THE REPRODUCTIVE HEALTH OF YOUNG PEOPLE IN THE MIDDLE EAST AND NORTH AFRICA[1]

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SUMMARY OF PAPER:

Due to past fertility rates, the Arab countries are currently experiencing an unprecedented demographic "youth bulge"; that is, young people in the age-group 10-24 now constitute roughly one third of the total population of the region. Yet despite this fact, there is a lack of basic information about key areas of young people's well-being, including sensitive issues pertaining to their sexual and reproductive health. There are few national government programmes addressing young people's sexual and reproductive health, with the exceptions of Tunisia, and only recently has some population-based data become available to guide such programmes. Lack of sufficient policy attention to young people's well-being feeds a deficiency in services available in this field. Although the strong emphasis on the integrity and strength of the family unit has a protective effect, young people lack access to information particularly about sexual and reproductive health. Education curricula that include these topics are rare and where they do exist, relevant sections are frequently skipped over by teachers, who are unprepared. Health service providers are not trained to recognise the needs of this age group and in some cases are reported to take a judgemental attitude towards young people, especially those who are unmarried. Increased education and employment mean the age at marriage is rising, but unprotected forms of marriage are also reported. Taboos surrounding discussion of sexuality remain a key constraint, and data on youth concerning most reproductive health topics are limited. Innovative programmes have been developed in the region, but many are small-scale, led by NGOs and not sufficiently evaluated. Building on existing efforts, there is a need for the development of national programmes to support the well-being of young people in all its aspects in this region.

INTRODUCTION

Beginning in the 1990s, programmes addressing the sexual and reproductive health of adolescents began to apply more systematically the findings from research on the protective and risk factors that enable behaviour change. This emerging evidence has led programmes to integrate work on health and development issues, and intervene with both young people and their social environments. These comprehensive strategies complement the more limited but necessary approaches that provide information, education and services on sexual and reproductive health with an "assets-building" approach that strengthens protective factors and reduces risk factors.[2] Accordingly, these approaches pay systematic attention to building young people's skills, expanding opportunities for education and livelihoods, providing safe and supportive environments that promote health-protective norms among both adults and peers, and promoting young people's participation in communities and programmes. The advent of the HIV/AIDS epidemic has added considerable urgency to the efforts to promote young people's sexual and reproductive health, given the predominance of

young people among those infected in most countries. This approach to young people was reinforced by the programmatic implications of the International Conference on Population and Development (ICPD) Programme of Action in 1994.

Despite the fact that the International Conference on Population and Development took place in the Middle East region in 1994, and it attracted significant media attention, unlike many other regions, there has been relatively little research on young people in the Middle East and North Africa. The traditional emphasis on fertility and family planning has meant that population-based data tended to be collected only on ever-married women. Only recently has the region seen the fielding of the first youth development surveys which sample young people married and unmarried under the auspices of independent research institutions and the Arab League.

This paper therefore aims to contribute to knowledge about an under-researched region and an age group that to date has received little attention. Following the above approach, it grounds the sexual and reproductive health of young people aged 10 to 24 in their political, economic and social context. It focuses on the 10– 24 age group, which the World Health Organization defines as "young people" (as opposed to adolescents aged 10–19 and young adults aged 15–24), on the premise that many of the sexual and reproductive health problems addressed, including early marriage and female genital mutilation, affect the younger ages within this category.

The paper is based on a review of unpublished, grey and published literature and interviews in person in Egypt, Lebanon, Jordan and Tunisia, and by telephone with key informants in other countries of the region. Overall, 51 interviews were conducted, including nine with people working at regional or international level, with expertise on adolescent sexual and reproductive health programmes in Morocco, Tunisia, Egypt, Lebanon, the West Bank and Gaza, Jordan, Yemen, Sudan, Oman, Bahrain, Djibouti and Syria. All interviews were open-ended but guided by a set of standard questions concerning interviewees' perceptions of the main challenges facing youth; key sexual and reproductive health issues; perceived risk and protective factors; strategies for overcoming challenges; existing programmes serving youth (whether governmental or not) and the evidence needed to support programmes. There are a number of possible biases in the choice of interviewees: firstly, government representatives were relatively under-represented as compared to personnel of non-governmental organizations; secondly, the interviewees support such programmes; and thirdly, interviewees from the Persian Gulf tended to be under-represented and those from Egypt and Tunisia over-represented in comparison with other countries.

The paper first reviews the demographic, political and social context of young people's sexual and reproductive health before turning to analysis of existing data on young people's reproductive health status. It then addresses research gaps in this area and takes a future look to what programs have and could be effective in this cultural context for addressing young people's reproductive health.

ARAB DEMOGRAPHY AND YOUNG PEOPLE

Because of past fertility trends, the Arab countries are now facing a unique demographic moment in that never before have there been so many young people in comparison to other age-groups. The age group 10 to 24 now comprises approximately one-third of the total population of the region; this proportion is as high as 36% in Syria, and 38% in Kuwait. Across the Arab countries, and particularly in North Africa, the average age at marriage has been rising for both sexes for a number of social and economic reasons. In Tunisia, the average age at marriage is the highest in the region, at 29 for women and 33 for men. This trend of later age at marriage, combined with a global trend in earlier age of puberty onset, has exposed young people to greater health risks associated with increasing pre-marital sexual activity and rising sexually transmitted infection rates, including HIV, in the region. This risk is heightened by young people's lack of information about their sexual and reproductive health, and lack of access to services. Educational levels have also risen rapidly, which together with greater exposure to the norms of global culture often create rifts between generations, particularly as social networks become more fragmented with greater urbanization and rapid social change. This generation gap deprives young people of the counselling and support they need from adults to face these risks and stay healthy. At the same time, young people's unemployment in this region is the highest in the world– 25.6% of young people 15 to 24 are actively searching for work[3] owing to this "youth bulge" in the population. This situation stifles opportunities to improve standards of living for the broadening cohorts of educated young people and creates widespread frustration, with multiple negative consequences both for young people themselves and for their societies.

