, each contribute one-third of the cost. For an urban, upper-class groom, his part amounts to an average of 52 months of earnings, as compared to 24 months for a groom living in rural areas, according to one study.[11] The study suggests that consanguineous marriage (marriage between relatives) reduces this financial burden by about 25 percent. Such economic benefits in part explain the persistence of consanguineous marriage in Egypt (one-fourth of all marriages), despite the known health risks to offspring of such unions and greater opportunities that young people have today to meet prospective spouses outside their family network.[12]

FIGURE 4

Average Cost of Marriage (in Egyptian pounds), Excluding Housing, for Young Married Egyptians Below Age 30 in 2009, by Wealth Quintile



Note: Wealth quintiles (five groups of equal size) were created using an index of household assets. The first, third, and fifth quintiles are shown here. (One US dollar was around 5.5 Egyptian pounds in 2009.)
Source: Population Council, *Survey of Young People in Egypt, Final Report, 2010* (Cairo: Population Council, 2010).

Gender Inequality

The MENA region is known for its rigid gender roles—the social roles assigned to men and women—that add to the challenges facing young women. Gender inequality has perpetuated harmful traditions such as female circumcision (also called female genital cutting), which involves the removal of part or all of the female genitalia. It has no medical or religious justification. A cultural practice that renders girls "marriageable," female circumcision poses both physical and mental health risks for girls and violates their right to bodily integrity. While it is not practiced in most parts of MENA, and it is declining in certain populations, the practice still touches the great majority of girls in Egypt and about one-third in Yemen.

Social norms that discriminate against women and limit their life choices exist worldwide, but the MENA region is distinguished by pervasive gender-based discrimination codified in family law, commercial and criminal codes, and laws governing political participation. Although countries vary greatly and there have been improvements on all of these fronts across the region, societies have a long way to go to achieve gender equality.

TABLE 1

MENA Countries' Ranking on the Global Gender Gap Index, 2010

COUNTRY	OVERALL	ECONOMIC PARTICIPATION AND OPPORTUNITY	EDUCATIONAL ATTAINMENT	HEALTH AND SURVIVAL	POLITICAL EMPOWERMENT
UAE	103	120	37	110	60
Kuwait	105	107	83	110	114
Tunisia	107	122	94	109	67
Bahrain	110	115	60	110	120
Lebanon	116	124	91	1	127
Qatar	117	116	74	126	131
Algeria	119	119	99	106	123
Jordan	120	126	81	87	117
Oman	122	129	90	61	128
Iran	123	125	96	83	129
Syria	124	130	104	60	107
Egypt	125	121	110	52	125
Turkey	126	131	109	61	99
Morocco	127	127	116	85	103
Saudi Arabia	129	132	92	52	131
Yemen	134	134	132	81	130

Source: World Economic Forum, *The Global Gender Gap 2010* (Geneva: World Economic Forum, 2010): table 3b.

The World Economic Forum has tracked and quantified the magnitude of gender-based disparities among countries around the world since 2006. In its most recent report, *The Global Gender Gap 2010*, MENA countries are once again clustered at the bottom of the rankings.[13] The Global Gender Gap Index examines differences in the status of men and women in four key categories: economic participation and opportunity, educational attainment, health and survival, and political empowerment (see Table 1, page 14). Overall, all MENA countries were ranked 103 or below, which means that 102 countries outside the MENA region fared better in terms of gender equality. Yemen came in last.

This gender gap reflects a lingering patriarchy that characterizes societies in the MENA region. When it comes to sexuality in MENA, double standards are the rule. Although the region's major religions condemn sex outside of marriage for both sexes, a blind eye is turned when men transgress, whereas society is far less forgiving where women are concerned—an intolerance enshrined in law. At home, this double standard finds powerful expression in the concept of "family honor," which largely depends on the social and sexual behavior of female family members. Honor remains one of the most powerful values for youth in MENA and serves to justify male regulation of female life, resulting in constraints on women's physical mobility and employment opportunities.

Wired to the World

While youth in MENA are strongly attached to customs and tradition, they are also increasingly exposed to new ideas in the world beyond their physical borders. By far the most popular medium is TV. More than 80 percent of people in MENA have access to satellite television, and watching TV—particularly entertainment and movies—is the leading form of recreation for youth in most countries in the region. In Egypt, for example, young women watch an average of more than two hours of TV a day.[14] Foreign programs and homegrown entertainment such as music videos, expose young people to different norms of sexual behavior.

The Internet is another window on the world for youth in MENA. Usage varies greatly across the region. People living in the United Arab Emirates are the most avid Internet users in the region—66 percent of households have access to the Internet (see Appendix A, Table 2). In Egypt, less than 10 percent of youth use it daily. The real-world gender divide of MENA crosses into cyberspace as well. Whereas the majority of young Egyptian men surfing the Web do so outside the home, most young women who use the Internet do so under the vigilant eye of the family at home.

When it comes to sex, the Internet is a mixed blessing. Although evidence remains sketchy, emerging research shows the avid consumption of pornography by some Arab youth.[15] Nonetheless, the Internet offers an effective means of communicating key messages on sexual and reproductive health that would be difficult to transmit through traditional channels.

Mobile phones are also breaking down traditional barriers. As with Internet use, access varies greatly across MENA. Mobile phones have a particularly significant effect on the lives of young women, bringing the public world into their private sphere

and allowing them to transcend some of the restrictions on their mobility and activity. While mobile phones are seen in some quarters as a source of danger and temptation to youth, their potential for education and empowerment on sexual and reproductive health, as well as on other life issues, is now starting to be explored.

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3 THE BIG PICTURE: POLICIES ON YOUTH SEXUAL AND REPRODUCTIVE HEALTH

KEY POINTS

- International agreements have created a common language for discussing sexual and reproductive health (SRH) issues and frameworks for addressing youth SRH needs.
- In the MENA region, policies addressing young people's SRH are still in their infancy.
- Regional agreements call on governments and civil societies to uphold the rights of young people to age-appropriate SRH information.

Despite advocates' urgent calls for educating young people about sexual and reproductive health and providing services to those in need, most countries in the MENA region have yet to place priority on these issues—a hesitation that stems in part from the cultural sensitivities surrounding sexuality in general, and youth sexuality in particular. As a consequence, progress on youth SRH has been modest and inconsistent. A few countries, however, such as Tunisia, Morocco, Yemen, Turkey, and Iran, have begun to focus on youth SRH issues, using international policy frameworks to map out their approach. This chapter explores selected international agreements, as well as regional declarations and national policies that relate to youth and SRH.

International Conference on Population and Development

The International Conference on Population and Development (ICPD), held in Cairo in 1994, laid the groundwork for today's policies on the SRH of young people (see Box 1, page 4).[1] ICPD was a landmark event, and its *Programme of Action*, also known as the Cairo Consensus, was the first global policy document to use the term "reproductive health." It was also precedent-setting in making women's rights and reproductive health central to social and economic develop-

ment, and in addressing the reproductive health needs of young people. Focusing on human development, the program calls for a wide range of investments to improve health, education, and rights—particularly for girls and young women. Since 1994, youth advocates, health professionals, and governments around the world have worked to translate the goals of the Cairo conference into national policies and action plans (see Box 2, page 19).[2]

The ICPD *Programme of Action* calls on countries "to meet the needs and aspirations of youth" and to involve them in planning, implementing, and evaluating development activities that have a direct impact on their daily lives.[1] It notes that: "This is especially important with respect to information, education, and communication activities and services concerning reproductive and sexual health, including the prevention of early pregnancies, sex education and prevention of HIV/AIDS and other sexually transmitted diseases. Access to, as well as confidentiality and privacy of, these services must be ensured with the support and guidance of their parents and in line with the Convention on the Rights of the Child." (paragraph 6.15)

Delegations from the MENA region (and Muslim countries outside the region) attending the Cairo Conference generally endorsed the *Programme of Action*, but many expressed reservations to statements supporting youth SRH and women's empowerment, noting that they would interpret the ICPD recommendations in accordance with Islam and national laws. The *Programme of Action* acknowledges that the implementation of its recommendations "is the sovereign right of each country, consistent with national laws and development priorities, with full respect for the various religious and ethical values and cultural background of its people."

Human Rights and Youth SRH

A number of international human rights conventions and covenants touch on aspects of youth SRH that MENA countries can draw upon in setting strategies to meet the SRH needs of young people.

CONVENTION ON THE ELIMINATION OF DISCRIMINATION AGAINST WOMEN

Adopted by the UN General Assembly in 1979, the Convention on the Elimination of Discrimination against Women (CEDAW) has become the major international agreement defining the rights of girls and women.[3] Article 1 of the convention defines discrimination against girls and women as: "Any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."

Dealing with all aspects of girls' and women's lives, including education, health, employment, and political participation, CEDAW requires governments to condemn all forms of discrimination against girls and women and pursue all appropri-

BOX 2

International Year Of Youth

The United Nations has declared the year from August 2010 to August 2011 as the International Year of Youth: Dialogue and Mutual Understanding, spotlighting the "World Programme of Action for Youth to the Year 2000 and Beyond," first adopted in 1995 and developed further since then. The World Programme of Action for Youth calls on governments to implement ICPD's recommendations related to youth SRH by involving youth and relevant organizations. It recognizes that the reproductive health needs of young people have largely been ignored by existing health services and points out: "It is the indispensable responsibility of each government to mobilize the necessary awareness, resources and channels" to ensure young people's access to basic health services that are based on equality and social justice.

ate means to eliminate it. This includes not just overturning discriminatory laws, but also changing harmful cultural stereotypes and practices and introducing gender-sensitive laws and policies.

All MENA countries (except for Iran) have ratified the convention, with reservations. But there has been little progress in implementing it because aspects of the convention are perceived to contravene Shariah—Islamic laws. From Muslim countries' perspective, the most contentious parts of the convention are those that call for equal rights for men and women in certain domains, such as inheritance and divorce, and those dealing with the right of unmarried women to access SRH information and services.[4] However, there have been a few successes in other areas where it has been easier to give women equal rights. After years of struggle, women activists in Egypt, for example, have succeeded in pressuring their judicial system to reform laws to give women the right to transfer their nationality to their children when the father is a foreigner. Tunis and Turkey are the only countries in the region with secular laws governing their family codes.

CONVENTION ON THE RIGHTS OF THE CHILD

Adopted in 1989, the Convention on the Rights of the Child (CRC) is a legally binding international instrument for the welfare of children—defined as those under age 18. The convention covers the full spectrum of human rights, including the right to survival; to full development; to protection from harmful influences, abuse, and exploitation; and to full participation in family, cultural, and social life. Also explicit in the convention are the rights of children to be protected from hazards of female genital cutting, child marriage, and sex trafficking. CRC stresses that all children have the same rights, and all rights are interconnected and of equal importance.

Nearly all governments in the world have ratified or acceded to the convention.[5] MENA countries have generally done so, again by expressing reservations that they interpret CRC's standards according to their national and Islamic laws. Nonetheless, MENA countries are increasingly adopting CRC's standards. In 2008, for example, Egypt raised its legal minimum age of marriage for women from 16 to 18—a CRC requirement—making it equal to the legal minimum age for men.

The Millennium Development Goals

The Millennium Development Goals (MDGs) grew out of the 2000 United Nations Millennium Summit, when leaders from around the world made a commitment to combat poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women.[6] The MDGs are routinely used in international, regional, and national policymaking and planning, and to track countries' progress toward development. There are eight, interrelated and time-bound goals:

- Eradicate extreme poverty and hunger.
- Achieve universal primary education.
- Promote gender equality and empower women.
- Reduce child mortality.
- Improve maternal health.
- Combat HIV/AIDS, malaria, and other diseases.
- Ensure environmental sustainability.
- Develop a global partnership for development.

Nearly all MDGs touch on areas that affect youth in one way or another, making the well-being of young people central to any national MDG-related policy. Moreover, youth SRH is key to achieving development goals.

Declarations and Strategies in the Arab World

The League of Arab States has led efforts to establish regional policies and strategies in the areas of population and development and youth well-being in the Arab world, defined in this context as the 22 member states of the league. Over the past decade, the League of Arab States has collaborated with the UN Economic and Social Commission for Western Asia (ESCWA), United Nations Population Fund (UNFPA), International Planned Parenthood Federation (IPPF), and other international development agencies in convening a series of population and development forums for Arab parliamentarians, heads of national population councils, and other high-level officials.

These efforts have resulted in a number of Arab declarations on population and development, as well as on youth. Some of the declarations include the SRH issues addressed in international agreements, especially the ICPD Programme of Action.[7] The declarations call on Arab governments and civil societies to:

- Narrow gender gaps and achieve equity between men and women in education, employment, and political participation.
- Provide universal access to reproductive health services.
- Provide adolescents and youth—both in and out of school—with information on reproductive health in age-appropriate language.
- Collect data on youth and establish databanks and networks for information sharing.
- Engage youth in drafting and planning policies and programs affecting them.

