

ADOLESCENT AND YOUTH REPRODUCTIVE HEALTH IN YEMEN

Status, Issues, Policies, and Programs

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ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
ARH	Adolescent reproductive health
ASFR	Age-specific fertility rate
CEDPA	Centre for Development and Population Activities
CPA	Country Population Assessment
CSO	Central Statistical Organization
FGC	Female genital cutting
HIV	Human immuno-deficiency virus
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
IEC	Information, education, and communication
KfW	Kreditanstalt für Wiederaufbau
MPD	Ministry of Planning and Development
NGOs	Nongovernmental organizations
RoY	Republic of Yemen
RTI	Research Triangle Institute
STI	Sexually transmitted infection
TFR	Total fertility rate
UNAIDS	Joint United Nations Programme on AIDS
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization
YDMCHS	Yemen Demographic and Maternal and Child Health Survey

1 INTRODUCTION

This assessment of adolescent reproductive health (ARH) in Yemen is part of a series of assessments in 13 countries in Asia and the Near East.¹ The purpose of the assessment is to highlight the reproductive health status of adolescents in each country. The report begins with social context and gender socialization issues that set girls and boys apart in terms of life expectations, educational attainment, job prospects, labor force participation, reproduction, and duties in the household. The report then outlines laws and policies that pertain to ARH and discusses information and services available, including delivery programs that provide reproductive health information and services to adolescents. The report goes on to identify operational barriers to ARH and ends with recommendations for improving ARH in Yemen.

The government of Yemen, led by President Ali Abdullah Saleh, is focusing more attention on the needs of Yemen's youth to ensure a healthy transition to adulthood. This is critical because Yemen's adolescent population (ages 15–24) of 3.35 million will double in just 20 years (Figure 1). Adolescents make up approximately 18 percent of the total population. Educational attainment for boys and girls is improving in Yemen. Between 1992 and 1997, the percent of boys with no education decreased from 12.7 to 5.9 percent (Figure 2). For girls, the percent decreased from 67.6 to 54.3 percent (Figure 2). There is a considerable gap between the educational levels of boys and girls. Sixty-eight percent of boys have a secondary or higher education, compared with only 21.1 percent of girls (Figure 2).

Marriage is socially important and proving fertility is paramount for couples when they first marry. Many women marry when still in their teens and have only vague information on reproductive health. Reproductive health information and services are considered the domain of married women, and, for the most part, young women do not obtain family planning services until they have had their first child. The number of births by adolescent girls will more than double in just 20 years from 302,000 to 630,000 (Figure 3). Yet, state entities do not have a clear or consistent definition of adolescence, and the group has received little attention within policies.

Contraceptive prevalence has risen for all married women (from 7% in 1992 to 21% in 1997) and for married adolescents, but unmet need for family planning is still high among adolescent and young women—36.7 percent for women ages 15–19 and 36 percent for ages 20–24 (Figure 4).² Some initiatives are underway to reach adolescents with reproductive health information and services. These initiatives have potential for success that is heightened by existing high-level political support.

Several challenges, however, remain. This calls for a multisectoral approach that includes health, education, and labor. Given its importance in the transition to adulthood and overall well being, sexual and reproductive health must be a part of the package. Young people need access to more information, through various sources, on reproductive health and they need access to services before they have their first child. Additionally, more information is needed on the reproductive and sexual behavior of youth; this research will provide a strong underpinning for future ARH programs.

¹ The countries included in the analysis are Bangladesh, Cambodia, Egypt, India, Indonesia, Jordan, Morocco, Nepal, Philippines, Sri Lanka, Pakistan, Vietnam, and Yemen.

² CSO and Macro International, 1998; CSO et al., 1999.

ARH indicators in Yemen

Figure 1. Total Adolescent Population (Ages 15-24)

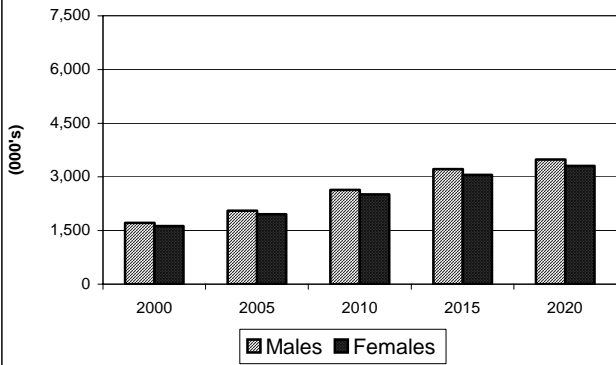


Figure 2. Years of Education Completed (Ages 15-24)