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

Singling out sexual and reproductive health for attention, by no means ignores the imperative of addressing the needs of young people in their entirety; like people of any other age, they do not compartmentalise their lives. Moreover, a focus on sexual and reproductive health ***problems*** ignores the positive aspects of this period of young people's lives as identities are forged, relationships fostered and for many, families are started. Media characterization of youth from the Arab countries as somehow "*politically dangerous*", both within and outside the region, has obscured the need for

positive attention to their needs, perspectives and aspirations. El Tawila distinguishes between the "*deviant*" paradigm of youth prevalent in the region with its negative expectations of youth and the new development approach recognizing young people's strengths and potential.[5]

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

THE POLITICAL CONTEXT OF YOUNG PEOPLE'S SEXUAL AND REPRODUCTIVE HEALTH

An analysis of the sexual and reproductive health needs of young people in the Arab countries cannot fail to address the particular historical and political circumstances of the region. Over the last twenty-five years, the region has experienced major conflicts and political upheavals, from the Iran-Iraq war of 1980-88, Gulf crises and wars in both 1990 and 2003, civil war in Sudan from 1983, civil war in Lebanon (1975-1990) and political unrest in both Egypt and Algeria, to the present, continuing unrest and lack of political resolution in Palestine and in Iraq. For many years sanctions with strong socio-economic implications have also been imposed on both Libya and Iraq.

Widespread conflict has resulted in untold numbers of casualties and people with disabilities, as well as broken families and orphans. Destabilization and disruption of the provision of health and education services is not the only outcome of prolonged conflict. Such conditions often lead to a breakdown in social networks and solidarity, thus undermining some of the main mechanisms protective of young people's health and development, including their sexual and reproductive health. Moreover, the mobility associated with conflict is itself a risk factor for the transmission of sexually transmitted infections including HIV/AIDS. In Sudan, for example, the HIV/AIDS epidemic has largely been driven by civil war in that country. The war-torn south of the country is on one of the main HIV-belts of Sub-Saharan Africa, and both widespread poverty and conflict have led to the emergence of a commercial sex industry there. The persistence of conflict weakens and disrupts government and public health surveillance capacity. Thus the transmission of infection to soldiers from the north of the country, and ultimately their wives, remains unchecked.

Sexual violence often increases in contexts of armed conflict. In Iraq, Human Rights Watch has documented a sharp rise in the incidence of sexual violence against women and young girls in Baghdad after the fall of the Ba'athist regime, for which the legal system, health services and other services are singularly unprepared.[6] To date, there has been little international assistance to address these concerns.

The effects of conflict or civil unrest on the sexual and reproductive health of young people may be more subtle and difficult to discern. In a study in Palestine, for example, Khawaja found that there was a rise in adolescent fertility at the time of the

first *intifada* (or uprising against Israeli occupation) from 1987 - 1990, a trend associated with a declining age at marriage for girls during that period. While further qualitative research is needed to investigate the reasons for this trend, and implications of the current unrest, the uncertainty and anxiety produced by political conflict may be one factor motivating parents to have their children married early.[7] Palestinian interviewees for this report repeatedly state that the threat of violence, disruption to education and health services, inability to move from place to place and other consequences of the ongoing conflict there are some of the main impediments to developing programmes to serve youth.[8]

Both the UNDP Arab Human Development Report[9] and the more recent World Bank report on governance in the Middle East and North Africa (MENA) region[10] point to the poor quality of institutions, political accountability and governance in the MENA region as a main feature holding back development. Despite evident demands for greater political participation, citizens of the region remain, to varying degrees, subject to under-representation within political systems that have been slow to reform. This situation applies equally to young people, most of whom do not have channels to participate in policy formation affecting their lives. In most Arab countries the legal voting age is 18, although young people must wait till they are 20 to vote in Tunisia and till 21 in Kuwait, Lebanon, Morocco, Oman and Saudi Arabia.[11] Oman has recently lowered the age at voting for women from 30 to 21.[12] Of the three countries in the world that deny both men and women the right to vote, two are in the region (Saudi Arabia and the United Arab Emirates); Bahrain only gave women the vote in 2001 and Kuwait is the most recent country to give women the vote, in 2005.[13]

The demographer, Philippe Fargues, in an analysis of the relationship between Arab demographic trends and political trends, has argued that the roots of political violence in the region relate to the combination of persistent paternalism with increasing differences in education between generations; the younger generation has the advantage in terms of education but the older generation still commands greatest authority and is living longer.[14] The ensuing generation gap deprives young people of "connectedness" to supportive adults -- a key protective factor for their health and development.

Social policy in the region remains a contested area given this political context and competing views over the appropriate role of religion in social policy. In particular, this is arguably the case in the field of sexual and reproductive health, given its association with deeply held religious and cultural values. The sexual and reproductive rights of young people and women are of utmost sensitivity.

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

CULTURAL AND SOCIAL CONTEXT: RISK AND PROTECTIVE FACTORS FOR YOUTH

The Arab countries demonstrate considerable gender disparities in access to education, social opportunities and political participation. Indeed the region ranks next to last (behind Sub-Saharan Africa) on UNDP's gender empowerment measure.[15] More than half of Arab women are illiterate. The region also has the lowest rate of female labour-force participation (26%) of any region in the world.[16] Such statistics, however, under-estimate the extent of women's participation in the informal sector and do not capture the rapid increase in both education and women's labour-force participation in recent years.

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

With urbanization and social change, the structure of households in the region is also in a state of flux. The traditionally dominant extended family form is increasingly giving way to nuclearisation, especially in urban areas.[17] Within both extended and nuclear households, however, the region is characterised by strong stratification of roles and authority along the lines of both gender and age. Within extended families, the mother-in-law often plays a key role in household decision-making, and typically, her daughter-in-law is weakest in power until childbearing proceeds and her age advances.[18] Brothers are also disproportionately powerful within the household, and are socialised to see it as their responsibility to defend family honour, especially as it pertains to the social and sexual behaviour of their unmarried sisters.[19]

Interviewees contacted for this study observed that family life in the region is changing because of migration, busy lives and changes in lifestyle brought by the mass media and consumerism.[20] They expressed concern that families are therefore not playing the traditional protective and information-providing roles they once did, and that young people as a consequence lack adult role models. While studies reveal that young people would prefer obtaining information about puberty and their health from their parents, the latter are often reluctant to provide it. Interestingly, a nationally representative survey of young people and their parents in Egypt found that although 42% of fathers with adolescent sons aged 10 to 19 indicate they talked to their sons about pubertal changes, only 7% of boys who reported knowing something about puberty changes learned from their fathers.[21]