How effective the Arab declarations have been in improving youth SRH is debatable. The declarations have rarely been followed by either action plans that guide governments on practical matters or by systems for monitoring countries' progress. Moreover, in individual countries, the turnover of agency heads responsible for setting policies and implementing action plans has generally been high—even before political upheaval began sweeping the region. Thus, it has generally been difficult to sustain efforts and produce results at the regional or national levels.

National Youth Policies and Strategies Related to SRH

Only in recent years have youth issues appeared on national policy agendas in the MENA region. Ministries of youth exist in a number of countries, but their programs more often than not focus on sports. For example, the Ministry of Youth and Sports exists in Algeria, Bahrain, Lebanon, Morocco, Palestine, and Yemen. In Egypt, the Ministry of Youth is a stand-alone ministry within which a Supreme Council for Youth and Sports coordinates national youth policy along with other youth-centered ministries and nongovermental organizations. In other countries, youth ministries are paired with other ministries such as culture (Jordan and Qatar) and education (Oman).[8]

In general, stand-alone programs on youth are not likely to be sufficient. Youth issues cut across a number of sectors (such as education, health, culture, planning, labor, justice, and social affairs), making it imperative for institutions to coordinate and cooperate when it comes to national youth programming. In 2001, Jordan replaced its Ministry of Youth and Sports with a Higher Council for Youth to lead such efforts and coordinate among several ministries in advancing its national youth policies and programs.

In 2004, UNESCO organized a Regional Seminar on National Youth Policies for the Middle East and North Africa, with the aim of sharing experiences in developing and implementing national policies. The seminar highlighted the lack of unity in the visions for youth development among the participating countries; there were even different interpretations of the definition of "youth."

Overall, policies and strategies addressing youth SRH are few and fragmented in the region. They tend to be part of national directives and strategies that address health or youth issues in general but do not necessarily recognize youth SRH as

a priority.[9] Morocco and Yemen stand out for having clear and detailed focus on youth SRH in their official national policy documents.[10]

While adopting national policies and strategies is important, what matters most is whether the content of the policies is well-defined and has action plans, and whether countries are able to establish the necessary mechanisms and well-funded institutions for successful implementation. Egypt, for example, has a number of important policies affecting adolescents, such as making age 18 the minimum legal age of marriage for girls, but the policies are not fully implemented because of a lack of operational coordination among official institutions.[11]

Today, as they are embracing political reforms, MENA countries have an opportunity to build on their past experiences and those of the international development community to advance policies that truly address the needs of today's youth, ensuring their health and well-being. The good news is that political support and commitment to youth SRH appear to be growing throughout the region and can help accelerate action.

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4 CAUGHT BETWEEN BIOLOGY AND SOCIETY: YOUNG PEOPLE'S KNOWLEDGE, ATTITUDES, AND SEXUAL BEHAVIOR

KEY POINTS

- Young people receive little education on sexual and reproductive health issues, relying largely on their peers for information.
- Because of social disapproval of sexual relations outside of marriage, survey data on young people's sexual activity are limited.
- In the few countries where surveys have been conducted, a majority of young men and a small minority of women report having sexual relations before marriage.

Sexuality and reproduction are important parts of life and should be sources of pleasure and fulfillment. In MENA, matrimony—that is, religiously sanctioned, family-recognized, and state-registered marriage—is the only socially accepted context for sexual and reproductive life. But what about those who are not married? Are they able to exercise sexual rights, defined as the ability to pursue a satisfying, safe, and pleasurable sexual life, when and with whom they choose, free of coercion, discrimination, and violence? (see Box 1, page 4)

These are pressing questions for youth living in MENA, for which there are no clear answers. Anecdotes still outnumber empirical evidence about sexual knowledge, attitudes and, crucially, the behaviors of young people in the region. However, with the emergence of HIV/AIDS in MENA, the door has been opened for public health experts to initiate small-scale studies and larger national-level surveys of young people and ask previously unacceptable questions. Some studies have also surveyed previously unreachable groups—men who have sex with men, sex workers, injecting drug users, street children, prisoners, and other people living at the margins of society.

This chapter presents key findings of some recent studies on youth knowledge, attitudes, and behavior related to sexual and reproductive health. It is drawn in large part from a forthcoming report on youth in the Arab world by UNICEF and the Issam Fares Institute at the American University in Beirut.

Knowledge, Attitudes, and Sources of Information

While a number of large-scale youth surveys have been conducted in the region, they have largely omitted questions about youth sexuality, particularly in more-conservative communities. The surveys described in this chapter do shed light, however, on what young people know and where they get their information.

Egypt's 2009 survey of more than 15,000 people ages 10 to 29 nationwide found that less than 15 percent of boys and 5 percent of girls got their information on puberty in school.[1] Around three-fifths of young women cited their mothers as their main source of information; less than 10 percent of young men spoke to their relatives about puberty. More-educated, wealthier, and urban youth were more likely to talk to their parents, although school seemed equally uninformative across socioeconomic groups. More than half of young men and one-fourth of young women mainly relied on friends for information. Less than 20 percent of young men turned to movies for information, and less than 5 percent to religious figures. The Internet barely figured as a source of information. These proportions were significantly lower for young women across the board. In this information vacuum, girls are particularly at risk: Two-thirds reacted with shock or fear to their first menstrual cycle. Almost half of the young men and women surveyed said they were dissatisfied with the information they had received; this proportion was greatest among those getting information from their friends. Around 10 percent of men and less than 5 percent of women believed that young women should be left in the dark about puberty.

Lebanon's 2005 survey of more than 5,000 students ages 13 to 15 found that 80 percent had never spoken to their teachers about reproductive and sexual health, and around 70 percent were silent on the subject with their parents as well.[2] Almost half of students surveyed wanted to see sexual and reproductive health discussed in school: One-fourth preferred the information around the time of puberty, and just under one-third thought it would be best covered in sex-segregated classes. Only one-third of students had learned from school how to avoid HIV infection, and three-fifths knew how to rebuff an unwanted sexual advance. Male students, particularly those in private schools, were more in favor of sexual and reproductive health education in schools, and they were more likely to ask teachers about such topics. More than 60 percent of female students did not broach such matters with their parents, and more than four-fifths never raised the issue with teachers.

Morocco's 2007 study of 2,000 youth ages 15 to 24 found that around three-fourths of young men and women claimed they had enough information on

puberty in general, and its sexual aspects in particular.[3] Two-fifths of youth cited teachers as a source of information on changes in puberty. Half of young men also cited friends, while around 30 percent of the young women in the study turned to friends or parents for this information. On sexual issues, however, more than three-fourths of men and just under one-half of girls relied on friends for details. Despite their self-declared satisfaction with the amount of information they received, one-fourth of young women surveyed were completely surprised by the changes their bodies underwent in puberty, compared with less than 5 percent of men.

More than one-fourth of young women saw family and the media as the most desirable sources of information on puberty and sexuality, closely followed by the Internet; other sources, such as friends and school, barely registered. For young men, however, the media and street life were by far their preferred sources of information. More than three-fifths of youth considered sexually transmitted infections and AIDS to be the most important subjects to understand; other issues such as family planning, reproduction, or sexual desires or preferences were seen as less important. While urban women showed a greater interest in information about HIV than their rural counterparts, other preferences related to information varied little according to location.

Among behavioral changes that Moroccan youth associated with puberty, more than 60 percent of young men, but only about 5 percent of women, cited an urge toward sexual activity. More than half of men and women thought it was acceptable for unmarried men and women to go out with one another. However, they drew the line at sexual activity. More than 70 percent of young men and 90 percent of women disapproved of sex outside of marriage; only one-fourth of the men surveyed and less than 5 percent of the women agreed that premarital sex could help couples get to know each other. More than 80 percent of men and women thought girls should remain virgins until marriage, and more than 75 percent thought that girls who have sex before marriage would regret their actions and would no longer be respected by men. As for male virginity, two-fifths of boys and just over one-third of girls thought men should refrain from sex before marriage, and a slightly smaller percentage of each thought those who failed to refrain would regret it.

Behaviors and Practices

A limited number of surveys shed light on young people's sexual behavior. One of the clearest pictures of youth sexual behavior comes from **Tunisia**, where several large-scale surveys have been conducted over the past decade. One of the most comprehensive of these, conducted in 2009, surveyed 1,200 unmarried out-of-school youth ages 15 to 24 from across the country.[4] Almost two-thirds of the young men surveyed considered sexuality an important aspect of life; their female counterparts were less enthusiastic, with more than one-fourth crediting it with little importance. This emphasis translated into greater ease among men in discussing sexual matters, around 75 percent of whom said they talked about

sexual issues, compared with just under 60 percent of young women. The majority of both sexes talked about sexual issues with their friends; around 10 percent or less discussed such matters with their parents.

More than 70 percent of the young men surveyed said their friends were having sex outside of marriage, the majority with multiple partners; just over one-fourth of the young women reported the same, mainly with a single partner. These proportions were higher among urban than rural youth. When it came to their own sexual experience, one-third of men under age 20, and more than three-fifths ages 20 and over, declared some sexual activity. These figures were just under 10 percent for women under 20 and just over 15 percent for women over 20. Again, urban youth were more likely than their rural peers to report sexual experience. Three-quarters of the sexually active youth surveyed made their sexual debut between ages 15 and 19, with around 10 percent beginning sexual activity before age 15; around two-fifths had their first sexual relation with someone roughly their own age.

Just under 5 percent of the sexually active men volunteered that they had experience of homosexual anal relations, although the question was not directly asked. More than one-third of the sexually active men, and just over one-tenth of their female peers, reported exchanging money for sex in the past year; whether this involved giving or receiving was not determined.

In **Lebanon**, asking high school students about their sexual behavior is culturally too sensitive, but it is less sensitive among university students. A 2005 study of more than 1,400 unmarried students from campuses across the country found that almost half of men but less than 20 percent of women reported a previous sexual relationship with vaginal penetration.[5] Of those who reported having sex, two-thirds of men said they used contraception (mainly condoms), but only one-fourth of the women reported using contraception (mainly oral contraceptives). One-half of the sexually active women said they would turn to abortion if they became pregnant. The most common places for sex were at home when the parents were away, in a car, or at a beach house; 15 percent said they had sex when their parents were at home.

What the Research Tells Us

While these studies are illuminating to policymakers, academics, activists, and others seeking information about young people's sexual lives, they are also isolated, making it difficult to generalize about regional trends. That said, a few observations can be made.

Young people are mainly in the dark about SRH. Access to sexual information and sexual health services remains limited for young people across the region, as reflected by low levels of accurate knowledge (even where self-declared satisfaction is high) and low use of contraception, including condoms. Although survey data are scarce for most countries in the region, the consequences of this lack of knowledge are apparent: undiagnosed sexually transmitted infections, unwanted pregnancies, abortion (which remains illegal in most

countries in all but limited circumstances), and out-of-wedlock births. The deficit in knowledge and access to services persists even in countries that have made concerted efforts to reach out to youth, such as Tunisia (see Chapter 6). This is more than a question of youthful ignorance or indolence. The extreme stigma attached to sex outside of marriage and the social pressure to conform make young people reluctant to talk to those in a position to provide reliable information or to plan ahead to protect themselves in such relations.

Gender, not rural-urban residence, makes the difference. Although attitudes and behaviors vary somewhat between rural and urban youth, these differences are not as great as in generations past, as greater education, media exposure, migration, and other factors have brought about a convergence between country and city. Gender is the dividing line in knowledge, behavior, and practices, as illustrated in the case of virginity. While the premarital sexual activity of young men is seen as more-or-less inevitable, young women are expected to refrain until marriage.

An array of physical and social restrictions is placed on young women to ensure that they do not have intercourse and thus present an intact hymen upon marriage. To meet this expectation, some young women may engage in hymen repair or anal sex, exposing them to substantial health risks. Girls and young women across the region generally have less information than young men about sex, less ability to speak about it, less negotiating power to protect themselves in the event of unplanned sexual relations, and less chance of remedying the consequences.

Because of social disapproval, unmarried women are reluctant to admit having sexual relations. Indeed, any socially stigmatized sexual behavior—same-sex relations, sex work, exposure to sexual violence—is undoubtedly underreported in surveys. In general, probing these delicate points is better done with in-depth, one-on-one interviewing than with focus groups or large-scale surveys. This more-personal approach may lack the statistical power of a survey but it provides greater insight on sensitive issues.