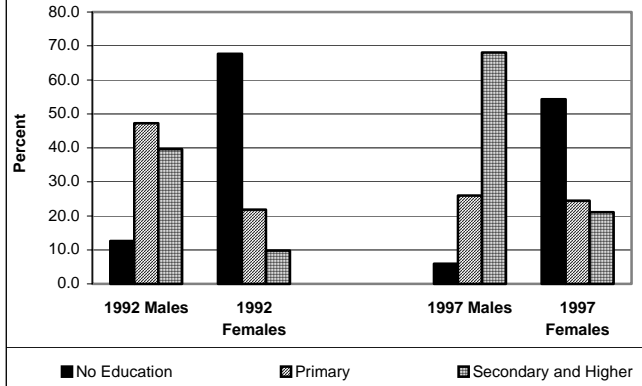


Figure 3. Annual Pregnancies and Outcomes (Ages 15-24)

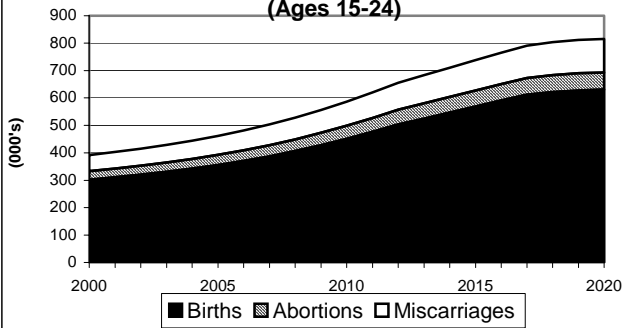
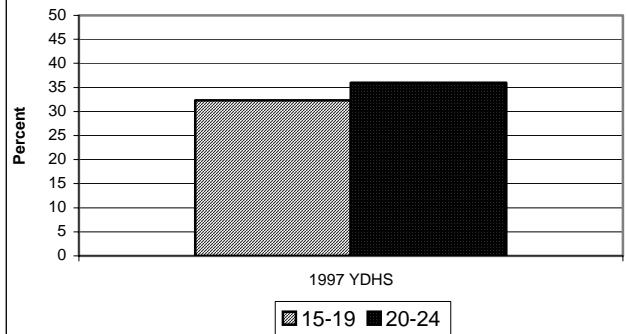


Figure 4. Total Unmet Need for FP (Ages 15-24)



Note: See Appendix 1 for the data for Figures 1 through 4

2 SOCIAL CONTEXT OF ARH

General socialization

In Yemen, social differentiation by gender starts early. In childhood, the male child's needs (e.g., education, care, and nutrition) take precedence. The focus for the female child is on having her become a good, obedient wife and mother, which entails early training in domestic activities and agricultural work, including the transportation of water in rural areas).³

Adolescence is a critical period for the socialization of gender roles and, in Yemen, strong gender differentiation occurs at that time. Girls have much less free time than boys, are much less mobile, are much less likely to participate in paid work, and have heavier domestic responsibilities regardless of whether or not they are in school. Adolescent girls' movements are restricted and their participation in public activities is severely limited. About 69 percent of all girls who are economically active are not involved in paid work.⁴ Instead, many work as unpaid workers for relatives.⁵ Seventy percent of young women are out of school,⁶ so they tend to spend their adolescence in relative seclusion within the family bounds.

Young women are taught to strive for "marriageability" and to fulfill the conventional vision of womanhood. Thus, women's decision-making powers are limited, which generally translates to a lack of decision-making power with regard to their own health care as well. Over one-third (36%) of women have their health care decisions made by their husband alone. Another 58 percent of women make these decisions jointly with their husbands. Only 2.3 percent make such decisions themselves.⁷ The small percentage of young women who work for money seem to have more decision-making power. Among the working women ages 20–24, over half (51.9%) said they alone decide how their earnings will be used. A further 25.1 percent say they decide with their husbands and 27.9 percent say they decide jointly with someone else (presumably another family member).⁸

Education

The Constitution guarantees the right of all citizens to free education at all levels and makes basic education compulsory for all children starting at age six. However, enrollment at age 15 years or more is still uncommon, especially in rural areas as a result of economic, political, and social circumstances. According to the last demographic survey in Yemen in 1997 and the last population census in 1999, about 42 to 45 percent of those currently of school age had not been enrolled in basic education classes. The illiteracy rate among age groups 10–14, 15–19, and 20–24 is 54.3, 60.4, and 70.1 percent for females, respectively, and 6.4, 7.8, and 14.0 percent for males.⁹ Clearly, there is a large gender gap in adolescent education. Yet, access to education has increased significantly since the Revolution of 1962, and the proportion of adolescents who have never attended school has fallen. This is due, in great part, to the increased enrollment of girls and adolescents from rural areas and poor households in basic education

³ Hommad and Al-Basha, 1992.