In a context where notions of honour and shame are deeply ingrained, an overt recognition within policy that, for example, youth have sexual needs and desires, may be sexually active before marriage, and that married couples experience sexual and reproductive health problems is deeply problematic. While one would hope to look to the public health community to address these difficult issues, as one interviewee articulated it, some public health authorities in the region "*subvert public health*

directives to the arguments of culture." The danger of this tendency is the result of "*saving face but not saving lives.*" [22]

Despite these numerous political and social constraints to the realization of sexual and reproductive health policies and programmes for youth in the region, however, there is nevertheless, evidence of considerable ingenuity on the part of young people to communicate, forge relationships and even address some of these controversial topics.[23] In many respects, young people have capitalised the most on globalization and the communications revolution, and are forming new social networks through mobile telephones and the Internet. According to a former minister of information technology in Egypt, most of the Internet users are young.[24] In Egypt, new sites are becoming accessible to young people that allow them to deal with stigmatised issues relating to sexual and reproductive health such as homosexuality, impotence and divorce (ibid). Nevertheless, the freedom of information that is actually available in some countries of the region is variable, and there are reports of Internet surveillance by the State leading to loss of confidentiality in some settings.[25]

Less emphasised in discussions of the sexual and reproductive health situation of youth in the region are the many <u>protective elements</u> intrinsic to the current social context in the region. First and foremost, the strong emphasis on the integrity and strength of the family unit prevailing within social and religious discourses in the region is favourable for the sexual and reproductive health of young people. In particular, a positive relationship with parents has been shown by WHO in an overview of studies internationally on young people's sexual and reproductive health was very important in protecting young people from sexual and reproductive health risks and other risks such as drug abuse. Similarly, a strong sense of social solidarity of many communities across the region provides young people with a sense of self-worth and identity that is key to protecting their sexual and reproductive health. Moreover, there is some evidence that youth in the region do not suffer from some of the problems reported among young people in other regions. For example, a nationally representative study of adolescents in Egypt found that only 12.4% of adolescents (12.8 for girls and 12.1 for boys) reported having a negative body image for any reason.[26]

Some aspects of gender roles, while in a state of flux, function positively for young women. For example, while the increasingly widespread phenomenon of veiling has attracted much negative attention, it may bring increased access for women to both education and the work-place by reducing familial and social opposition to their studying or working outside the home. Similarly, the predominant model in the region of single-sex schools, particularly at secondary level, has been a facilitating factor for greater access of girls to education.

Having spiritual beliefs and regular religious attendance has been identified by WHO as a protective factor for young people's health and development.[27] Religious values in the region also protect young people's sexual and reproductive health by connecting them with a supportive multi-generational community, and by discouraging behaviour that would put them at risk. Islam in particular, as a number of authors have argued, plays a positive role in sexual health in its recognition of the importance of sexual fulfilment for both men and women independent of procreation.[28] There is a diversity of interpretation of religion across the region,

however, and as Makhlouf-Obermeyer has argued using case-studies of reproductive choice in Iran and Tunisia "*Like other religious doctrines, Islam has been used to legitimate conflicting positions on gender and reproductive choice.*"[29]

MARRIAGE PATTERNS

When, how and whom young people marry in the region is central to any discussion of the sexual and reproductive health of young people. The universal valuation of marriage compounded by religious and social sanctions against pre-marital and extramarital sexuality, places significant pressure on young people, particularly women to marry early and start families immediately. A premium is placed on virginity before marriage, particularly of girls, which is reflected in the traditionally widespread but now waning practice of producing the 'blood-stained' sheet on the wedding night and in the more modern (but under-researched) practices of medical virginity tests and hymen repair operations.[30] Religion plays an important role in the choice of partner for Muslims and Christians alike, both for social and religious reasons and due to legal sanctions against inter-faith marriages. Divorce is generally stigmatised, although this has been abating somewhat in recent years. Contrary to popular conception, divorce rates have been declining in recent years, according to survey data.[31]

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

- Rising age at marriage for both males and females
- Early marriage still a problem in pockets of all societies
- High incidence of consanguineous marriages
- Persistence, but decline, in polygamy in some countries
- Higher numbers of single women
- Resurgence of forms of non-conventional marriage

The rising age of marriage in the region is a positive sign –- particularly for women -- in that it is protective against early childbirth and is associated with greater educational and employment opportunities; at the same time the greater period between onset of menarche and marriage is a risk factor for premarital and unprotected sexual activity. Without sufficient information or education, young unmarried people engaging in sexual relations are exposed to significant risks. Moreover, given prevailing social norms, a young single woman in an Arab country who becomes pregnant due to lack of information about or ability to negotiate use of contraception is placed in a highly difficult and marginalised position, and in extreme cases may be subject to violence from male family members. Although the increased average age at marriage has been widely documented in population-based surveys across the region, there has been relatively little research on the reasons for this trend.[32] Interviewees and anecdotal evidence point to increased educational opportunities, economic deterioration and the rising cost of housing, as well as the

improved social status of women as possible explanations. In a nationally representative survey of adolescents aged 10 to 19 in Egypt, when parents were asked about the main problems facing youth, 59% identified buying housing for marriage, 21% replied that youth lacked money and 10% identified problems in furnishing the marital home.[33] Certainly the rise in age at marriage for women is also closely linked to education; the chances of an uneducated woman in the region being married at ages 20-24 – are approximately twice those of educated women of the same age.[33] Rashad argues that the contribution of changing marriage patterns to the fertility transition in Arab countries is a subject that has received little research attention in comparison to other factors such as contraceptive use.[34]

Expectations that women – Muslim and Christian -- will marry their first (parallel patrilineal) cousin remain ingrained in many parts of the region. Consanguinity in marriage ranges from a low of 18% in Lebanon to a high of 56% in Sudan,[35] and in seven countries of the region at least 30% of ever married women 15-49 are married to their first cousin.[36] As with other observed marriage patterns, research is needed to understand the sexual and reproductive health implications of this phenomenon. While consanguineous marriage is known to be a risk factor for children's health, some observers suggest that in some respects, it may be protective of sexual and reproductive health problems such as domestic violence, given the likelihood of the relatives on both sides of the marriage intervening to mediate any conflicts.