Sexual activity can be risky. The studies cited above and other research show that a significant proportion of young men, and some young women, are engaged in some form of transactional sex (sex in exchange for money or gifts), either by choice or coercion. To better serve these young people, more research is needed on both the providers and clients of such part-time prostitution. More work is also needed to understand the risk factors associated with unsafe sex, including substance use. Despite religious prohibitions, alcohol and drugs are fact of life for some young people in MENA. In Morocco, for example, 10 percent of young men and 4 percent of young women admit to drinking alcohol; 16 percent of men and just under 2 percent of women report experimentation using illegal drugs.[6] Just under one-half of these men and one-fifth of the women say they look for (by-and-large unprotected) sex after using drugs, making sexual activity all the more hazardous.

Sexual harassment is common. In Lebanon, sexual harassment was reported by just under 20 percent of male students, and just over 15 percent of their female peers.[7] In Egypt, more than 60 percent of young women ages 10 to 29 in urban areas say they have been sexually harassed, mainly in the form of verbal abuse by strangers; around half of those experiencing harassment kept it to themselves.[8] These figures, and those from other studies, are likely underestimates, given the tremendous social pressure on young people to remain silent. More research is needed to investigate all forms of sexual abuse involving young people, including sexual violence (rape and incest), to better shape the emerging efforts to address these issues.

Research on youth sexuality in MENA is still in the early phase of establishing a baseline of information about knowledge, attitudes, and behaviors among diverse populations. The next frontier is to fully examine the forces shaping these elements—including religion, law, economics, education, family, and the media—to advance efforts already underway in some countries to address young people's needs. At the moment, there are more questions than answers regarding the sexual lives of the region's youth. However, a new generation of researchers, supported by philanthropic organizations, is ready and able to ask these tough questions. What has been lacking is political and societal backing. To move forward, the new political order emerging in the region will need to provide freedom and support to these researchers.

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5 STANDING UP AND SPEAKING OUT: INFORMING YOUNG PEOPLE ABOUT SEXUAL AND REPRODUCTIVE HEALTH

KEY POINTS

- Schools are an important venue for informing young people about sexual and reproductive health.
- Peer education is an effective way to increase knowledge and encourage positive behaviors by engaging young people as communicators and audience members.
- Nongovernmental organizations can fill important gaps by reaching out to young people where government programs cannot.

The MENA region is known for strong family values and conservative cultures that, for the most part, benefit and protect young people. But these same norms can become barriers to informing young people about sexual and reproductive health (SRH), including the health hazards of unplanned and unprotected sexual relations. Having informed discussions on these issues is no easy task because of an unfounded belief that talking openly about SRH issues might encourage unmarried youth to have premarital sex. In fact, reviews of sexuality education programs worldwide show that they generally do not encourage early sexual activity. On the contrary, if done right, the programs can delay first intercourse and lead to more consistent contraceptive use and safe sexual practices.[1]

In spite of good intentions, limiting young people's access to information can actually increase their vulnerability to health problems. Better informed young women and men—whether sexually active or not—are more empowered to protect themselves against sexual health risks. But youth are often reluctant to ask elders for details, fearing suspicion of illicit activity. Elders, on the other hand, may wish to discuss sexuality with young people but are not equipped to do so.

While young people's experiences vary greatly across the MENA region, they all share a need for more and better SRH information and services. Thus, a range of communication channels and approaches are needed to reach young people with accurate and age-appropriate information as they progress through their formative years.

Family Values and the Role of Parents

Across the MENA region, family remains central to young people's lives. Connections between young people and their relatives, and their parents in particular, go beyond financial and material support to emotional and psychological identification. In Lebanon, for example, widely perceived to be one of the most "Westernized" countries in the region, a nationally representative survey that asked youth to define their identity, allegiance, and welfare interests found that their strongest affiliation was to "family" (along with country), with "self" ranking second to last.[2]

The strength of family in young people's lives is closely related to their religion. Today's youth in MENA profess strong faith. According to the World Values Survey, more than 90 percent of Egyptian and Jordanian youth, and just under 90 percent of Moroccan young people, consider religion an important part of their lives.[3] Such religiosity does not necessarily translate into religious observance: Only one-fourth of Egyptian youth surveyed actually attend a place of worship once a week. Nonetheless, more than four-fifths of Egyptian youth surveyed agreed on the importance of preserving customs and traditions grounded in religion and the family.

Consistent with these beliefs, young people spend a great amount of time with their parents and family, whose attitudes play a prominent role in shaping their behavior. Sexuality education thus needs to incorporate key family and cultural values, as well as religious beliefs. While families are a tremendous resource, they have played a minor role in informing young people about sexual matters.

Too often in MENA, parents are reluctant and ill-equipped to discuss sexuality with their children because their own formal education on such issues is extremely limited. Nevertheless, programs can benefit from involving parents in activities informing young people about SRH matters. Some programs in the region have proved successful. In Egypt, the Coptic Evangelical Organization of Social Services (CEOSS) provides sex education for young people and newly married couples. One component of the program is devoted to helping parents deal with these issues.[4]

Sexuality Education in Schools

Given high youth enrollment in formal education across MENA, schools represent a potentially effective means of communicating information on SRH—school-based sexuality education programs are also more cost effective.[5] Tunisia was the first country in the region to introduce information on reproduction and family planning in its school curriculum in the early 1960s.[6] By the early 1990s, reproductive health

education had been introduced for both girls and boys as part of the public school science curriculum, although anecdotal evidence suggests young people would like to see a more extensive curriculum, particularly as it relates to sexuality.[7] In Iran since the mid-1990s, all university students—male and female, regardless of their field of study—are required to take courses on population and family planning that include condom use to prevent pregnancy and HIV transmission.[8] And more recently, a special course on AIDS was developed as an appendix to biology books, and 13,000 teachers and school physicians have been trained to educate 1.5 million students in high schools.[9]

Turkey also stands out for its coverage of SRH topics in the school curriculum and the willingness and openness of teachers to discuss these issues in the classroom. Its "Puberty Project" provides sexuality education in the last three years of its eight-year primary school system, including such topics as "How to be sure of ejaculation," "What are the probable hazards of masturbation?" "How to cope with pimples," and "Is shaving pubic hair a problem?" Students receive a textbook on sexual health issues, and trained health experts visit their classrooms—divided by sex and grade level—to talk to them and answer questions. In each grade, a male and a female teacher are trained and assigned to answer students' questions throughout the school year. While such efforts have been applauded by women's groups, the program has been criticized for its scant discussion of gender issues—the socially defined roles of men and women—and their implications for health and well-being.[10]

Elsewhere in MENA, coverage of reproductive health issues in school curricula is generally very limited. Too often, the information is extremely basic or skipped altogether as teachers are unwilling or ill-prepared to discuss these issues in class. Beyond "the birds and the bees," sexuality education in schools is still a contentious issue in most MENA countries, and progress is uneven. In Lebanon, efforts to introduce reproductive health education in schools for 12-to-14-year-olds were scrapped in the late 1990s. Today, however, the government of Lebanon, in conjunction with international partners, is preparing a new national curriculum on sexual and reproductive health for a wider group of school-age children to be introduced across the country in the coming years.

Another example of uncertain progress is in Egypt, where the Ministry of Education, in 2010, decided to delete material on reproductive and sexual health from the curriculum introduced in the 2009-2010 academic year. If the new government also adopts this change, 16-to-17-year-old biology students will no longer study material on reproductive health, and students ages 13 to 14 will see their science books lightened by a few pages with the removal of drawings of male and female genitalia, as well as the entire lesson on sexually transmitted diseases. As an alternative, the previous Education Ministry proposed "activities in which the teacher will lead a class discussion on the subject"—a suggestion that is difficult to take seriously, since teachers are unprepared to handle such issues in the classroom.[11]

Ahmed Awadallah

In an activity organized by the Cairo Family Planning and Development Association, Egyptian Y-PEER members discuss HIV/AIDS prevention with high school students.

Extracurricular and Peer Education

To fill the gaps in educational systems on SRH, high schools and universities, often in partnership with nongovernmental organizations (NGOs), are increasingly taking on extracurricular activities to inform young people about SRH matters. In Egypt, for example, the Egyptian Family Health Society (EFHS) has held rallies in universities across the country since 1999 and, more recently, seminars in secondary schools, by joining forces with the Egyptian National Council for Childhood and Motherhood. During the rallies, presenters from EFHS discuss a reproductive health issue for just under an hour followed by written questions from the audience. So far, more than 300 rallies have been conducted for more than 50,000 male and female university students in all governorates across the country. Experience from these rallies and seminars shows that misinformation and misconceptions are common among students; however, students are extremely enthusiastic to attend and are open to learning new information—a promising sign for redressing such deficits.

Peer education, often organized through schools and youth clubs, is another route to imparting knowledge on SRH to youth. Peer education aims to change behavior

BOX 3

The Y-PEER Initiative: A Personal Testimony

"Apart from the technical support that it provides you with, one of the best advantages of joining the Y-PEER network is the networking itself, since for Tunisia it helped us establish strong connections between youth from different NGOs. For example, it helped the organization of large scale events such as the 2008 World AIDS Day celebration that consisted of a big concert where three different NGOs were involved and more than 600 people attended, and that wouldn't have been possible before. Also, the networking has helped the planning of national trainings of trainers (ToT) of peer educators, where multiple NGOs are represented...

On an international scale, the different events (workshops, trainings, meetings) that we participated in permit us to know different people from other countries, and it has been very useful in sharing experiences and knowing about what's happening around us. Also, these events, with the addition of the local ones, give you each time a huge boost of motivation that allows you to always go forward, which is, for a young volunteer, essential."

Wessim Amara, Y-PEER Tunisia, 2009

by training young people to talk about healthy lifestyle choices to their counterparts, who in turn pass it on to contacts in their social networks. Peer-education programs in MENA are often run in collaboration with experienced international programs. The Youth Peer Education Network (Y-PEER), supported by the UN Population Fund (UNFPA), is among the best known of such programs; it is active in more than 45 countries, including a number of countries in the MENA region. Its groundbreaking, comprehensive, youth-to-youth initiative has engaged more than 600 nonprofit organizations and governmental institutions around the world, and its membership includes thousands of young people who work in areas related to adolescent SRH. The network is built on a participatory approach, with the goal of empowering young people and building partnerships between young people and adults—parents, schoolteachers, health professionals, religious and community leaders, and policymakers.

While adapting its activities to the local and cultural context in individual countries, the Y-PEER network advocates to:

- Establish national youth development strategies.
- Increase access to SRH information and services.
- Share lessons learned across borders and between cultures.
- Establish standards of practice and improve training resources for peer educators.
- Strengthen the knowledge base of peer educators and trainers of trainers.
- Establish Y-PEER country networks designed by and for young people.

Studies have shown that youth peer education is an effective way to increase knowledge regarding sexual and reproductive health and encourage positive behaviors.[12] The activities of Y-PEER networks generally go beyond sexuality education and help young people develop their life skills and self-confidence.[13] They use a variety of channels to get their messages across, including music and other forms of entertainment (see Box 3, page 33).

Tunisia was the first MENA country to join the network and to organize youth activities, followed by a number of NGOs and youth from other countries. Y-PEER Egypt, for example, has organized a national campaign entitled "Live Your Life" to raise awareness among high school students about various topics such as child marriage, family planning, HIV/AIDS prevention, STI prevention, nutrition, smoking, substance abuse, and acne. By the end of 2010, the campaign was implemented in 30 schools in conjunction with the Cairo Family Planning and Development Association and other organizations. In Iran, a peer education program in high schools has trained thousands of students to educate peers on HIV.[14]

Hotlines

Hotlines were among the first channels used in making SRH information accessible to young people. Today a number of established hotlines, which are run by a government agency or NGO, allow people to ask SRH questions anonymously. The Egyptian Ministry of Health has been operating its hotline since late 1990s. The Egyptian Family Health Society, an NGO, launched its free hotline in 2004 through its headquarters in Cairo. The counselors—young, well-trained, male and female physicians—answer calls from 10 a.m. until 10 p.m. daily except Fridays. The caller can choose to talk to a male or female counselor. Callers are only asked about their age and governorate of residence for statistical purposes. In 2009, nearly half of the more than 12,000 calls—an average of 40 per day—were from Cairo and Giza governorates. The data show that 65 percent of the calls were from females and 35 percent from males; each sex had a similar age distribution, with more than half the callers under age 25 (see Table 2, page 35). Interestingly, a significant number of older callers were parents asking about problems involving their adolescent children, and callers included people living outside Egypt. Table 3 (page 35) ranks most frequently asked questions by female and male callers.

Premarital Counseling

Iran was the first country in the region to make premarital counseling mandatory for prospective brides and grooms. Couples who are planning to marry must participate in government-sponsored classes before receiving their marriage license. Premarital counseling that usually takes a couple of hours came about in the mid-1990s as part of a revival of Iran's family planning program, supporting its goal of reducing unintended pregnancies and increasing male involvement and responsibility in family planning. Depending on the degree of conservatism in the community, classes can be held for the prospective brides and grooms together

TABLE 2

Distribution of Hotline Callers by Sex and Age, Egypt 2009

AGE GROUPS	FEMALES	MALES
10-14	1%	2%
15-19	18%	16%
20-24	34%	36%
25+	47%	46%

Source: Egyptian Family Health Society.