⁴ CSO and MPD, 2001.

⁵ CSO and Macro International, 1998.

⁶ CSO, MPD, and RoY, 2000.

⁷ Hommad and Al-Basha, 1992.

⁸ CSO and Macro International, 1998.

⁹ Women National Committee, 1998; CSO and MPD, 1999; CSO and MPD, 2001.

classes (34% of the enrollees are girls and 65% are boys), and in secondary school (26% of the enrollees are girls and 74% are boys).

Curtailed education: In the 1997 Yemen Demographic and Maternal and Child Health Survey (YDMCHS), 32.8 percent of females ages 15–24 not currently in school reported that they left because they got married, 18.2 percent left because they graduated or had enough school, and 2.3 percent reported pregnancy was the cause. About 13 percent said were not in school because they did not like it. Other reasons for not attending school included parents refused to allow their daughter to continue with school (9.7%) and family needed help (5.4%).¹⁰

Employment

The legal age of employment is 12 years and older.¹¹ According to a 1996 national survey, a demographic study of the work force, and the last census (1999), 21 percent of children ages 10–14 (8% of girls) participate in the labor force, rising to 48 percent for those ages 15–19 years. According to official statistics, this percentage is increasing annually.¹² The 1997 YDMCHS found that around three-quarters of females ages 15–24 did not work at all during the past 12 months; of those who did, 83 percent were employed by a relative but did not earn cash, mostly in seasonal (agricultural) jobs. This work pattern is similar for other women. Among all age groups of women, no more than 38 percent of women worked – mostly at seasonal jobs earning no cash.

Of all those who are potentially active economically within the Yemeni population, the percentages of those who are economically active is 25 percent of women compared with 74 percent of men. The majority of the Yemeni labor force is concentrated in rural areas—15 percent in urban areas and 85 percent in rural areas for women and 28 percent in urban areas and 72 percent in rural areas for men. Most of the young people who work identified that they had to work because their family needed money or because they had to help the family, although they were not being paid.¹³ It was clear that unemployment is concentrated among adolescents and youth, with 12 percent of females and 25 percent of males ages 15–19 unemployed compared with 7 percent of females and 17 percent of males ages 20–24.¹⁴

Marriage

Age at marriage: Yemen's legal age at marriage is 15, but a significant percentage of young women marry before age 14. The 1997 YDMCHS recorded a median age at marriage of 16.5 for women ages 20–49. There is evidence that the median age at marriage is rising: among young women ages 20–24, the median age at marriage was 18.2 in 1997, compared with 15.7 for women ages 45–49.¹⁵ Still, according to a recent study on family health care, 43 percent of the women in the study married between the ages of 12 and 17.¹⁶ Fifty percent of women aged 15–19 have married by the age of 15; the median age at marriage is higher for urban than rural women in this age group.

¹⁰ CSO and Macro International, 1998.

¹¹ Hommad and Al-Basha, 1992.

¹² Woman National Committee, 1998; National Population Council, 1996.

¹³ CSO and Macro International, 1998.

¹⁴ National Population Council, 1996; CSO and Ministry of Planning and Development, 2001.

¹⁵ CSO and Macro International, 1998.

¹⁶ Hommad and Al-Basha, 1992.

Adolescent marriages are still preferred by the majority of Yemenis.¹⁷ Two ages stand out as considered the ideal age at marriage, even by young females ages 15–19 and 20–24: ages 15 and 20–21. Around a quarter of women in each age group in the 1997 YDMCHS considered those the ideal ages to marry. Age 16–17 was the next most popular response. Fewer than 6 percent of the women, including those ages 15–24 considered and age younger than 15 as ideal for marriage for females.

Virtually all women in Yemen marry men older than themselves. Only around 2 percent of young females ages 15–24 were married to younger men. Among the age groups 15–19 and 20–24, women were married to men who were an average of six years older than themselves, respectively. Still, the trend in age cohorts of women shows that the age gap between wives and husbands is narrowing somewhat—for women ages 45–49, the husbands were, on average 8.3 years older than their wives. Young girls are more likely than boys to marry as adolescents. One woman in 10 is married to a man at least 15 years older, and one-half are married to men at least 20 years older.

Young females may be getting some positive reinforcement from their mothers about waiting to get married. The 1997 YDMCHS found that half the mothers in the study indicated that their daughters should get married at a later age than they themselves had married.¹⁸ Furthermore, as females get more education, they are more likely to consider early marriage as less than ideal.