A more recent and striking phenomenon is the growing cohort of young women who remain unmarried up until the 30-39 age group. In almost half of Arab countries, more than 40% of women aged 15 to 49 have never married and between 7 and 21 per cent of women in many Arab countries remain never-married by age 30 to 39.[37] However, the research base is extremely weak on this trend and its underlying reasons[38] and little attention has been paid to the health and economic well being of unmarried women in the region.[39]

Early Marriage

Given the pressure prevailing in the region to initiate childbearing as soon as possible after marriage, early marriage translates into early childbearing, which poses documented health risks to women and their babies. Early marriage and consequent early childbearing is less common in the region than in South Asia or Sub-Saharan Africa,[40] although there has been relatively little research in the region on the practice, despite its major implications for sexual and reproductive health. Early marriage is declining with the general trend towards increased age of marriage,[41] but there are still pockets of high prevalence of early marriage within all societies of the region. As shown in the Synoptic Table, the median age at marriage is 17.5 in Oman, 19.5 in Saudi Arabia and 18.6 in the United Arab Emirates. It is estimated that across the region, about 1.6 million girls are married before the age of 20 and every year about 900,000 babies are born to teenage mothers.[42] In Egypt, a nation-wide survey on adolescents aged 10 to 19 found a national prevalence of marriage of 11.7% among this age group.[43] Given that marriage below the stipulated minimum age is illegal, however, there may be misreporting concerning this issue.

As Table 1 below shows, the legal minimum age at marriage for girls in the Arab countries is as low as 15 in Kuwait, the West Bank and Yemen, and 16 in Egypt. One of the few socio-cultural studies in the region of the reasons for early marriage,[44]

although from fieldwork in the early 1990s, found that in two villages of Upper Egypt, 44% of girls married before the legal marriage age of 16, 68% before the age of 18 and 81% before the age of 20. There the author found that: "*It has been a common practice for a bride-to-be who is under-age (or her family) to declare that she has no birth certificate and present, instead, an age estimation by an accommodating physician.*"[45] She singled out girls' education as the most important factor in preventing early marriage.

While there are few reliable statistics from the region on links between early marriage and maternal risks, worldwide statistics suggest that these young brides are at very high risk. Early childbearing poses severe health risks to women in the form of maternal mortality, morbidity such as the problem of obstetric fistulae (known to be a problem in Yemen and Sudan particularly), as well as jeopardizing opportunities for education and involvement in community life. Pregnancy-related deaths are the leading cause of mortality for 15-19 year old girls (married and unmarried) worldwide according to UNICEF. In another culturally conservative context, recent research in Pakistan has shown that women in low-income areas of Karachi who marry early are at higher risk of reproductive morbidity, including uterine prolapse and pelvic inflammatory disease.[46]

Table 1. LEGAL MINIMUM AGE FOR FEMALES TO MARRY IN ARAB COUNTRIES[1]							
Puberty	**Age 9**	**Age 15**	**Age 16**	**Age 17**	**Age 18**	**Age 20**	**Unlegislated**
Sudan	Gaza	Kuwait West Bank Yemen	Egypt	Syria[2] Tunisia	Algeria Djibouti[3] Iraq[4] Jordan[5] Lebanon[6] Morocco	Libya	Bahrain Oman Qatar Saudi Arabia UAE

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

[2] In Syria women can be married at 13 with the permission of a judge.

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

[4] Women can get married in Iraq at 15 with parental consent.

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

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

There have been few initiatives in the region addressing early marriage, and those that have been established are relatively small-scale. For example, the NGO, Women's Affairs Centre in Gaza initiated a programme of research and intervention with parents and local *mukhtars* (community leaders), who certify that girls are at the minimum age of marriage, to educate them about the negative effects of early marriage. Similarly, a small-scale programme in Moqattam, Cairo among the families of *zabaleen* (garbage-collectors) has aimed to both raise the income-earning capacity of young girls and to help them to resist early marriage. The programme included rug-making, paper recycling and embroidery projects that provide an alternative to garbage sorting and enhance the skills and income of these girls. To encourage delayed and consensual marriage, a sum of 500 Egyptian pounds is offered to any girl who defers her marriage until age 18 and a Crisis Committee was established to counsel parents who attempt to have their daughters married under the age 18 against their will.[47] An interesting trend in the Gulf countries to encourage men to marry compatriot women is the establishment of marriage funds which help pay dowries and

provide housing. Such funds exist in Saudi Arabia, Bahrain, Qatar and the United Arab Emirates.[48]

Diversity of Marriage Patterns

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

Customary ('Urfi) Marriage

Anecdotal and journalistic evidence has drawn attention to the resurgence of *'urfi* (or customary) marriage in Egypt. Drawing on the Islamic requirements of only two witnesses and that the betrothal become public knowledge, this practice has evolved into one in which Egyptian youth are obtaining clandestine marriage certificates without announcing to their families their intentions to marry.[49] Elsewhere, however, particularly in countries that do not have large urban populations, it has not been recorded. In Jordan, there have been recent media reports that it is practised particularly among university students, and in Yemen it occurs very rarely and only if marriage to a non-Yemen is involved.[50] As in the case of temporary marriage in Iran, customary marriage represents a new response of young people to the economic and social impediments to conventional marriage. As Rashad and Osman state, it:

"*...may represent a coping strategy among youth as a compromise to the economic constraints to marriage and the cultural denial of extra-marital relations.*"[51]

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

"Summer Marriages"

A phenomenon with significant repercussions for the sexual and reproductive health of young people is the documented but under-researched pattern whereby Arab tourists from elsewhere in the region become engaged to and marry young Egyptian girls over the summer in return for a significant bride-price. In many cases, these unions end in divorce at summer's end and thus any children borne have, until recently, neither been entitled to Egyptian citizenship nor to the associated benefits of free government education and health-care.[52] Further research is needed both on the prevalence of this practice and whether it is taking place in other countries of the region, such as Morocco and Tunisia for example, which have significant tourist industries.[53]