TABLE 3

Most Frequently Asked Questions by Hotline Callers, Egypt 2009

RANK	FEMALES	MALES
1	Nutrition and weight problems (12%)	Marital relations (20%)
2	General medical problems (10%)	Genital organs (17%)
3	Fertility and pregnancy (10%)	Masturbation (16%)
4	Social problems (10%)	General medical problems (16%)
5	Psychiatric problems (10%)	Psychiatric problems (6%)
6	Irregular menstruation (10%)	Fertility and pregnancy (6%)
7	The hymen (6%)	Social problems (3%)
9	Marital relations (5%)	Questions about females (3%)
10	Vaginal discharge (5%)	Nutrition & weight problems (2%)

Source: Egyptian Family Health Society.

or separately, with same-sex instructors. In the early years of the program, classes were heavily focused on family planning issues, but now include discussions about sexually transmitted infections, especially HIV. As part of counseling, participants receive information about locations where they can access government-sponsored sexual and reproductive health services, usually free of charge.

Other governments in the region are also introducing premarital counseling. Egypt, for example, has recently made it mandatory for prospective brides and grooms to receive family planning counseling. But it is still not clear how well the Egyptian Health Ministry will be able to implement it countrywide and what shape it will take. In many countries in the region, particularly those in the Gulf, premarital counseling is linked to premarital testing for inherited disorders and some infectious diseases.

While such testing is generally accepted by couples in this part of the Arab world, it has been challenged elsewhere in the region, including Egypt.

New Communication Technologies and the Media

Youth across the region are avid consumers, and increasingly active producers, of new and old media regionally and internationally.[15] Young people are particularly keen to embrace new communication technologies, such as the Internet, cell phones, and satellite television for entertainment and education. TV effectively reaches young people on a variety of issues related to sexual and reproductive life, including female genital cutting, family planning, and HIV/AIDS. Music and other forms of entertainment are also powerful tools to inform and change behavior.

Programs such as Y-PEER use local artists and sports figures as ambassadors. Acting as role models with whom youth can identify, celebrities are effective in bringing the attention of young people to health issues. To better communicate their message, NGOs are also partnering with international groups such as Dance4Life, an international initiative that uses dance and music to involve young people in the struggle against HIV and AIDS.

In several MENA countries, such as Algeria, Egypt, Jordan, Iran, Morocco, Tunisia, and Turkey, national media campaigns have been used to inform people about HIV/AIDS, especially during the week surrounding World AIDS Day. Media coverage helps young people learn more about the issue and alerts them to local events organized specifically for them. These media activities vary in the extent to which SRH issues are covered broadly, and effectiveness is limited by an unwillingness to tackle the more sensitive aspects of HIV, such as the sexual transmission of HIV. With the largest number of people living with HIV in the region, Iran has been relatively open in discussing how to prevent HIV transmission and promoting "safe sex" in its media campaigns.

Various youth programs in the region have taken advantage of the growing use of the Internet. One example is the website of *Nazra* (Arabic for "view") (www.nazra.org), established by a group of young Egyptians dedicated to expanding the debate on gender in Egypt and the Arab region. In 2010, the group launched a project called *Tankeeb fil Tabohaat* ("exploring taboos"), to help young men and women discuss issues of sexual diversity, male-female relations, gender equality, and other sensitive topics in an open, frank, and informed manner online. Some of the early contributions from project participants dealt with commercial sex, machismo, homosexuality, female genital cutting, sexual harassment, and the uncertain state of sexuality education in the country. While *Nazra's* outreach is still small, its potential for helping young people articulate and communicate their ideas on a variety of pressing issues, including sex, is considerable.

In Tunisia, the national family planning program's (ONFP) website (www.onfp.nat.tn) has a special page dedicated to youth, covering such topics as sexually transmitted infections and pregnancy prevention. The website is in three languages:

Farzaneh Roudi

"How to prevent HIV transmission?" is the title of a banner displayed on a busy street in central Tehran, Iran, for the occasion of World AIDS Day. Messages encourage readers to have "safe sex" by using condoms, not having multiple partners, and not using illicit drugs that could potentially lead to unprotected sex. One line in the banner says that, "Remember that using condom is the surest way to prevent AIDS." The concluding line says, "Let us live and let others live." A telephone number is also provided for people to call if they have questions or need services.

Arabic, English, and French. Further west, the Moroccan Family Planning Association (AMPF) has started "cyber health," an education project for youth through its cybercafés. When accessing the Internet, users must first view a reproductive health website that has links to additional sources of SRH information and services. Another online initiative, *Info Santé Jeunes* (www.infosantejeunes.usj.edu.lb), was established by the University of Saint Joseph in Lebanon. These websites generally have a page where users can ask specialists about sexual and reproductive health matters or any other youth-related subject.

A number of other websites across the region are providing young people with information and a space to explore sexual issues in Arabic—a productive step forward, but with still limited reach given the low Internet use in many countries in the region. To enhance the utility of these and other innovative tools, including Facebook and mobile messaging, more research is needed on how best to deploy old and new media to inform young people and change behavior. Further examination is also needed of the impact of entertainment media (movies, television series, and videos) on youth attitudes and practices. Providing accurate

information to young people is vital, but without more research, how this information is shaping young people's sexual and reproductive lives will remain uncertain.

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6 MINDING THE GAP: EXPANDING SEXUAL AND REPRODUCTIVE HEALTH SERVICES

KEY POINTS

- Specially designed youth-friendly services are needed to encourage young people to seek information, counseling, and other services that are vital to protecting their health.
- Providing SRH services to unmarried young people is a new concept, as these services have traditionally been limited to maternal and child health care.
- Tunisia has been at the forefront of providing SRH services to both married and unmarried couples.

The universal value attached to marriage, compounded by religious and social rejection of premarital sexual relationships, places considerable pressure on young people—particularly young women in MENA—to marry and reproduce. Reproductive health services in the region have evolved in this context and, as a result, are largely limited to maternal and child health care.

Providing SRH services to unmarried young people is a new concept that requires a pragmatic approach to meet the needs of this growing population, while respecting cultural sensitivities about premarital sex. As discussed in Chapter 4, the limited research available in the region suggests that a significant proportion of young people are having sex outside of marriage, without the knowledge or means to protect themselves from the potential consequences of their largely hidden relations.

Early Childbearing and Antenatal Care

The rising age of marriage in MENA has benefited women greatly by reducing the health risks associated with early childbearing. Still, early marriage and childbearing remain common among some groups. Female education is the most important factor in determining early marriage and childbearing. Young Egyptian women ages 15 to 19 who have never been to school are three times more likely

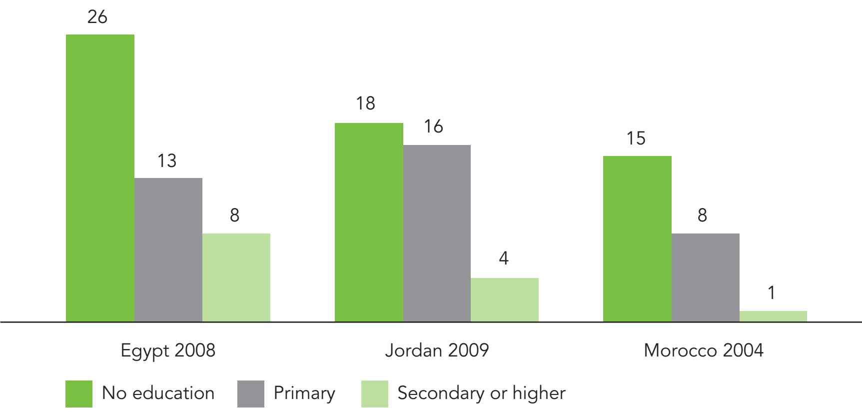
to be pregnant or have already given birth as those with high school education or higher; in Morocco, it is 15 times higher (see Figure 5). In Egypt and Morocco, young women living in rural areas are twice as likely to begin their childbearing while they are in their teens as those living in urban areas.

A delay in first births can be beneficial for young mothers' and children's health. Teenage mothers face greater risk of injuries and death due to childbirth than women in their 20s. Pregnant teenagers, particularly from the poorest segments of society, may not have completed their physical growth, which increases their risk of complications requiring medical care. For example, malnourished young women may not have developed sufficiently for the baby's head to be able to pass safely through the birth canal. This complication can lead to death and disability.[1] According to one study, one in four maternal deaths in Egypt is among women under age 25.[2]

Receiving medical care during pregnancy, at the time of delivery, and during the postpartum period is an important part of maternal care. While nearly all women in industrialized countries and some countries in the region, such as Jordan, receive antenatal care, many pregnant women in the region seek antenatal care only when they have a complaint. In Egypt, for example, one-third of teenage mothers do not receive regular antenatal care—defined as four or more visits to a health care provider during pregnancy.[3] The relatively low rates of antenatal care

FIGURE 5

Percent of Young Women Ages 15-19 Who Are Pregnant or Already Have Given Birth, by Education in Selected Countries



Sources: Fatma El-Zanaty and Ann Way, *Egypt Demographic and Health Survey 2008* (Cairo: Ministry of Health, El-Zanaty and Associates, and ICF Macro, 2009); Ministere de la Sante DPRF/DPE/SEIS, ORC Macro, and Project PAPFAM, *Morocco Demographic and Health Survey 2003-04, Final Report* (in French) (Rabat, Morocco: Ministere de la Sante DPRF/DPE/SEIS, 2005); and Jordan Department of Statistics and ICF Macro, *Jordan Population and Family Health Survey 2009* (Calverton, MD: ICF Macro, 2010).

in some populations are due in part to lack of public awareness about the importance of medical care during pregnancy. Widespread ignorance about anemia is a good example. Anemia lowers a woman's tolerance to blood loss and resistance to infection, contributing to maternal illness and death. Although anemia is common throughout the MENA region, few anemic women recognize the symptoms and seek treatment.[4]

Cultural obstacles can also prevent young women from seeking health services. For example, women generally prefer to see female health care providers, but few are available in parts of the region. Also, women who marry in their teenage years are typically more socially isolated, lack knowledge about family planning and reproductive health services, and may also lack the power to make decisions about their own health. Young pregnant women are often not the ones who decide whether to seek health care, so educating husbands and other family members about reproductive health issues is particularly important.

Family Planning Services

Family planning services have expanded throughout the region, mainly serving married women. Young married women, however, typically do not start using family planning until after they have their first child. In Egypt, while 60 percent of married women of childbearing age use contraception (58 percent use a modern method), married women with no children rarely do (0.4 percent).[5] In Yemen, where the rate of contraceptive use is the lowest in the region, only 5 percent of married women ages 15 to 19 and 10 percent of married women ages 20 to 24 use a modern method. The majority of women in Yemen report that their husband has the final say in decisions relating to contraception; roughly one-fourth of women surveyed in Palestine assert the same. In Palestine, 7 percent of married women ages 15 to 19 and 23 percent of married women ages 20 to 24 reported using a modern method.[6]

Family planning is permitted in Islam.[7] Women using family planning in the MENA region largely rely on modern contraceptives, with IUDs and the pill being the most common methods. Women in Iran and Turkey stand out for their relatively high reliance on traditional methods. In Turkey, around one-fourth of young married women under age 25 use a traditional method (mainly withdrawal), compared to a tiny percentage of those in Egypt, where breastfeeding is the most common traditional approach to contraception (see Figure 6, page 42). And condoms are the most popular modern method among young Turkish couples, meaning that Turkish couples are far more likely than Egyptian couples to rely on methods that require active male involvement.