Social pressure: Once married, couples are under social pressure to prove their fertility and begin childbearing immediately. A woman's status in her family is usually enhanced and stabilized as a result of having children.¹⁹

Orfi: In Islamic societies, a marriage becomes official through its blessing by the couple's families and its public announcement from the families. *Orfi*, however, is a weak substitute for formal marriage in which the couple obtains a clandestine marriage certificate without announcing their intentions to marry to their families. Since the families have not blessed these unions and because pregnancy to unmarried women is unacceptable, pregnancies resulting from *Orfi* unions are presumably unplanned and unwanted. The risk of unwanted pregnancy is high, as is a negative response from families. The phenomenon of *orfi* occurs rarely, and when it does, it occurs mainly between Yemeni women and non-Yemeni men.²⁰

Consanguineous marriage: A number of marriages in Yemen take place between family members, most often between cousins. The YDMCHS (1997) notes that four out of 10 women had married a blood relative.²¹ Evidence suggests that consanguineous marriages are becoming more common. Among young females ages 15–19, nearly half (47.1%) of marriages were between relatives, compared with 30.4 percent for women ages 45–49.

Polygamy: Polygamy is legal in Yemen. A man may take up to four wives at a time, provided the husband is able to treat all of them equally. Polygamy is more common as the age of the woman increases; 4 percent of women ages 15–19 are a part of a polygamous relationship and 10 percent of women ages 45–49 are involved in one. Polygamy is more common in rural and mountainous areas than in urban and coastal regions and is also more common among those who are illiterate.²²

¹⁷ CSO and Macro International, 1998.

¹⁸ CSO and Macro International, 1998.

¹⁹ Aoyama, 2001; CSO and Macro International, 1998.

²⁰ From opinions from courts.

²¹ CSO and Macro International, 1998.

²² CSO and Macro International, 1998.

3 ARH ISSUES

Early, high-risk pregnancy

Half of all women (ages 25–49) had their first birth before age 20: the median age at first birth was 19.5 in 1997. Twelve percent of Yemeni women ages 15–19 have given birth to at least one child, and 16 percent have started childbearing, which means they have had a pregnancy in the past, but have not had a live birth (0.9%), they are mothers (12.1%), or they are currently pregnant but have not had a live birth (3.4%). Table 1 shows that 2 percent of women age 15 have started their childbearing, rising steadily to 39.4 among young women age 19. Seventeen percent of women aged 15–19 in rural areas had begun childbearing, compared with 14 percent in urban areas. Early commencement of childbearing was more common in mountainous and plateau/desert areas (16.7% and 18.0%, respectively) than in the coastal region (12.0%). Illiterate women were more likely than those with schooling (particularly secondary school) to start childbearing early (20.4% compared with 12.2%).²³

Table 1. Childbearing Among Young Females Ages 15–19, by Selected Characteristics, 1997

Background characteristics	Percentage of young females who:				Number
	Had pregnancy in the past, no live birth	Are mothers	Are currently pregnant, no live birth	Have started childbearing	
Age					
15	0.4	1.0	0.6	2.0	1,040
16	0.8	3.2	2.0	5.9	851
17	1.4	9.3	2.9	13.6	716
18	0.9	20.1	7.7	28.7	896
19	1.0	34.0	4.4	39.4	634
Residence					
Urban	0.6	10.3	3.0	14.0	1,138
Rural	1.0	12.8	3.5	17.3	2,984
Region					
Coastal	0.4	10.2	1.8	12.4	1,007
Mountainous	0.8	11.8	4.1	16.7	1,182
Plateau and desert	1.1	13.1	3.8	18.0	1,957
Education					
Illiterate	1.0	15.4	4.1	20.4	2,267
Literate	0.7	7.6	1.3	9.6	657
Primary complete	1.2	11.9	3.9	17.0	585
Preparatory complete	0.3	6.2	2.7	9.2	384
Secondary complete+	0.8	6.2	5.2	12.2	124
Total	0.9	12.1	3.4	16.3	4,137

Source: CSO and Macro International, 1998.

²³ CSO and Macro International, 1998.

Unwanted pregnancy, abortion

Abortion is legally restricted in Yemen and cannot be performed in public health facilities. It is only permitted in cases in which it will save a woman's life, when the woman was a victim of rape, or when the fetus has a congenital abnormality.²⁴ While there are no data on abortion in Yemen, there are some abortions taking place in private facilities, although there are no statistical reports available on the numbers of abortions occurring.