Revisions of marriage legislation

A number of countries have introduced revisions to marriage legislation, although these have always been controversial and subject to intense public debate, and their sexual and reproductive health implications have not been researched. Most recently in Morocco, for example, the King authorised a substantial reform of the personal

status code in 2003 which was adopted in 2004 after decades of lobbying by women's groups in that country; its provisions include raising the age of marriage to 18 and making it easier for women to obtain a divorce.[54] Similarly in Jordan a temporary law issued by Royal Decree (but yet to be ratified by parliament) has also raised the legal minimum age of marriage for both girls and boys to 18 (see Table 2 above). There is public discussion about a similar reform in Egypt. Generally speaking, most of the campaigns to revise marriage legislation have as their objectives: 1) making explicit women's right to divorce within Islam; 2) increasing awareness of the options women have in contracts; and 3) raising public debate and awareness about the significance of marriage contracts for women's rights and well-being.[55]

THE REPRODUCTIVE HEALTH STATUS OF YOUNG PEOPLE

Unwanted pregnancy and abortion

Lack of information about services, fear of side effects and social taboos all contribute to the barriers young people face in obtaining contraception in the Arab region.[56] Unmarried young people are unlikely to be able to avail themselves of services and risk stigma in using family planning, but equally those who marry early often lack knowledge and access to services such as for contraception. In Oman, fewer than one per cent of women are reported to use contraception before their first child given expectations they will give birth during the first year of marriage.[57] In the five countries where DHS surveys have been conducted, Egypt, Morocco, Yemen, Sudan and Jordan, ever-married women aged 15 to 19 and 20 to 24 have significantly lower rates of contraceptive use than all ever married women;[58] in Yemen, only six per cent of ever-married women aged 15 to 19 and 15.6% of women aged 20 to 24 have ever used a modern method of contraception, compared to the figure of 37.7% for all ever-married women.[59]

Among the Arab countries, only Tunisia has legalised abortion on request; abortion is only legal to save a woman's life in Egypt, Lebanon, Libya, Oman, Syria, the United Arab Emirates and Yemen, to preserve the physical health of the mother in Kuwait, Morocco and Saudi Arabia, and for reasons due to mental health of mother in Algeria, Iraq and Jordan.[60] A recent initiative to legalise abortion in Egypt has been overturned by the Shoura Council, or Upper House of parliament. There are few community-based studies on the prevalence of self-induced abortion among young women. Among women admitted to hospital for complications of abortion in a nationally representative study in Egyptian public sector hospitals in 1996, the mean age was 27.4; 4.6% of post-abortion patients were 15–19 years old and 14.5% were 20–24.[61]

The Arab states account for only 3% of maternal deaths worldwide, most of which are concentrated in Yemen, Sudan, Djibouti, Morocco and Egypt.[62] Few studies have looked at maternal deaths among younger cohorts. In Egypt, there has been a significant decline in the maternal mortality ratio from 174 to 100,000 live births in 1992–3 to 84 to 100,000 in 2000. The 2000 study found that 5% of maternal deaths were in the 15–19 age group and 19% in the 20–24 age group, but notes that although younger women are at higher risk of a maternal death, fewer births occur to women in this age group.[63]

National data is non-existent about the extent of reproductive morbidity in the region among women, and little is known about young women's morbidity. The Giza study among 508 low-income women in Egypt in 1993 raised awareness in the region and internationally of the heavy burden of mostly undiagnosed reproductive ill health, much of which was associated with higher parity, with only low prevalence in those aged 14–24. Nevertheless, the prevalence of reproductive tract infection was 45% among 14-19 year olds, and 55% among 20–24 year olds and the prevalence of genital prolapse was 24% for 14–19 year olds and 43% for 20–24 year olds. IUD use was a risk factor for gynaecological morbidity, due to inadequate screening for pre-existing infection.[64]

Given the sensitivity associated with research about sexual behaviour in the region, there is little known about the sexual behaviour of young people, particularly unmarried people, in stark contrast to other regions. The few studies of sexual behaviour in the region show wide variation. At the low end of the range, in Jordan, a 1994 study showed that 7% of college students admitted to non-marital sex, and in a national study among the general population ages 15 to 30 in 1999 4% did so.[65] In Egypt, in 1996 in a survey in four universities, 26% of young men and 3% of young women reported having sexual intercourse at least once.[66]

Reporting of STIs in general is low in the region, and there are few studies on the incidence of sexually transmitted infections among youth. The WHO Eastern Mediterranean Regional Office (EMRO) received reports of a total of 73,000 STIs from 5 out of 23 countries for 2002, but note that this is no doubt under-reported.[67] Available national data, however, does not break these figures into age groups. In Morocco, one study found that 40% of STIs recorded were among young people aged 15–29.[68]

HIV/AIDS in the region among young people

The Arab region is one where perhaps the least is known about the dynamics of the HIV/AIDS epidemic as compared to any other region. This is due to the inter-related problems of widespread public policy denial of the region's epidemic potential, public belief in the region's immunity from the global epidemic, and because of the sensitivities involved in conducting socio-behavioural research on sexual patterns. Although overall the region is currently classed as low prevalence, (at an estimated 0.3 adult prevalence rate or approximately 540,000 adults)[69] there are pockets of worryingly high prevalence, and fast growth, particularly in Sudan, Djibouti and Libya. UNAIDS estimates that AIDS killed an estimated 28,000 people in 2004 in the region and it seems likely that the proportion of new infections in the 10 to 24 age group is around 50%, given worldwide patterns of transmission.[70]

Although the region as a whole is considered low-prevalence, the dynamics of the epidemic vary considerably across countries. Some countries, particularly those in complex political emergencies, have generalised epidemics (e.g. Sudan and Djibouti). Others have epidemics mainly related to injecting drug use (e.g. Libya), affecting mostly young males. According to WHO, heterosexual transmission, however, remains the dominant mode of transmission. Based on reported cases made available to WHO EMRO, infections are higher among men than women in the region, and women tend to acquire HIV at a younger age (25–29) than men (35–39).