Emergency contraception, which consists of contraceptive pills that can prevent pregnancy if taken within the first 120 hours after unprotected sexual intercourse, has been available in the MENA region since 2001, when it was first registered in Tunisia. It is now available in Algeria, Egypt, Iran, Lebanon, Libya, Turkey, and Yemen. But neither young women nor health care providers are well informed

about how to use the method. In 2003, an Arabic website set up solely to discuss emergency contraception attracted considerable traffic from Arab youth.[8]

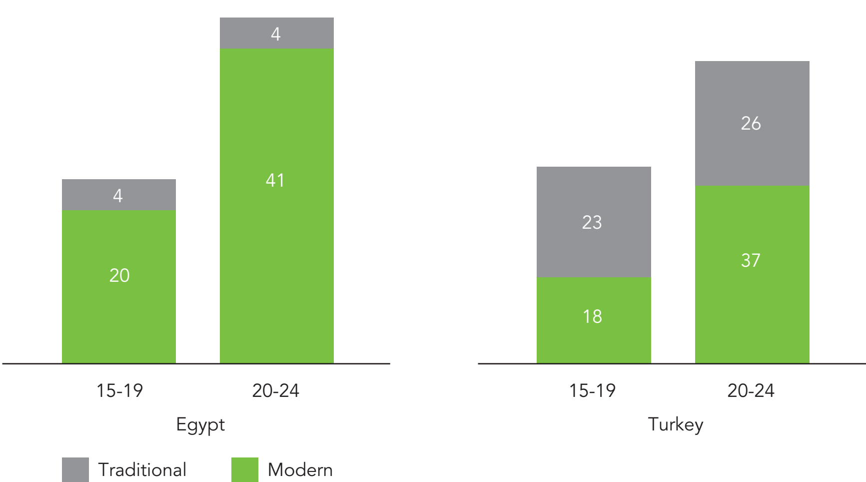
Unmet Need for Family Planning

A desire to become pregnant is the main reason women do not use contraception. Still, some women would prefer to avoid a pregnancy but do not use any contraceptive method; they have an "unmet need" for family planning. Unmet need can arise from a lack of knowledge about or access to contraceptive services, fear of side effects, or social or religious objections to family planning. In Egypt, where modern contraceptives are widely available, one in 11 married women ages 15 to 24 have unmet need; fear of side effects and husband's objections are generally the most frequently cited reasons for not using contraception. Unmet need for family planning is highest in Yemen, where one in five young women ages 15 to 24 do not want to become pregnant but are not using a family planning method.[9]

As for contraceptive use among unmarried women, an emerging body of evidence from the region suggests that it is infrequent and irregular. In Morocco, for example, a national survey found that only 3 percent of unmarried sexually active women ages 15 to 24 used a modern method of contraception.[10] Surveys of

FIGURE 6

Percent of Married Women Ages 15-19 and 20-24 Who Are Practicing Family Planning in Egypt and Turkey, 2008



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unmarried youth are likely to underestimate both sexual activity and contraceptive use, because young women are reluctant to admit to premarital sex and to contraceptive use, which implies some degree of premeditation, and therefore—in society's judgment—culpability. Single men and women may avoid family planning and reproductive health services because of a lack of confidentiality, as well as moral judgments by providers.

Unintended Pregnancies

Women with unmet need for family planning—regardless of their marital status—are at risk of unintended pregnancy. In Egypt, where the family planning program mainly serves married women, the rate at which married women stop using a contraceptive method is a major concern. On average, one-fourth of Egyptian married women who use a modern method discontinue its use within a year, and only 8 percent of those who discontinued switch to another method. Concern about side effects is the main reason for discontinuation, followed by a desire to become pregnant, and for other personal reasons such as marital separation.[11]

Young married women in their 20s account for a significant portion of unintended pregnancies in the region, because they make up a large share of all married women of childbearing age and because young married women are generally more sexually active and likely to become pregnant than older married women. Young women in their 20s account for 60 percent of all unintended pregnancies in Palestine and 45 percent of unintended pregnancies in Egypt.[12] Preventing unintended pregnancies among young married women goes a long way toward reducing the overall number of unintended pregnancies in the region.

Young women who are sexually active outside of conventional marriages are at particular risk of unintended pregnancy. Because of secrecy and a lack of social acceptance, pregnancies that occur outside of conventional marriages are likely to be unintended and often voluntarily aborted—data on these pregnancies are scarce. Social and legal constraints, inability to pay for services, and shyness can deter these young women from seeking family planning services.

Abortion and Post-Abortion Care

Abortion is one of the oldest medical practices, evidence of which dates back to ancient Egypt. Today, medical and scientific advances have made abortion a safe procedure when offered under medical supervision and high standards of care. Yet unsafe abortion—performed in unsanitary settings, by unskilled providers, or both—is one of the most serious public health challenges in the MENA region.[13]

Many women in MENA with unintended pregnancies voluntarily end their pregnancy—some legally, but most illegally. More than 80 percent of young women in the region live in countries where abortion laws are restrictive: 60 percent live in countries where abortion is prohibited except to save the mother's life, and 23 percent live in countries where abortion is permitted only to preserve a woman's physical or mental health. Only 17 percent of the MENA population lives in Tunisia

and Turkey, where abortion is legal on request during the first trimester of pregnancy (see Table 4).

In countries where access to legal abortion is limited, women risk injury or even death as they resort to clandestine operations to terminate their pregnancy, placing a large burden on health care systems. International agreements on women's health recognize that the prevention and treatment of unsafe abortion are essential elements of women's health care (see Box 4, page 45).

One of the myths about abortion in MENA that buttresses support for restrictive laws is that legalization would encourage premarital relations. Moreover, conservative interpretations of Islam forbid abortion in all but the narrowest circumstances. In many of the main schools of Islamic jurisprudence, however, there is considerable latitude on when, why, and how abortion can be undertaken. Legalizing abortion services does not necessarily lead to an increased number of abortions, but it does make them safer because the services can be regulated, health providers can be trained, and standards implemented and monitored.

In Tunisia and Turkey, where abortion services are available on demand in both private and public health facilities, survey data show that most abortions are performed on married women.[14] In Turkey, less than 4 percent of married women ages 15 to 25 reported that they have ever had an abortion, compared with nearly 40 percent among women ages 45 to 49; women in their late 40s are three times more likely than women in their late 20s to report that they ever had an abortion.[15]

In other countries where abortion is restricted, such as Iran and Syria, studies show that abortion is widespread, and an established black market exists that caters to both married and unmarried women. In Iran, women spend millions of dollars each year to obtain abortion services that are mostly clandestine and potentially unsafe, according to a recent study of married women in Tehran.[16] The study estimates that 12,000 abortions were performed in Tehran in 2009, accounting for 9 percent of all the pregnancies in the capital city. The average age of women who had an abortion was 34 years, and the highest rate of abortion

TABLE 4

Abortion Laws in MENA Countries

PROHIBITED EXCEPT TO SAVE A WOMAN'S LIFE	PERMITTED TO PRESERVE A WOMAN'S PHYSICAL/ MENTAL HEALTH	PERMITTED WITHOUT RESTRICTION AS TO REASON
Egypt, Iran, Iraq, Lebanon, Libya, Oman, Palestinian Territory, Qatar, Syria, United Arab Emirates, Yemen	Algeria, Bahrain, Jordan, Kuwait, Morocco, Saudi Arabia	**Tunisia, Turkey**

Source: United Nations Population Division, *World Abortion Policies 2011* (New York: United Nations, 2011).

BOX 4

ICPD Consensus on Abortion

A number of United Nations agreements have highlighted the public health impact of unsafe abortion, calling on governments to reduce the need for abortion and protect women's health when abortions do occur. The 1994 International Conference on Population and Development (ICPD), held in Cairo, was the first UN meeting to forge a global consensus on abortion. The ICPD *Programme of Action* states that:

> "In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services.
>
> Prevention of unwanted pregnancies must always be given the highest priority and all attempts should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counseling. Any measure or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process.
>
> In circumstances in which abortion is not against the law, such abortion should be safe. In all cases women should have access to quality services for the management of complications arising from abortion. Post-abortion counseling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions." (paragraph 8.25)

This commitment was reiterated in 1999, at the five-year review of the implementation of the ICPD *Programme of Action*, by the UN General Assembly in New York. The assembly further agreed that, "in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible."

Source: United Nations, *Report of the Programme of Action of the International Conference on Population and Development* (New York: United Nations, 1995).

was among women ages 30 to 34. Only 7 percent of abortions were performed to delay childbearing, including pregnancies occurring outside of marriage or before or during a couple's engagement. And in Syria in 2006, according to a study conducted by the health ministry, 20 percent of married women of reproductive age in the country had at least one abortion and 14 percent had two or more. The study found that, on average, 4 percent of pregnancies were voluntarily aborted, mostly using surgical procedures (see Appendix 2, Glossary).[17]

Use of "medical abortion" is generally more limited throughout the region. Medical abortion uses one or more drugs to induce an abortion and can be performed outside a clinical setting, allowing women to avoid invasive surgical procedures. It is safe and effective when used correctly. But too often women in countries with restricted abortion laws are not given the correct pills or instructions on how to use them. Nonetheless, medical abortion is increasingly popular among women, who acquire the necessary drugs legally or illegally. In the absence of oversight to ensure quality and correct use of such drugs, women may unknowingly purchase counterfeit products. Medical abortion has been legally used by millions of women globally—including those in Tunisia and Turkey—for terminating early pregnancy. Its relative absence in most countries of MENA is a loss for women and the health care systems to which they must turn when the more-common and more-complicated surgical procedures go wrong.

POST-ABORTION CARE

Post-abortion care is particularly important in countries with restrictive laws, making it an essential element of reproductive health services. Several MENA countries, including Egypt, Iran, and Yemen, have introduced post-abortion care programs that allow for training of health care providers in handling complications of unsafe abortion. Post-abortion care includes:

- Emergency treatment for complications of abortion or miscarriage.
- Counseling to identify and respond to a woman's emotional and physical health needs and other concerns.
- Family planning services to help prevent another unintended pregnancy.
- Reproductive or other health services provided on site or through referral to other facilities.

Restrictive laws make it difficult for researchers to collect data or study the incidence, circumstances, and impact of abortion on women and societies in the region. Lack of data is a major challenge in developing post-abortion services. In countries where abortion is restricted, no one knows whether abortion rates are increasing or declining, or where the need is greatest for post-abortion care.[18]

Sexually Transmitted Infections

According to a recent World Bank report, *Characterizing the HIV/AIDS Epidemic in the Middle East and North Africa: Time for Strategic Action*, a number of studies have documented substantial levels of sexually transmitted infections (STIs) in the MENA region. According to this report, each year an estimated 7 percent of the general population in MENA is infected with the four leading curable STIs—gonorrhea, chlamydia, syphilis, or trichomoniasis (see Appendix 2, Glossary).[19] Herpes simplex virus (HSV-2) is also prevalent in the region: 32 percent of female clinic attendees in one study in Egypt were infected with the virus, and as many as 63 percent in Turkey. In Jordan, HSV-2 was detected in 53 percent of male and 42 percent of female university students ages 18 to 24.[20]

STIs are a particular problem for female sex workers in the region and their clients. In Iran, for example, 64 percent of gonorrhea patients reported acquiring their infection through contacts with female sex workers. In Kuwait, 77 percent of clients at clinics treating STIs reported acquiring their infection from female sex workers.[21]

When women engage in unprotected sexual relations, they are more vulnerable than men to the transmission of STIs, and such infections are more damaging to their health. Women's vulnerabilities stem from the interplay of biological and social factors:

- Women are biologically more susceptible to STIs than men when engaging in vaginal sexual intercourse, and young women are more biologically susceptible to infection than older women.[22]
- STIs in women are more likely to cause secondary disease than in men; some can lead to infertility in women or even become fatal if not treated, such as cervical cancer caused by the human papillomavirus (see Appendix 2, Glossary).
- Young women generally marry men who are older and more likely to have had sexual experiences and multiple partners before marriage. This increases the likelihood that the husband will transmit an STI to his young wife.

Studies in MENA have found age to be an important risk factor for STIs among married women. In Oman, 4 percent of married women of reproductive age were found to have STIs, and a study in Babol, a city in northern Iran, found that 16 percent of women attending gynecology clinics had trichomoniasis. In both studies, women under age 25 were twice as likely to have an STI as women ages 25 and older. In the Iranian study, most women were unaware of their STI; they all claimed to have never had a sexual partner other than their husbands.[23]

Youth in MENA form the largest vulnerable population and contribute disproportionately to the burden of STIs in the region. More than half of known STI cases in Egypt are among young and predominantly single adults. In Morocco, 40 percent of recorded STI cases are among young people ages 15 to 29. The dominant profile of STI clinic attendees in Tunisia is that of young single men with multiple sexual partners. Most reported STIs among clinic attendees in Kuwait are also among those in their 20s.[24]

In Iran, 10 percent of all cases of STIs involve teenagers. In response, the Iranian Ministry of Health and Medical Education is establishing STI counseling centers for adolescents and youth. The ministry is also taking on a number of STI related activities, including a situation analysis of STIs and management guidelines for STI treatment.[25]

Treating STIs is an increasing burden on health care systems throughout the region. Preventing STIs requires both behavior change and health promotion. Using condoms helps prevent the transmission of STIs (including HIV) and pregnancy, providing "double protection." In Iran and Turkey, condom use is promoted and condoms are made accessible to young people. The World Bank report

notes that "Continuing to ignore the sensitive but essential issue of condom accessibility and neglecting the promotion of its protective role for everyone, particularly for people most at risk, are undoubtedly crippling effective HIV prevention efforts, as is the case in many countries of the region."[26]

Voluntary Counseling and Testing Services for HIV/AIDS

Voluntary counseling and testing (VCT) is important because effective HIV prevention and care requires people to know their HIV status. VCT can also provide an entrée to other reproductive health services such as contraception. In MENA, most VCT centers were initially located in capital cities in government health facilities, which discouraged those fearing stigma from checking their HIV status. While VCT services have been expanding, they are still limited to major cities in most countries. A few countries are exceptions, however. The government of Morocco, for example, was the first to establish VCT centers with broad national coverage; Algeria has expanded its VCT network across the country; and the Lebanese National AIDS Program has adopted an innovative model of managing VCT services through NGOs.[27]

Family Health International, a U.S.-based NGO, has helped the governments of Egypt and Jordan to develop their national HIV/AIDS strategies and has provided training on VCT services. The government of Jordan opened its National VCT Center in Amman in 2008 and has since expanded its services to other governorates. Some NGOs in Jordan have also begun to offer pretest counseling and referral to government services for HIV testing. This initiative by NGOs in Jordan has helped reach high-risk groups such as female sex workers.[28] The introduction of mobile testing centers in several countries of the region, including Morocco, is also expanding access to populations outside of cities.