Female genital cutting (FGC)

In Yemen, FGC is observed among Somali and Ethiopian descendants in coastal areas such as Hodiedah and Aden. According to the 1997 YDMCHS, FGC prevalence in Yemen is 22.6 percent, that is, nearly one in four Yemeni women. However, younger women (ages 15–19) were less likely than older women (ages 45–49) to be circumcised (19.3% compared with 25.0%). The practice is fairly concentrated in the Coastal region, where 68.9 percent of women are circumcised compared with 15.3 percent in the mountainous region, and 4.8 percent in the plateau and desert region.²⁵

Contraceptive knowledge and use

Young women are generally aware of contraception—in 1997, 72.5 percent of young women ages 15–19 had heard of at least one modern method of contraception, rising to 81.3 percent of young women ages 20–24.²⁶ Over half (54.9%) of the women ages 20–24 knew of a source for a modern method compared to 41.8 percent of the younger women ages 15–19. Current use of contraception in 1997 was low among young married women: 8.6 percent of married women ages 15–19 were using a method (2.7% were using a modern method), rising to 18.7% among women ages 20–24 (6.1% was modern method use). The two most common methods were prolonged breastfeeding (the lactational amenorrhea method, LAM) followed by the pill. Among all Yemeni women who were married in 1997, 20.8 percent were using contraception (9.8% were using a modern method). With age, use of the pill, the IUD, and female sterilization increases.

Approval of contraceptive use

More than half of the married women ages 15–19 and 20–24 who knew of a contraceptive method said they approved of family planning (56.9% and 61.0%, respectively).²⁷ They were less sure that their husbands approved (according to the women ages 15–19 and 20–24, 36.6% and 44.4% of husbands approved, respectively). It is encouraging to note the approval of family planning does increase between the two age groups, possibly as couples have children their approval of family planning increases.

²⁴ Woman National Committee, 1999; CSO and Macro International, 1998.

²⁵ Aoyama, 2001.

²⁶ CSO and Marco International, 1998.

²⁷ CSO and Macro International, 1998.

Unmet need for contraception

Not surprisingly, unmet need for family planning is high among Yemeni women, including young women, who tend to be married and have already started childbearing.²⁸ Total demand for family planning²⁹ among young women ages 15–19 is 40.9 percent and rises to 54.7 percent for young women ages 20–24. Among the age group 15–19, only 21.1 percent of that demand is satisfied, compared with 34.5 percent among young women ages 20–24. Most of the need for family planning among these age groups is for spacing methods.

Sexually Transmitted Infections and HIV/AIDS

Data on sexually transmitted infections (STIs) are lacking and the data that exist may not be accurate. In 2000, the HIV/AIDS National Committee reported one case among males and two cases among females ages 15–19 and 11 cases among males and 14 cases among females ages 20–24 years.³⁰ The percentage of adults living with HIV/AIDS at the end of 2001 is estimated at 0.1 percent. Presumably, the estimate for youth is lower than the estimate for adult prevalence.³¹

²⁸ CSO and Macro International, 1998.

²⁹ Total demand for family planning includes unmet need for spacing and limiting and current use for spacing and limiting. Unmet need for spacing includes pregnant women whose pregnancy was mistimed, amenorrheic women whose last birth was mistimed, and women who are neither pregnant nor amenorrheic and who are not using any method of family planning but say they want to wait two or more years for their next birth. Also included in unmet need for spacing are women who are unsure whether they want another child or who want another child but are unsure when to have the birth. Unmet need for limiting refers to pregnant women whose pregnancy was unwanted, amenorrheic women whose last child was unwanted, and women who are neither pregnant nor amenorrheic and who are not using any method of family planning but want no more children. Excluded from the unmet need category are menopausal and infertile women.

³⁰ Woman National Committee, 1998; The Report of High Committee of AIDS, 2000.

³¹ UNICEF, UNAIDS, and WHO, 2002.

4

LEGAL AND POLICY ISSUES RELATED TO ARH

Legal barriers

There is no clear or consistent legal definition of “adolescent” in Yemen, and this group is not singled out for special treatment under the law.

Existing ARH policies

A 1999 review of Yemeni policy with regard to adolescents and youth found that there are important policies, such as the National Strategy for Mother and Child, the Strategy for Illiteracy Reduction, the National Strategy for Female Education Enhancement, and the Strategy for Reproductive Health and Family Planning, that refer to adolescents. In addition, 10 ministries, a specialized committee for youth within the Peoples’ Assembly, and two specialized councils exist that are responsible for addressing the needs of adolescents. However, state entities do not have a clear or consistent definition of adolescence, and policies and programs have largely neglected adolescents.