The region is also closely integrated –- as well as sharing a common cultural and religious heritage -- and National AIDS programme managers recognise the need to work regionally and inter-regionally on issues such as cross-border movements related to conflict, economic migration, sex tourism and trafficking, despite the many political and social sensitivities to addressing these concerns. In their 2004 report on the regional epidemic, UNAIDS notes that there is significant cross-border movement of people living with HIV/AIDS. They estimate, for example, that over half of infections officially reported in Tunisia represent individuals from Libya seeking ARV or other drug treatment in Tunisia.[71]

Despite the known vulnerability of young people internationally to the HIV/AIDS epidemic, there is strikingly little information on the HIV/AIDS related knowledge and behaviour of the group aged 10-24 years in the region. In some countries, however, there is some evidence that youth are highly at risk. In Djibouti, for example, the country with the highest AIDS prevalence in the region, among recorded AIDS cases, 3.8% are found among those 15 to 19 years old, and 43.6% among those 20-29 years old.[72] A recent prevalence survey in Djibouti found that although the adult prevalence rate is 3.4%, the prevalence rate among the 14 to 35 age group is 50%.[73]

Evidence from different countries of the region shows that whereas young people have heard of HIV/AIDS, they do not always have specific knowledge regarding prevention. They may also be lacking in awareness that healthy looking people can be HIV-positive. For example, in a nationally representative survey of adolescents in Egypt, among 16 to 19 year-olds, 65.8% of girls and 76% of boys had heard about HIV/AIDS, but this knowledge was not matched by knowledge of condoms; only 5.1% of girls and 14.3% of boys reported knowledge of condoms. The authors of this survey, however, note that the association between condom use and illicit sexual relationships may lead to under-reporting on this question, particularly by girls.[74] Similarly in Sudan, UNFPA reports that only 12% of young women aged 15 to 24 are aware that consistent condom use prevents HIV/AIDS.[75]

Female Genital Mutilation

Female genital mutilation (FGM) is practiced in only four countries, namely Egypt, Sudan, Yemen and Djibouti in this region. With the Demographic and Health Survey (DHS) of 1990, Sudan had the earliest nationally representative, population-based data on FGM,[76] which found that over 89% of ever-married women aged 15-49 had had a severe form of FGM. In Egypt, the DHS of 2000 found that 97.3% of ever-married women aged 15-49, both Muslims and Copts (Christians), had FGM.[77] In Yemen, the practice is concentrated in the coastal areas with a national prevalence of 22.6% of ever-married women aged 15–49, according to the DHS of 1997.[78] While in Egypt and Yemen the practice is mainly carried out before puberty, in Yemen it is frequently performed on infants. In Djibouti, there have been no national population-based studies, but there is a reported diversity in both prevalence and severity across ethnic groups.[79]

Violence against Women

NGOs and women's groups have led the public discussion on violence against women in the region, starting a network of counselling centres in the Maghreb countries, the West Bank and Gaza, Lebanon and Jordan. In some cases, their advocacy has succeeded in encouraging governments to address the issue, such as in Morocco[80], but in most cases activities are restricted to NGOs and are small-scale. So-called "honour" killings, the murder by relatives of girls and women who are deemed to have transgressed sexual mores, are known to occur across the region, although the research base is weak, both because of sensitivity of the topic and under-reporting. The perpetrators are often brothers who see it as their responsibility to defend family honour, especially as it pertains to the social and sexual behaviour of their unmarried sisters. In Jordan, one of the most active on this issue, although a Family Protection Department has been established in the police force, an amendment to the penal code that would increase the sentence for perpetrators has twice been rejected.[81]

YOUNG PEOPLE'S INFORMATION ABOUT SEXUAL AND REPRODUCTIVE HEALTH

Both qualitative research and population-based in the region indicate that young people's knowledge about their own physiology and about sexuality and reproduction is highly limited. Sexuality education is rarely included in school curricula, and where it does exist is often not taught by teachers who are too embarrassed or too unprepared to teach it.[82] There is some comparative data (albeit from different age-groups) from the existing youth and development surveys cited above, for example, about young people's knowledge about puberty changes. It must be taken into account, however, that responses to questions about knowledge about sensitive issues relating to puberty – and particularly puberty changes of the opposite sex – are likely to be subject to reporting bias. This said, however, as Table 2 below shows there is evidence that a significant proportion of young people in the region lack knowledge about puberty changes, particularly about the opposite sex. These data also confirm that young people have few legitimate sources of correct information about their own physiology, and came by and large to learn by themselves about puberty changes.

Table 2. Young People's Knowledge about Puberty Changes as Reported in Population-Based Surveys

Country	**Egypt**	**Jordan**	**Palestine**	**Syria**	**Algeria**
% females who do not know about puberty changes	30%	In females: 11.6% In males: 17%	In females: 5.3% In males: 10.3%	In females: 9.7%	N/A
% males who do not know about puberty changes	55%	In females: 24.6% In males: 12.6%	In females: 28.9% In males: 14.1%	In males: 9.5%	N/A
% females who learned by self about puberty changes	60%	N/A	N/A	59.3%	73.3%
% males who learned by self about puberty changes	69%	N/A	N/A	76.8%	95%
Age group	10 – 19	10 - 24	12 - 19	15 – 24	15 – 24
Source:	Tawila et al. 1999 (see FN 4)	Jordan National Youth Survey[83]	Palestinian Youth Survey 2003[84]	Arab League PAPFAM Youth Survey	Arab League PAPFAM Youth Survey

RESEARCH GAPS ON YOUNG PEOPLE'S SEXUAL AND REPRODUCTIVE HEALTH

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

Although a wealth of population-based data exists on health and population issues in the region, these have not been disaggregated sufficiently to analyse the situation of young people and very few have addressed unmarried young people. In some cases, data availability to researchers is limited because of the need to obtain government

clearance. Moreover, comparative research is hampered by the lack of standardisation of these sources across the region and variable political willingness to address sensitive questions. In addition to nationally sponsored and executed population-based surveys, Demographic and Health Surveys have been regularly conducted in Egypt, Jordan, Morocco, Tunisia and Yemen sponsored by USAID. Historically these have focused on demographic and family planning related questions, although in recent years have broadened to include the reproductive health of married women. The Gulf States have implemented the Gulf Family Health Surveys. In addition, the Arab League has supported PAPFAM Surveys in a number of countries with valuable population and health-related data. While these have followed the DHS in tending to sample only ever-married women, the Morocco survey included unmarried women. Of particular relevance, PAPFAM has developed a youth module that covers a range of issues pertaining to the health and welfare of youth, including their sexual and reproductive health.[85] In the case of Tunisia and Algeria, the government permitted questions related to sexual behaviour to be asked. However, this module and the questions therein are optional, limiting the potential for comparative analyses of this data across countries. Moreover, as countries have different needs in relation to the youth population, the age groups sampled vary (e.g. 18 to 28 years in Tunisia, 15 to 29 in Algeria while other countries have sampled the 15 to 24 age group). Nevertheless, this youth module presents an important opportunity to provide nationally representative population-based data on youth for the first time in the region.