The recent increase in VCT services in the region, however, has not necessarily translated into an increased number of people knowing their HIV status. VCT services are generally underused for a variety of reasons, including no or low coverage of HIV prevention programs among high-risk groups and vulnerable populations; lack of referrals to VCT centers; concerns that confidentiality may not be maintained; and the negative attitudes of service providers in the VCT centers.

The majority of people in MENA learn their HIV status through mandatory testing, not through voluntary services. With the exception of Morocco, all countries in the region have mandated HIV testing under a variety of circumstances including presurgical procedures, pre-employment, immigration, and high-risk populations upon arrest or admission to health care services. Youth-friendly VCT services are more the exception than the rule. Morocco has the most organized STI/HIV surveillance system in the region and does mandatory testing only on military recruits to establish physical fitness.[29]

Egyptian Family Health Society

In 2010, the Egyptian Family Health Society opened a youth-friendly clinic at Assiut University—the first such clinic on a university campus in Egypt.

Youth-Friendly Services

SRH services are considered youth friendly if they have policies and attributes that attract youth to the facility or program, provide a comfortable and appropriate setting for serving youth, meet the needs of young people, and are able to retain their youth clientele for follow-up and repeat visits (see Box 5, page 50). The concept of youth-friendly services and centers is largely new to the region. The National Office for Family and Population (ONFP) of the Tunisian Health Ministry has been at the forefront of establishing youth-friendly services. For example, ONFP has succeeded in incorporating SRH services for adolescents within the school health clinics of all major towns. The school clinics can refer students to specialists for counseling and treatment when required.

In Egypt, NGOs and the Health Ministry have been running youth-friendly clinics in some major cities. The Egyptian Family Health Society (EFHS) began offering youth-friendly services in its clinics in 2004. In 2010, EFHS opened a youth-friendly clinic at Assiut University—the first such clinic on a university campus in Egypt. The clinic started its work with two male physicians and four female physicians. The physicians and all other staff are trained to deal with young people's health care needs. Initially, a group of 15 peer educators (boys and girls) were trained to deal with students' questions and guide them to the clinic. The clinic is open six days per week—three days for boys to see a male physician and three days for girls to see a female physician.

BOX 5

Characteristics of Youth-Friendly Services

Youth-friendly services have providers and facilities with special characteristics, including the following, to address young people's needs.

Provider Characteristics

- ***Specially trained staff*** who are able to work competently and sensitively with young people is often considered the single most important condition for establishing youth-friendly services.
- ***Privacy and confidentiality*** must be arranged for counseling sessions and examinations; young people must feel confident that their concerns are not communicated to other people.
- ***Adequate time for counseling and dialogue*** is important, because young people often require strong reassurance and active encouragement to speak freely.
- ***Peer counselors*** can supplement some aspects of the counseling activities, as young people often feel more comfortable talking to people their own age.

Service Characteristics

- ***Separate space, special times, and comfortable surroundings*** are important for adolescent clients, especially first-time clinic users and marginalized young people who are often not comfortable with mainstream health services.
- ***Convenient hours***, such as late afternoons (after school or work), evenings, and weekends, are fundamental to serving youth.
- ***Convenient locations*** are those in safe surroundings and ideally available by public transportation.
- ***Educational materials*** should be available on site and to take away, because some young people prefer to learn on their own.
- ***Appointments*** should be easily arranged and drop-ins allowed, because adolescents often don't plan ahead.
- ***Free or affordable services*** should be available so that cost is not a barrier to use.
- ***Publicity and outreach*** are needed to inform young people which services exist and where, and reassure them that they will be served respectfully and confidentially.
- ***A wide range of SRH services****,* if possible, should be available so that the most urgently needed services can be accessed with "one-stop shopping." These services should include SRH counseling, contraceptive counseling and provision (including emergency contraception), STI and HIV prevention, STI diagnosis and treatment, nutritional services, sexual abuse counseling, prenatal and postpartum care, abortion services (where legal), and post-abortion care.
- ***Necessary referrals*** must be made for services that are not provided on site.

Source: Judith Senderowitz, "Making Reproductive Health Services Youth Friendly," *Research, Program, and Policy Series: Focus on Young Adults* (Washington, DC: Pathfinder International, 1999).

The Role of NGOs

Local and international NGOs play a key role in conducting research on issues related to youth SRH and providing SRH services to young people all over the world. The largest is the network of family planning associations that make up the International Planned Parenthood Federation (IPPF). Young people's SRH is a priority focus of IPPF and its affiliates, including those in the MENA region. The Cairo Family Planning and Development Association (see Chapter 5), for example, is an IPPF affiliate.

NGOs have been critical in implementing activities related to the prevention of HIV and other STIs and their treatment among high-risk groups—sex workers, men who have sex with men, and injecting drug users—as well as addressing the needs of socially marginalized populations such as refugees and street children. Youth are a significant portion of these population groups who need special care because of their age and stage of life.

NGOs are generally well positioned to work at the grassroots level, involving local communities, providing a mix of services, and dealing with the stigma surrounding youth SRH needs. Youth clubs sponsored by NGOs are good examples. While organizing sports, entertainment, and/or vocational activities for youth, they can also offer SRH information and services or referrals to the services for those who need them. NGOs can reach out to out-of-school children and homeless and runaway youth.

NGOs operate within government systems. Therefore, being responsive to the SRH needs of youth requires efforts by both private and public sectors, including ministries and agencies dealing with health, education, youth, communications, labor, planning, and finance. Governments should facilitate the registration and operation of NGOs providing such services, which help ministries to address population needs, thereby strengthening their legitimacy. For their part, NGOs should coordinate their efforts with the government to avoid duplication and ensure efficient use of resources. Such coordination can also help ensure the quality of SRH information and services—correct and current information, consistent messages, and mutually reinforcing interventions.

Because of societies' reticence about youth sexuality, programs in MENA face an uphill battle to provide well-functioning, youth-friendly services that can meet the needs of diverse populations. The greatest challenge is serving unmarried women who are sexually active. Local innovation is key, tailored to the particular characteristics of societies in the region yet grounded in universal human rights. MENA countries now have the opportunity to learn from the experiences and lessons in other countries and regions and adapt best practices to their own needs and situations. To do so, however, countries need to first understand the unmet SRH needs of their own youth populations to ensure that investment is appropriately structured and implemented.

In summary, programs—whether sponsored by NGOs or government agencies—need to recognize urgent sexual and reproductive health needs of youth, communicate in language and concepts that youth understand, and involve youth in program design and evaluation. Above all, programs should remain optimistic about young people and support efforts to improve their health, education, and employment opportunities. Investing in youth today leads to stronger nations tomorrow.

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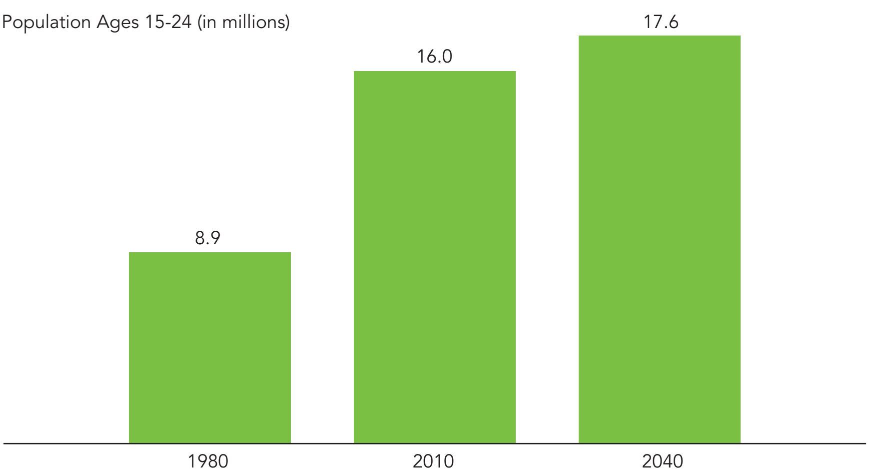
APPENDIX 1
DATA BY COUNTRY

FIGURE 1

Youth Population Growth in Egypt



Source: United Nations Population Division, *World Population Prospects: The 2010 Revision* (New York: United Nations, 2011).

TABLE 1

Total Population and Population of Youth in MENA Countries, 2010

	POPULATION (IN THOUSANDS)		
COUNTRY OR TERRITORY	ALL AGES	AGES 15-24	POPULATION 15-24 AS PERCENT OF TOTAL POPULATION
Algeria	35,468	7,292	21
Bahrain	1,262	188	15
Egypt	81,121	16,009	20
Iran	73,974	16,253	22
Iraq	31,672	6,205	20
Jordan	6,187	1,332	22
Kuwait	2,737	423	15
Lebanon	4,228	759	18
Libya	6,355	1,124	18
Morocco	31,951	6,268	20
Oman	2,782	611	22
Palestine	4,039	858	21
Qatar	1,759	256	15
Saudi Arabia	27,448	4,947	18
Syria	20,411	4,166	20
Tunisia	10,481	1,994	19
Turkey	72,752	12,883	18
UAE	7,512	1,211	16
Yemen	24,053	5,327	22
Total	446,191	88,106	20

Notes: The percentages of youth in the oil-rich Gulf countries are low because large populations of foreign workers living there offset the more youthful indigenous populations. The data for Palestine refer to the Arab population of Gaza and the West Bank, including East Jerusalem.
Source: United Nations Population Division, *World Population Prospects: The 2010 Revision* (New York: United Nations, 2011).

TABLE 2

Selected Socioeconomic Indicators for MENA Countries

COUNTRY OR TERRITORY	GNI PPP PER CAPITA (US$) 2008	PERCENT OF POPULATION LIVING IN URBAN AREAS	MOBILE PHONE SUBSCRIBERS PER 100 INHABITANTS	PERCENT OF HOUSEHOLDS WITH INTERNET
Algeria	7,940	63	93	8
Bahrain	—	100	186	48
Egypt	5,460	43	51	13
Iran	*10,840*	69	59	10
Iraq	—	67	58	—
Jordan	5,530	83	87	13
Kuwait	*52,610*	98	100	30
Lebanon	10,880	87	34	20
Libya	15,630	77	77	5
Morocco	4,330	57	72	14
Oman	20,650	72	116	22
Palestine	—	83	28	—
Qatar	—	100	131	63
Saudi Arabia	22,950	81	143	42
Syria	4,350	54	33	31
Tunisia	7,070	66	85	5
Turkey	13,770	76	89	25
UAE	—	83	209	66
Yemen	2,210	29	16	2

— Data not available

Notes: GNI PPP per capita is gross domestic national income in purchasing power parity (PPP) divided by midyear population. GNI PPP refers to gross national income converted to "international" dollars using a purchasing power parity conversion factor. International dollars indicate the amount of goods and services one could buy in the United States with a given amount of money. Figures in italics are for 2006 or 2007. The data for Palestine refer to the Arab population of Gaza and the West Bank, including East Jerusalem.

Sources: Carl Haub, *2010 World Population Data Sheet* (Washington, DC: Population Reference Bureau, 2010); and International Telecommunications Union, *Measuring the Information Society 2010* (Geneva: ITU, 2010).

TABLE 3

Number of Females per 100 Males Enrolled in School

COUNTRY OR TERRITORY	SECONDARY SCHOOL	TERTIARY SCHOOL
Algeria	108	140
Bahrain	104	253
Egypt	94	77
Iran	98	114
Iraq	67	59
Jordan	104	111
Kuwait	104	214
Lebanon	111	119
Libya	117	110
Morocco	86	89
Palestine	107	123
Oman	97	118
Qatar	146	605
Saudi Arabia	85	165
Syria	98	—
Tunisia	108	149
Turkey	89	78
UAE	102	205
Yemen	49	42

—Data not available
Note: The data for Palestine refer to the Arab population of Gaza and the West Bank, including East Jerusalem.
Source: United Nations, "Millennium Development Goals Indicators, the Official United Nations Site for MDG Indicators," accessed at http://unstats.un.org/unsd/mdg/Data.aspx. The data are for years from 2005 to 2008.