Population policy: Yemen’s Population Policy does not adequately address the issues of reproductive health information and services for young adults.³² The prevalent attitude in the country regarding how to protect children and young adults from engaging in unacceptable behaviors (such as premarital sex) is that it is best done by maintaining adolescents’ ignorance of such practices.³³

School health: Preventive health care including checkups, vaccinations, and limited curative services are provided through the school health system and Ministry of Health services. University clinics and hospitals are available to people of all ages. However, these services, as a whole, do not systematically include reproductive health care.³⁴

Marriage: State policy accords great importance to marriage and motherhood. The legal age at marriage is 15 years. Age 15 is considered too young for marriage by many women, as noted above; yet, there is still a significant number of underage marriages.

Motherhood and childhood: A number of efforts are in place to guarantee the well being of mothers and children. The Constitution provides for the protection of mothers, children, and youth and guarantees the right of women to medical, physical, psychological, and social health care. In 1991, a presidential decree established the National Council for Childhood and Motherhood. An entire chapter of the current five-year plan (2001–2005) is devoted to motherhood and childhood.

Civil Service Law No. 19 of 1991 and the Labor Law No. 15 of 1995 entitle working women to maternity and child leave with full pay for 60 days, with an additional 20 days if the delivery involved an operation or twins, and reduced working hours (no more than 5 hours) for both pregnant mothers in their sixth

³² NPC, 2001.

³³ NPC, 1996.

³⁴ RoY et al., 1998.

month of pregnancy and beyond and for breastfeeding mothers for up to six months after delivery. Additionally, the new mother can get unpaid leave for one year if requested.³⁵

Abortion: In Yemen, abortion is considered a crime punishable under the law, regardless of whether the consent of the woman has been obtained. From a religious point of view, abortion is forbidden by the Sharia (Islamic law), which considers it an act of murder. However, abortion is permitted by the Sharia and by the government in the following cases:

1. The pregnancy endangers the mother's life.
2. Serious deformation of the fetus.
3. The pregnancy is a result of rape.
4. Intrauterine fetal death.
5. Inevitable abortion (miscarriage or the pregnancy cannot continue due to the opening of the cervix causing very premature labor).

Under all circumstances, abortion requires the consent of the husband.³⁶

ARH policy initiatives

ARH strategy: Yemen is committed to implementing the National Strategy for Integrating Youth into Development (1998), developed by a team of specialists in the Ministry of Youth and Sports. The strategy was developed with input by various representatives including the Boy Scouts and Girl Guides Association. The process was supervised by both national and international population and development experts with specific expertise in integrating youth, development, population, and reproductive health issues. The purpose of the strategy was to provide a sound basis for action as defined by the 1994 International Conference on Population and Development (ICPD) *Programme of Action*.

The strategy presents an analysis of the issues and unmet needs of adolescents and young people in the areas of health, education, economics, law, mental health, and social concerns. It offers recommendations for addressing the needs of adolescents and provides strategic actions that stress the importance of coordination and cooperation among sectoral governmental agencies, the civil society, and popular organizations helping to ensure high-level strategic support and activities. The National Strategy for Integrating Youth into Development supports the development of subcommittees composed of both governmental and nongovernmental organizations (NGOs) to coordinate and follow up on activities, including the implementation of information, education, and communication (IEC) activities in support of adolescent reproductive and sexual health and the provision of services to young married couples. It stresses the crucial importance of providing information to decision makers on the adverse health effects, the psychological and social impacts of early marriage and early pregnancy, and the advantages of birth spacing. The goal of this process is to review legislation that has an impact on the minimum age of marriage and the provision of quality reproductive health services to young married couples.³⁷

Another national strategy for reproductive health 2001–2005 stressed important principles such as political commitment of the government in support and provision of reproductive health services and the right of every citizen to an acceptable standard of reproductive health services.

³⁵ Woman National Committee, 1999.

³⁶ Woman National Committee, 1999.

³⁷ RoY, et al., 1998.

New political support to focus on adolescents: President Ali Abdullah Saleh is paying more attention to the needs of youth, as reflected in speeches he has given recently. He has stated that Yemen needs to focus on its youth given that its status will greatly affect the demographic characteristics of Yemen. The president also stated that investing in youth is the best investment for yielding a better future and overall quality of life.

In the Second National Conference on Population Policy (1996), more attention is paid to female education and reducing girls' illiteracy and gender discrimination. It is complemented by the National Population Program 2001–2025, which focuses attention on improving maternal and child health care.³⁸ President Ali Abdullah Saleh declared youth a national priority for 1999 and named that year the National Year for Yemeni Youth and Sport. Subsequently, a 1999 decree (No. 59) by the Prime Minister established the General Strategy for Youth, Adolescents, and Sport (2000–2004), which is aimed at providing a planned and scientific base for ensuring the infrastructure necessary to make headway on youth-oriented issues in Yemen.³⁹

³⁸National Population Council

³⁹Ministry of Youth and Sport, 1999.