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

The degree to which existing research is accessible varies across the region; it is important to distinguish between countries where data is available but not accessible for largely political reasons, and others where the relevant data has not been collected at all. If proper and comparative research is to be undertaken, greater advocacy is needed by all those with a stake in disseminating research, including researchers, NGOs and donors to make collected data available.[86]

Despite the research gaps identified throughout this report, there is an evident paradox that although reproductive health issues are highly sensitive within this cultural context, some pioneering research has been conducted in the region that has informed both reproductive health policy as well as international debates.[87] Improved dissemination of existing research is needed both to share results across the region through translation into Arabic and French, and to increase its availability internationally through more extensive publication in the international literature.

THE VIEW FORWARD: WHAT CAN BE DONE?

For young people with sexual and reproductive health concerns, public health services in the region provide few services and do not cater specifically to their needs. Where services are available, they may not always be conveniently located or staffed. Furthermore, there are significant cultural barriers to young women and men using

them. Few government services are equipped to counsel and answer young people's questions pertaining to their sexual and reproductive health –– despite the known stigma and psychological suffering associated with sexual and reproductive health problems -- and there is often little scope for confidentiality. In some cases, unmarried young people report being distrustful of public services, such as in Morocco,[88] and in Syria where it has been reported that health service providers are sometimes hostile or judgmental.[89]

Nevertheless, across the region, there have been some promising initiatives starting to address youth reproductive and sexual health, some of which are documented here, which need to be built upon, evaluated and where appropriate, replicated. Tunisia, is exceptional with its longstanding government commitment to young people's sexual and reproductive health. It has attempted to scale up programmes for youth to a national level through the introduction of adolescent health clinics, the provision of information to young people whether married or unmarried, and supporting peer education interventions in Tunisian universities on sexual and reproductive health topics among other initiatives. There have also been many efforts by women's groups and non-governmental organizations in this field. Generally, however, there also has not been sufficient opportunity to share within the region lessons emerging from these programme models.

Another Muslim, although not an Arab country, Iran has initiated many programmes addressing the sexual and reproductive health of young people in an innovative manner consistent with the country's religious values that could be especially instructive for similar efforts in Arab countries. In particular, Iran's compulsory premarital counselling programme, which is linked to the issuing of marriage certificates, entails a mandatory counselling and provision session for all couples intending to marry. These sessions address even sensitive questions of sexual and reproductive health.[90] Although some Arab countries have a similar programme, making such sessions mandatory would be culturally acceptable in this context. According to UNFPA's 2004 report on Iran, health authorities there have also instructed health service personnel not to inquire about the marital status of their patients, and since that decision condom use has reportedly risen.

An example of national-scale programme which has been effective in reaching large number of young people with sexual and reproductive health information was the initiation in the mid 1990s of an AIDS hot—line "Ask about AIDS" by the Ministry of Health and Population in Egypt. At its peak this confidential counselling and information provision service, with trained male and female respondents, was receiving 1,000 callers a month, primarily young, unmarried people.[91] Other hot-lines have been initiated by NGOs in Palestine, Lebanon, the Maghreb countries, Jordan and most recently in Oman. Given pervasive stigma associated with the provision of reproductive health information, a confidential and anonymous means of communication such as this one avoids face-to-face contact, and thus this programme model is culturally acceptable in the region. In many contexts, developing separate "youth friendly" services may not be necessary, but health care personnel need greater training on the specific needs of young people and more resources need to be allocated to confidential and non-judgemental counselling for young people, whether married or unmarried.

Much more could be done in the region to intervene within educational contexts with programmes addressing sexual and reproductive health, but this often faces strong resistance. While there have been a number of initiatives to develop age- and culturally appropriate sex education curricula, there is an urgent need for the training of teachers and working both with educational authorities and parents to gain acceptability of such initiatives. Tunisia's effort to introduce peer education in university dormitories, arising out of its concern about the lack of information about reproductive health among young people and particularly young female migrants from rural areas, is exemplary in this respect and has proven to be effective.[92] Interviewees across the region stressed the particular vulnerability of university students to sexual and reproductive health problems, and their lack of information. Even in a country which has been at the forefront of implementing reproductive health programmes in universities, Tunisia, there is widespread misinformation about sexual and reproductive health among university students.[93] Therefore, programmes in this area are particularly needed.

In most Arab countries, there is considerable untapped potential for reaching young people with sexual and reproductive health information in fields or venues where they congregate in significant numbers – for example, in the military, in mosques or through religious leaders, and in social development or livelihoods programmes. Youth centres may be another venue to reach boys, although girls in the region tend to use these centres less.

CONCLUSION

The evidence on the reproductive and sexual health of young people in the region is relatively weak compared to many other regions. Taboos against discussion of sexuality are a major impediment to further research on the topic. In other comparably conservative settings, such as India, for example, the HIV/AIDS epidemic has opened up possibilities for discussion and research on matters related to sexuality.[94] However, this is not the case in the Arab countries, given widespread perceptions that HIV/AIDS is not yet a major problem.