TABLE 4

Percent of 15-to-24-Year-Olds Who Are Literate

COUNTRY OR TERRITORY	TOTAL	MALE	FEMALE
Algeria	92	94	89
Bahrain	100	100	100
Egypt	85	88	82
Iran	97	97	96
Iraq	82	85	80
Jordan	99	99	99
Kuwait	98	98	99
Lebanon	99	98	99
Libya	100	100	100
Morocco	77	85	68
Palestine	99	99	99
Oman	98	98	98
Qatar	99	99	99
Saudi Arabia	97	98	96
Syria	94	96	93
Tunisia	97	98	96
Turkey	96	99	94
UAE	95	94	97
Yemen	83	95	70

Note: The data for Palestine refer to the Arab population of Gaza and the West Bank, including East Jerusalem.
Source: United Nations, "Millennium Development Goals Indicators, the Official United Nations Site for MDG Indicators," accessed at http://unstats.un.org/unsd/mdg/Data.aspx. The data are for years from 2005 to 2008.

TABLE 5

Percent of Women Ages 15-19 and 20-24 Who Are Ever Married

COUNTRY	AGES 15-19	AGES 20-24
Algeria 2006	2	17
Egypt 2008	13	54
Iraq 2009	12	44
Iran 2006	17	50
Jordan 2009	6	36
Lebanon 2004	3	18
Libya 2007	1	9
Morocco 2004	11	37
Palestine 2006	9	48
Syria 2001	11	42
Tunisia 2001	1	14
Turkey 2008	10	46
Yemen 2003	17	57

Note: The data for Palestine refer to the Arab population of Gaza and the West Bank, including East Jerusalem.
Sources: Pan-Arab Project for Family Health, Demographic and Health Surveys, UNICEF Multiple Indicator Cluster Surveys, and the Statistical Center of Iran.

TABLE 6

Percent of Currently Married Women Ages 15-19 and 20-24 Using Contraception

	AGES 15 -19		AGES 20-24	
COUNTRY OR TERRITORY	ANY METHOD	ANY MODERN METHOD	ANY METHOD	ANY MODERN METHOD
Algeria 2006	20	17	43	37
Egypt 2008	23	20	45	41
Iran 2000	34	9	58	44
Iraq 2009	21	10	37	22
Jordan 2009	27	16	43	31
Lebanon 2004	22	13	39	21
Libya 2007	14	6	26	12
Morocco 2004	38	36	58	53
Palestine 2006	10	7	36	24
Syria 2006	22	11	40	26
Tunisia 2006	20	20	42	38
Turkey 2008	40	18	63	37
Yemen 2006	10	6	25	16

Note: The data for Palestine refer to the Arab population of Gaza and the West Bank, including East Jerusalem.
Sources: Pan-Arab Project for Family Health, Demographic and Health Surveys, UNICEF Multiple Indicator Cluster Surveys, and the Iranian Ministry of Health and Medical Education.

TABLE 7

Percent of Married Youth Ages 15-29 Who Made the Final Decision to Marry Their Spouse Themselves, by Sex and Socioeconomic Background, Egypt 2009

	MALE	FEMALE
EDUCATION		
Illiterate	89	44
Primary	93	55
Preparatory	88	53
General secondary	100	59
Vocational secondary	95	61
Postsecondary institute	95	70
University and higher	95	74
WEALTH QUINTILE		
Lowest	89	44
Second	91	53
Middle	95	58
Fourth	95	64
Highest	100	74
TOTAL	93	57

Source: Population Council, *Survey of Young People in Egypt, Final Report, 2010* (Cairo: Population Council, 2010): table A6.7.

APPENDIX 2
GLOSSARY

Abortion: Termination of pregnancy (expulsion or extraction of an embryo/fetus) before 22 weeks of gestation or when the fetus weighs less than 500 grams. Abortion may be spontaneous, that is, due to natural causes (a miscarriage), or induced.

Abortion procedures: For pregnancies up to 12 weeks gestation—that is, 12 weeks since the woman's last menstrual period—vacuum aspiration, dilation and curettage (D&C), and medical abortions, defined below, are typically used. For pregnancies of more than 12 completed weeks since the woman's last menstrual period, the two most widely used methods are dilation and evacuation (D&E) and medical abortion. In some countries, women within a few weeks of a missed menstrual period can undergo a procedure called *menstrual regulation*, which uses vacuum aspiration or medication to induce menstruation, but does not test for a pregnancy.

- **Vacuum aspiration** removes the contents of the uterus by applying suction through a tube that is inserted through the cervix into the uterus. It is widely used through 12 weeks of pregnancy, though experienced providers can perform it safely through 15 weeks.
- **Surgical abortion**: The most common types are dilation and curettage (D&C) and dilation and evacuation (D&E). The method used depends on the length of the pregnancy.
- **Medical abortion**, also called medication abortion or the abortion pill, uses one or more drugs, most commonly mifepristone (known as RU486) and misoprostol (also known as Cytotec), to expel the contents of the uterus. In the 2 percent to 5 percent of cases where medical abortion is incomplete, vacuum aspiration or D&C is required.

Abortion rate: The number of abortions per 1,000 women ages 15 to 44 or 15 to 49 in a given year. This measure describes the level of abortion in a population.

Abstinence: A conscious decision to refrain from sexual activity.

Adolescence: The transition between puberty and adulthood, generally defined as ages 10 to 19. Data on adolescent health, education, employment, and behaviors are often available for ages 15 to 19.

Adolescent birth rate: The annual number of births to women ages 15 to 19 per 1,000 women in that age group.

Acquired immune deficiency syndrome (AIDS): A progressive and usually fatal condition that reduces the body's ability to fight certain infections. It is caused by infection with human immunodeficiency virus (HIV).

Child marriage: Marriage before age 18.

Chlamydia: A sexually transmitted infection caused by the bacterium *chlamydia trachomatis*, often causing irregular bleeding and pain during intercourse in women, burning during urination in men, and discharge in both men and women. If left untreated, chlamydia can lead to pelvic inflammatory disease.

Circumcision (male): Removal of the foreskin or prepuce of the penis. (For *female circumcision*, see Female Genital Cutting)

Clitoris: A small, erect body of the female genitalia, partially hidden by the labia. It is highly sensitive and can be a source of sexual pleasure and female orgasm. A clitoridectomy involves the removal of part or all of the clitoris. (See Female Genital Cutting)

Conception: Union of an ovum (egg) and a sperm. Also known as fertilization.

Consanguineous marriage: Marriage between relatives, most commonly between cousins in the MENA region.

Contraceptive methods: Modern methods include the pill (oral contraceptives), injectables, implants, IUD, condom, diaphragm, spermicides, Lactational Amenorrhea Method, and male and female sterilization. Traditional methods include periodic abstinence, withdrawal, and breastfeeding.

Contraceptive use (prevalence): The percentage of currently married women of reproductive age (usually ages 15 to 49) who are using any form of contraception.

Dual protection: Using two types of contraceptive methods, a barrier method such as a condom and another method such as the pill or IUD, to provide a simultaneous safeguard against both pregnancy and sexually transmitted infections (STIs), particularly HIV.

Emergency contraception (EC): Methods used to prevent pregnancy when a contraceptive fails or when sex occurs without contraception. Two types of EC are emergency contraceptive pills (ECPs)—also known as the "morning after pill"—and emergency IUD insertion. Both methods are safe and effective if service delivery guidelines and patient instructions are followed correctly.

Family planning: The conscious effort of couples to regulate the number and spacing of births through artificial and natural methods of contraception. Family

planning usually implies preventing conception to avoid pregnancy and abortion, but it also includes efforts of couples to become pregnant.

Female genital cutting (FGC): All procedures involving cutting away all or part of the external female genitalia or other injury to the female genital organs whether for cultural, religious, or other nontherapeutic reasons. There are three different types of FGC. In the first, the clitoris is partly or completely removed. In the second, the clitoris along with small skin folds of the outer genitals is removed. In the third type, infibulation, the outside genitals are cut away and the vagina is sewn shut, with only a small hole left through which urine and blood can pass. FGC is also referred to as female genital mutilation (FGM) and female circumcision.

Fertility: The number of live births that women have. It differs from fecundity, which refers to the physiological capability of women to reproduce. (See Total Fertility Rate)

Fistula: A hole that develops between the vagina and the rectum or bladder, often as a result of obstructed labor (when the baby cannot pass through the birth canal). Openings in the birth canal allow leakage of urine or feces through the vagina, causing shame and stigma to women who suffer this maternal disability. It is also called obstetric fistulae.

Gender: The socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for men and women. These culturally defined roles and responsibilities for females and males are learned and may change over time, and vary among societies.

Gender-based violence (GBV): The terms "gender-based violence" and "violence against women" are often used interchangeably. Technically, the term gender-based violence refers to violence directed against a person because of his or her gender and expectations of his or her role in a society or culture. But it most often is used when describing violence against women because women are far more likely than men to experience discrimination or abuse. The United Nations defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."

Violence against women can take many forms, including honor killing; domestic violence; harassment of women and girls in public, in schools, and in the workplace; trafficking of women and girls; and female genital cutting and other harmful traditional practices such as child marriage. The common theme among these diverse acts is that the violence is directed against a person on the basis of gender.

Gender equality: The absence of discrimination based on gender determinants for both sexes in access to opportunities and services and allocation of resources and benefits.

Gonorrhea: A sexually transmitted infection caused by the bacterium *Neisseria gonorrhoea*. It is a common cause of urethral and vaginal discharge and of discharging eyes in newborns. During pregnancy, gonorrhea infections can cause premature labor and stillbirth. Gonorrhea does not have symptoms in all women and, if left untreated, can lead to pelvic inflammatory disease and infertility.

Herpes: There are two types of genital herpes: herpes simplex virus-1 and herpes simplex virus-2. Herpes is transmitted through sexual contact and is a common cause of genital blisters and ulcers. During pregnancy, herpes may cause miscarriage or stillbirth. There is no cure, though the symptoms can be managed.

Human immunodeficiency virus (HIV): A virus that attacks the body's immune system, making the body unable to fight infection. It can cause AIDS, which is the last stage of HIV infection. HIV is the most dangerous sexually transmitted infection.

Human papillomavirus (HPV): A sexually transmitted agent that infects the cells of the cervix and slowly cause cellular changes that may result in cancer. HPV is one of the most common STIs in the world and has dozens of sub-types, some of which lead to cervical cancer if cellular changes are not detected and treated early.

Induced abortion: The act of ending a pregnancy with surgery or medicine. (See Abortion)

Information, education, and communication (IEC): Activities designed to increase awareness or promote a certain health intervention or behavior.

Integrated services: Availability of multiple health services, such as family planning and STI treatment through a single facility. It also implies a degree of coordination across services.

Maternal morbidity: Illness or disability occurring as a result of or in relation to pregnancy, childbirth, or in the postpartum period.

Maternal mortality: The death of a woman while pregnant, during delivery, or within 42 days (six weeks) of termination of pregnancy. The cause of death is always related to or aggravated by the pregnancy or its management; it does not include accidental or incidental causes.

Maternal mortality ratio: The number of women who die during pregnancy or during the first 42 days after delivery per 100,000 live births in a given year from any cause related to or aggravated by pregnancy.

Mean age: The mathematical average age of all the members of a population.

Median age: The age that divides a population into two numerically equal groups; that is, half the people are younger than this age and half are older.

Millennium Development Goals (MDGs): A set of measurable goals that came about as the result of the 2000 United Nations Millennium Summit, where world

leaders committed to combat poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women.

Obstetric complication: A dangerous health condition related to pregnancy or delivery that requires medical care to prevent injury, illness, or even death of the woman. Complications can occur any time during a pregnancy or up to six weeks after childbirth, and occur suddenly without warning.

Peer education: The process whereby well-trained and motivated young people undertake informal or organized educational activities with their peers (those similar to themselves in age, background, or interests). These activities, occurring over an extended period of time, are aimed at developing young people's knowledge, attitudes, beliefs, and skills and at enabling them to protect their own health.

Pelvic inflammatory disease (PID): A progressive infection that harms a woman's reproductive system. It occurs throughout the pelvic area, the fallopian tubes, the uterus, the uterine lining, and ovaries. PID can lead to infertility (sterility), ectopic pregnancy, and chronic pain.

Post-abortion care: Includes emergency treatment of incomplete abortion and potentially life-threatening complications. It also refers to post-abortion family planning counseling and services.