5 ARH PROGRAMS

To date, reproductive health services and other educational information specifically targeting young adults in Yemen have been very limited.

Nevertheless, promising efforts are being made. Yemeni NGOs, such as the Yemeni Association of Family Planning, and international agencies, such as the European Project on IEC, fund reproductive health and sexual health education in schools (implemented by the National Population Council). The government has started adolescent health programs that are intended to educate youths about risky behaviors.⁴⁰ Kreditanstalt für Wiederaufbau (KfW) also helped catalyze action on reproductive health in Yemen. Government institutions mobilized around the Second National Conference on Population Policy in 1996 and NGOs also become quite active conducting reproductive health education in schools and camps and providing outreach education and services to young people. United Nations agencies (UNAIDS and UNFPA) IPPF, WHO, and other donors have been playing supportive roles. The National Population Strategy objectives have been broadened to support the availability of reproductive health services and community development efforts of NGOs. The National Strategy for Integrating Youth into Development (1998) also stresses female education and calls for increased employment opportunities for women to reduce the gender gap in that area.⁴¹

School health education: There are few health education activities, including those focused on HIV/AIDS. Reproductive health education is weak in schools and should be strengthened. The topic of reproductive health is not fully included in medical schools or in health institutes. The National Population Council and the Yemeni Family Care Association also have some activities in health education and family planning services.

Nongovernmental sector: Institutions that focus on issues other than health also have youth programs that can positively affect reproductive health outcomes. The National Council for Childhood and Motherhood and the Ministry of Youth are working to raise awareness, particularly among youth, on reproductive health issues. The head of Shoura Council, which is a national policymaking body, has recently advocated for preparing youth to participate in the planning and implementation of national development programs. The National Women's Committee was formed by a Prime Minister's decree (No. 98) in 1996 with the objective of expanding the role of women in society and decreasing educational and employment disparities between genders.⁴²

Access to information: Few young women receive messages about family planning through the media. Television and radio are the major sources of information about family planning, yet in 1997, among young women ages 15–19, 30 percent said they had received family planning messages through one or the other (or both) sources.⁴³ Among young women ages 20–24, the percentage receiving messages about family planning from television and/or radio increased slightly to 34.2 percent. Differences in reported reception of messages were small across all age groups (ages 15–49). Furthermore, 5.2 percent of young women ages 15–19 and 4.9 percent of young women ages 20–24 said they received print messages on family planning (e.g., from newspapers/magazines, posters, or leaflets/brochures). The percentages of women receiving print messages on family planning did not increase with age.

⁴⁰ Aoyama, 2001.

⁴¹ RoY et al., 1998.

⁴² Hommad, 1992; National Women's Committee, 1999.

⁴³ CSO and Macro International, 1998.

6

OPERATIONAL BARRIERS TO ARH

Inability to obtain services

It is difficult for adolescents, particularly those who are unmarried and not in school, to obtain reproductive health information and services.⁴⁴ Thus, they have remained largely uninformed.

Lack of knowledge

Weak awareness among both parents about reproductive health issues in general and ARH in particular has had an adverse impact on the behavior of their children, both male and female. The following represent some of the issues that continue to inhibit relevant information dissemination on reproductive health to adolescents and the problems associated with that lack of information:

- Lack of responsiveness of curricula through educational programs and activities on the needs of young people in the areas of life skills, puberty, reproductive health, and family life.
- Scarcity of Arabic-language scientific and other objective references on ARH and young people's inability to access them, where they do exist.
- Weakness of radio and TV programs targeting adolescents and youth, and the use of inappropriate broadcasting times.
- Low priority given by the Ministry of Health to support reproductive health programming.
- Weakness of content of reproductive health information in the school curricula and insufficient training of teachers in this field.
- Limited types of health services in schools, with little attention paid to adolescent health.
- Scarcity of scientific information on youth health, education, and psychological and social problems, and little use of reproductive health indicators in the planning, implementation, monitoring, and evaluation of ARH activities and programs.

The result of the inability of adolescents to gain information results in young couples knowing little about sexuality and reproductive health when they marry. Thus, they embark on their sexual and reproductive life with little or no knowledge and limited skills for discussing or negotiating sexual and reproductive preferences and needs.⁴⁵

⁴⁴ Aoyama, 2001.

⁴⁵ RoY et al., 1998; Hommad and Al-Basha, 1992; Ministry of Youth and Sport, 1999.