Reproductive health: A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

Sexually transmitted infection (STI): An infection acquired through sexual contact. It is also called a sexually transmitted disease (STD).

Sex education: Basic education about reproductive processes, puberty, sexual behavior, and related topics. Sex education may include other information, for example, about contraception, protection from sexually transmitted infections, and parenthood.

Sex work: Performing sex acts for pay; also called commercial sex.

Sexuality: The sexual knowledge, beliefs, attitudes, values, and behaviors of individuals. Its dimensions include the anatomy, physiology, and biochemistry of the sexual response system; identity, orientation, roles, and personality; and thoughts, feelings, and relationships. The expression of sexuality is influenced by ethical, spiritual, cultural, and moral concerns.

Spontaneous abortion: Miscarriage, or loss of a pregnancy due to natural causes.

STI or STD management: The care of a client with an STI/STD; this includes activities such as history taking, physical examination, laboratory tests, diagnosis, treatment, and health education about treatment and prevention, follow-up assessment, and referral when indicated.

Syphilis: A sexually transmitted infection caused by the bacterium *Treponema pallidum*; one of the causes of genital ulcers. If left untreated, it can cause damage to the nervous system, heart, or brain and lead to death. In pregnant women, the infection greatly increases the risk of stillbirth and birth defects, making early testing during pregnancy critical.

Total fertility rate: The average number of children born in a woman's lifetime if she were to conform to the age-specific fertility rates of a given year. Also expressed as "lifetime births per woman" or "births per woman" and used to indicate the average number of children that women are having today.

Trichomoniasis: A sexually transmitted infection caused by the bacterium *Trichomonas vaginalis*; one of the causes of vaginal discharge.

Unmet need for family planning: The percentage of married fecund women who prefer to space or limit their births but are not using contraception.

Unsafe abortion: A procedure for terminating an unwanted pregnancy performed by persons lacking the necessary skills or in an environment lacking the minimal medical standards.

Vagina: The tube that forms the passage between the cervix/uterus and the vulva. It receives the penis during sexual intercourse and serves as the delivery passage for birth and for menstrual flow.

Voluntary counseling and testing (VCT): The process by which an individual undergoes counseling, enabling him or her to make an informed choice about being tested for HIV. This decision must be entirely the choice of the individual and he or she must be assured that the process will be confidential.

Youth: The United Nations defines youth as people between ages 15 and 24. Individual countries may identify slightly different age groups as "youth" in their policy documents. In this report, *young people* is used interchangeably with youth.

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APPENDIX 3
SOURCES OF INFORMATION

Below are major sources of information on youth and sexual and reproductive health. The organizations are listed alphabetically. Also listed are selected training materials, many of which were produced collaboratively among multiple organizations.

Centre for Development and Population Activities (CEDPA)
www.cedpa.org
CEDPA designs and implements programs to improve the lives of women and girls, focusing on increased educational opportunities and increased access to reproductive health and HIV/AIDS information and services. Some projects also focus on improving opportunity for boys. A number of CEDPA's publications are drawn from program experiences in Egypt.

Coalition for Sexual and Bodily Rights in Muslim Societies (CSBR)
www.wwhr.org/csbr.php
CSBR strives to promote sexual, bodily, and reproductive rights as human rights in Muslim societies. It includes 40 NGOs and many academics from the Middle East, North Africa, and South and Southeast Asia. CSBR takes an inclusive and affirmative approach to sexuality, recognizing its importance in private, public, and political life. The coalition has played a pivotal role in establishing and expanding the notion of sexual rights in parts of MENA.

Family Health International, YouthNet
www.fhi.org/en/youth/youthnet/index.htm
Supported by the U.S. Agency for International Development from 2001 to 2006, YouthNet conducted research, disseminated information, improved services, and strengthened policies and programs related to youth reproductive health and HIV/AIDS prevention. Their website hosts resources and training materials for those working with youth.

Foundation for the Future
www.foundationforfuture.org
Foundation for the Future is a multilateral nonprofit organization supported by the governments of more than a dozen countries both in and out of the Middle East and North Africa (MENA). The foundation focuses on grantmaking in support of rule of law, independent media, empowerment of women, civic education, and engagement of youth in MENA countries.

Interagency Youth Working Group (IYWG)
www.infoforhealth.org/youthwg
IYWG provides global technical leadership to advance the reproductive health of young people ages 10 to 24 in developing countries by sharing research results and program lessons on youth reproductive health and promoting strategies that prove promising on health education and awareness. It works in eight countries in MENA.

International Federation of Red Cross and Red Crescent—Youth
www.ifrc.org/youth/index.asp
The International Federation's programs are grouped into four core areas: promoting humanitarian principles and values, disaster response, disaster preparedness, and health and care in the community. The Federation has a specific youth program focusing on each of the core areas, maintains youth directories and other resources, and works throughout the MENA region.

International Labor Organization (ILO)—Youth Employment
www.ilo.org/public/english/employment/yett/index.htm
The ILO collects data, conducts research, and advises governments to help mobilize support and implement integrated policies and programs to achieve the global commitment to decent and productive work for youth. In collaboration with the United Nations and the World Bank, it supports the Youth Employment Network—a network of organizations devoted to youth employability, equal opportunity, entrepreneurship, and employment creation.

International Youth Foundation (IYF)
www.iyfnet.org
The IYF is an international NGO working in nearly 70 countries to improve conditions and prospects for young people. IYF works with hundreds of companies, foundations, and civil society organizations to strengthen and ”scale up” existing programs that are making positive and lasting difference in young people's lives. IYF's global initiatives focus on four core areas of education, employability, leadership and engagement, and health education and awareness.

Population Council
www.popcouncil.org
The Population Council conducts research worldwide to improve policies, programs, and products in three areas: HIV and AIDS; poverty, gender, and youth; and reproductive health. In particular, the *Transition to Adulthood* program seeks to better understand adolescents' lives and develop effective policies and programs to improve them. The Council is especially active in Egypt, where it has a regional office and has recently conducted a survey of young people in Egypt. The survey reports and database are available online at www.popcouncil.org/projects/SYPE/index.asp.

Population Reference Bureau
www.prb.org
The Population Reference Bureau informs people around the world about population, health, and the environment, and empowers them to use that information to advance the well-being of current and future generations. PRB focuses its work around these core themes: reproductive health and fertility; children and families; global health; population and the environment; aging; inequality and poverty; migration and urbanization; and gender.

PRB's Middle East and North Africa (MENA) program, initiated in 2001 with funding from the Ford Foundation, responds to the region's need for timely and objective information on population, socioeconomic, and reproductive health issues. The project explores the linkages among these issues and provides evidence-based policy and program recommendations for decisionmakers in the region. Working closely with research organizations in the region, the project team produces policy briefs and reports (in English and Arabic) on current population and reproductive health topics, conducts workshops on policy communications, and makes presentations at regional and international conferences.

Sexuality Information and Education Council of the United States (SIECUS)
www.siecus.org
SIECUS provides resources and research on sexuality and sexual and reproductive health to domestic and international programs.

The Joint United Nations Program on HIV/AIDS (UNAIDS)
www.unaids.org
UNAIDS coordinates the UN system's response to AIDS.

United Nations Programme on Youth
www.un.org/youth
The UN Programme on Youth aims to enhance global awareness of youth issues and increase recognition of the rights and aspirations of youth; to promote national youth policies, national youth coordinating mechanisms, and national youth programs of action; and to strengthen the participation of youth in decisionmaking at all levels.

United Nations Population Fund (UNFPA)
www.unfpa.org
UNFPA is an international development agency that promotes and protects the rights of young people, among other goals. It helps governments, at their request, to formulate policies and strategies to reduce poverty and support sustainable development. UNFPA also assists countries to collect and analyze population data that can help them understand population trends. It supports collection and use of information on adolescents and youth, in particular.

Located in Cairo, the UNFPA Arab States Regional Office (ASRO) is collaborating with Sussex University in England to assess adolescent sexual and reproductive health services in the region and help strengthen institutional capacities to

develop HIV/AIDS prevention programs and deliver high quality sexual and reproductive health services for young people.

United Nations Children's Fund (UNICEF)
www.unicef.org
Present in 190 countries and territories around the world, UNICEF focuses on programs and research to aid children and young people. UNICEF has been active in the MENA region, focusing on nutrition, adolescent health, life skills, and monitoring and evaluation of interventions. For example, the *Youth Voices Initiative* aims to offer children and adolescents in the region a safe and supportive global cyberspace where they can explore issues through participation with their peers and with decisionmakers globally.

Wolfensohn Center for Development, Middle East Youth Initiative
www.shababinclusion.org
The Middle East Youth Initiative was launched by the Wolfensohn Center for Development at the Brookings Institution and the Dubai School of Government in 2006. Its objective is to accelerate the international community's ability to understand and respond to the changing needs of young people in the Middle East. By creating an international alliance of academics, policymakers, youth leaders, and leading thinkers from the private sector and civil society, the initiative aims to develop and promote a progressive agenda of youth inclusion.

World Health Organization, Child and Adolescent Health
www.who.int/child_adolescent_health/en/
WHO's Department of Child and Adolescent Health and Development aims to improve health and development from birth through age 19, by advocating for a comprehensive, multisectoral approach and focusing its technical assistance on the health sector. Its current priorities include integrated management of childhood illness, child and adolescent rights, adolescent sexual and reproductive health, and HIV/AIDS. The department also supports the collection and analysis of data to monitor implementation and progress towards global goals.

World Health Organization, Reproductive Health and Research
www.who.int/reproductivehealth/topics/adolescence/en/index.html
WHO's Department of Reproductive Health and Research develops research tools for gathering information on the experience and barriers adolescents face in accessing sexual and reproductive health information and services. It also supports social science and operations research to identify strengths and weakness in program implementation.

Y-Peer Network
http://38.121.140.176/web/guest/home
Y-Peer is a network of young people from dozens of countries and hundreds of youth clubs and organizations, with thousands of members around the globe. It works to mobilize youth about issues related to sexual and reproductive health and rights. The network aims to empower young people with the knowledge and skills to make healthy choices, partnering with local, regional and national orga-

nizations to bring about positive social change. The network also has an Arabic website (www.youthpeerarabic.org) and works in Egypt, Lebanon, Morocco, Tunisia, and UAE, among other MENA countries.

SELECTED TRAINING MATERIALS

It's All One Curriculum (2010)
www.popcouncil.org/publications/books/2010_ItsAllOne.asp
The Population Council and the International Planned Parenthood Federation have collaborated with international experts to produce this resource kit. Educators worldwide can use the kit in developing locally appropriate curricula to educate young people on their sexual and reproductive health with a focus on gender equality and human rights.

Girls' Success: Mentoring Guide for Life Skills (2009)
www.ungei.org/resources/files/LifeSkills.pdf
Produced by the Academy for Educational Development, this guide discusses mentoring girls to help them develop important life skills. Some of the topics covered include healthy living, inner strength, making good choices, reproductive health, and sexuality. The guide provides discussion questions about each topic and learning activities that can be conducted in mentoring sessions when girls are in school or with their families.

Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings (2009)
www.unfpa.org/public/publications/pid/4169
UNFPA and Save the Children developed this toolkit to guide humanitarian program managers and health care providers in implementing SRH interventions that address the unique needs of adolescents both during and after a crisis.

Youth-Friendly Services for Married Youth: A Curriculum for Trainers (2008)
www.engenderhealth.org
The ACQUIRE Project of EngenderHealth developed this manual to help health care providers better understand and meet the reproductive health needs of young married men and women.

EDUCAIDS Overviews of Practical Resources (2008)
http://portal.unesco.org
This guide is produced by UNESCO and UNAIDS to help technical staff, program implementers, and managers in ministries of education and civil society organizations dealing with HIV and AIDS. It contains an analysis of resources on the essential components of a comprehensive, education-sector response to HIV and AIDS. The guide is available in a number of languages, including Arabic.

Faith-Based Family Life Education Curricula (2006-2007)
www.iywg.org/youth/resources/faith-based_FLE
Family Health International/YouthNet developed these curricula, one for a Christian audience and one for a Muslim audience. They provide a training curriculum for adults and faith-based professionals to learn how to communicate with youth about sexuality and reproductive health issues, including HIV.

The World Health Organization Orientation Programme on Adolescent Health for Health-Care Providers (2006)
www.who.int/child_adolescent_health/documents/9241591269/en/index.html
This comprehensive program for providers contains a planning and preparation section and nine training modules covering the meaning of adolescence, adolescent sexual and reproductive health, adolescent-friendly health services, sexually transmitted infections in adolescents, care of adolescents during pregnancy and childbirth, unsafe abortion in adolescents, pregnancy prevention, and other topics. Only selected modules are available online, but the entire module can be ordered on a CD-ROM or in print.

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