7 RECOMMENDATIONS

The following are broad recommendations to help ensure high quality reproductive health services among adolescents in Yemen:

- Generate and ensure political commitment and support at the highest level for the development and implementation of programs to meet the needs of adolescents. The president speaks about the needs of young people for a healthy transition to adulthood, so it appears that political support for programming for adolescents is available and should be tapped.
- Reinforce coordination and cooperation among sectoral governmental agencies, civil society, popular organizations, and international agencies to develop and implement strategies and programs to meet youth's needs, including integrating reproductive health information and programming.
- Inform decision makers about the wide-ranging negative effects of early marriage and early pregnancy, and the benefits of birth spacing. Encourage a review of legislation and laws on the minimum age at first marriage with the view to change the legislation.
- Provide good quality reproductive health services to young married couples.

Within the broad recommendations identified above, the following are specific issues to address:

- Provide information to adolescents. Although a number of activities address adolescents' needs for information on reproductive health, this remains a critical area for expanded intervention through a variety of channels, including in-school and out-of-school information programs, peer counseling, provider counseling, and mass media.
- Encourage political, legal, and social conditions conducive to increasing adolescent's access to health care services, and render those services acceptable to young people in terms of cost and quality. As a part of this effort, encourage a positive atmosphere and reception, giving high importance to health promotion and education activities related to communicable diseases, STIs, and HIV/AIDS.
- Encourage and standardize processes for premarital counseling.
- Work through the pharmacy network. Pharmacists could, and sometimes already do, serve as reliable, confidential, and accessible providers of basic information and services.
- Undertake research and studies on youth and ARH. Additionally, train field researchers in the areas of reproductive health and health behavior; research methodologies, including new developments in qualitative research; and participatory methodologies that can be used to involve young people in needs analysis, program design, planning, implementation, and evaluation.
- Train teachers, educators, curricula specialists, senior media officials, and journalists on the importance of dealing with issues related to adolescent sexuality and reproductive health.
- Promote awareness and sensitize young people, community leaders, and parents about the importance of ARH.⁴⁶

⁴⁶ Various sources, including Ministry of Youth and Sport, 1999.

APPENDIX 1. Data for Figures 1 through 4

1. Adolescent Population (Ages 15–24) ('000s)					
	2000	2005	2010	2015	2020
Males	1,718	2,058	2,641	3,220	3,484
Females	1,631	1,954	2,512	3,060	3,307
2. Level of Education (%) (Ages 15–24) ('000s)					
	1992 Males	1992 Females	1997 Males	1997 Females	
No Education	12.7	67.7	5.9	54.3	
Primary	47.2	21.8	26.0	24.5	
Secondary and Higher	39.6	9.8	68.0	21.1	
3. Pregnancy Outcomes ('000s)					
	2000	2005	2010	2015	2020
Total Pregnancies	392	462	587	738	815
Births	302	355	451	569	630
Abortions	31	37	48	58	63
Miscarriages	59	69	88	111	122
4. Unmet Need (%)					
	1997				
Total Unmet Need (ages 15–19)	32.3				
Total Unmet Need (ages 20–24)	36.0				

Assumptions and Sources:

Figure 1. Adolescent population projections were made by entering the base year population estimates from the UN medium population projection, World Population Prospects, The 2000 Revision, into the POLICY Project's SPECTRUM Model and projecting the population to 2020.

Figure 2. Level of education for 1992 was taken from the 1991/92 YDMCHS report, and for 1997 it was taken from the 1997 YDMCHS report. The figures cited are a weighted average of household educational attainment statistics for 15–19 and 20–24 year-olds.

Figure 3. Births, abortions and miscarriages were calculated by multiplying the appropriate age-specific rates (i.e., fertility, abortion, and miscarriage) by the estimated number of adolescent females (single-age population estimates were calculated using the SPECTRUM Model). Total pregnancies were calculated by summing the total number of births, abortions, and miscarriages. The total fertility rate (TFR) and age-specific fertility rates (ASFRs) for the base year were taken from the 1997 YDMCHS report. TFR assumptions for future years were derived from the World Population Prospects data. Mortality and migration rates were derived from World Population Prospects data. The abortion rate was assumed to be 19 per 1,000 (Profiles estimate). Since no age-specific rates were given for adolescents, the overall abortion rate for women was used. The miscarriage rate was assumed to be 15 percent (Guttmacher Institute estimate). Since no age-specific rates were given for adolescents, the overall miscarriage rate for women was used.

Figure 4. Levels of unmet need were taken from the 1992 and 1997 YDMCHS reports.

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