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

As noted above, if programmes take a positive youth development approach, in which the reproductive and sexual health needs of young people are framed within a wider perspective of their needs, clear progress can be made. As one interviewee, Shadia Wannous, from Syria noted, this approach requires working with key gatekeepers:

> *"Winning community support requires helping parents and leaders to understand health issues inherent in young adult's sexual behavior, to recognize the need for programme action, to agree on solutions, and to work with health professionals to carry them out."*

If such action is linked to the opportunity offered by growing access to education and electronic media, culturally sensitive sexual and reproductive health programmes for young people can help them to reach their full potential as active citizens of their societies.

END-NOTES

[1] Some of this material has been published in a shorter article by the same authors in *Reproductive Health Matters*, Vol. 13, No. 25, May 2005.

[2] For more information on the above approach, see for example: Kirby, Douglas 2001. "Understanding What Works and What Doesn't In Reducing Adolescent Sexual Risk-Taking." in *Family Planning Perspectives*, November/December 2001, Vol. 33, No. 6.; WHO/UNICEF/UNFPA, Action for Adolescent Health: Towards a Common Agenda. WHO/FRH/ADH/97.9, 1997; WHO. Broadening the horizon: Balancing protection and risk for adolescents. WHO/FCH/CAH/0.2, 2002.

[3] ILO, *Global Employment Trends, 2004* (Geneva: ILO, 2004).

[4] El Tawila et al. 1999 on Egypt. El-Tawila, Sahar, Barbara Ibrahim, Omaima El Gibaly, and Fikrat El Sahn, Sunny Sallam Lee, Barbara Mensch, Hind Wassef, Sarah Bukhari, and Osman Galal, *Transitions to Adulthood; A National Survey of Egyptian Adolescents*, (Cairo: Population Council, 1999); Johns Hopkins University, Centre for Communication Programs and National Population Commission (Jordan), *Jordanian Youth Survey: Knowledge, Attitudes and Practices on Reproductive Health and Life Planning* (2001), authors: J. Shoemaker, M. Yassa, N. El Sararah, S. Farah, L. Wadan and L. Jaroudi. Amman, Jordan.

[5] El-Tawila, Sahar, *Youth in the Population Agenda: Concepts and Methodologies,* MEAwards Regional Papers, West Asia and North Africa, No. 44 (Cairo: Population Council, 2002).

[6] Human Rights Watch, "Climate of Fear: Sexual Violence and Abduction of Women and Girls in Baghdad," *Human Rights Watch* 15(7) (Washington, DC: Human Rights Watch, 2003).

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[8] For example, Izzat Ayoub, Palestinian Family Planning Association, July 2003.

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[10] World Bank, Better Governance for Development in the Middle East and North Africa: Enhancing Inclusiveness and Accountability, Charles Humphreys and Arup Banerji, eds. (Washington, D.C.: World Bank, 2003).

[11] See the Arab election law compendium website, www.arabelectionlaw

[12] UNIFEM Arab States Regional Office, *Progress of Arab Women 2004* (Amman: UNIFEM, 2004).

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

[14] Fargues, P., "Changing Hierarchies of Gender and Generation in the Arab World" in Mackhlouf Overmeyer, C., ed., *Family, Gender and Population in the Middle East: Policies in Context* (Cairo: American University in Cairo Press, 1995), 179-198.

[15] Department for International Development (UK), Regional Assistance Plan Middle East and North Africa, Consultation Draft, 2003.

[16] DFID 2003.

[17] Note, however, that Rashad and Osman (2003 p. 31) finds a decrease in the proportions of women setting up their own homes with their husband at marriage over time, which she suggests may be tied to the rising cost of housing. Rashad, H. and M. Osman, "Nuptiality in Arab Countries: Changes and implications" in N. Hopkins, ed., *The New Arab Family*, Cairo Papers in Social Science, Vol. 24, Nos. 1-2 (Cairo: The American University in Cairo Press, 2003), 20-50.

[18] See, for example, Doan and Bisharat's 1990 study on the extended family residential unit in Amman, Jordan. Doan, R.M. and L. Bisharat "Female Autonomy and Child Nutritional Status: the Extended-family residential unit in Amman, Jordan," *Social Science and Medicine 31*(7) (1990): 783-789.

[19] This tendency is particularly pertinent to the so-called "honour killings" discussed above.

[20] For example, Tandiar Samir, Centre for Development Services, July 2003; Shadia Wannous, Syria, July 2003.

[21] El Tawila et al 1999.

[22] Robert Thomspon, UNFPA, July 2003 [quoted with permission].

[23] A point made by Robert Thompson, formerly WHO and UNFPA in the region, July 2003.
[24] BBC programme "Egyptians Tackle Taboos Through the Net" Tuesday, 2 September, 2003, 09:22 GMT 10:22 UK, available on <http://news.bbc.co.uk/go/em/fr/-/2/hi/technology/3199007.stm >
[25] BBC programme "Egyptians Tackle Taboos Through the Net" Tuesday, 2 September, 2003, 09:22 GMT 10:22 UK, available on <http://news.bbc.co.uk/go/em/fr/-/2/hi/technology/3199007.stm >
[26] El Tawila et al 1999
[27] WHO Department of Child and Adolescent Health and Development, *Broadening the Horizon: Balancing Protection and Risk for Adolescents* (WHO, 2003). http://www.who.int/child-adolescent-health.
[28] For a historical analysis of Islam and sexuality, see Musallam, B., *Sex and Society in Islam: Birth Control before the Nineteenth Century* (Cambridge: Cambridge University Press, 1983.)
[29] Makhlouf Obermeyer, C. 1994. "Reproductive Choice in Islam: Gender and State in Iran and Tunisia" *Studies in Family Planning* 25(1) (1994): 49.
[30] The latter topic has received little research attention. Exceptions are Foster (2002) on Tunisia and Cindoglu (in Ilkkaracan 2000) on Turkey. Foster, Angel, **"**Young Women's Sexuality in Tunisia: The Health Consequences of Misinformation among University Students" in D.L. Bowen and E.A. Early, eds., *Everyday Life In The Muslim Middle East* (Bloomington, IN: Indiana University Press, 2002), 98-110; Cindoglu, D., "Virginity Tests and Artificial Virginity in Modern Turkish Medicine," in P. Ilkkaracan, ed., *Women and Sexuality in Muslim Societies* (Turkey: Women for Women's Human Rights, New Ways, 2000), 215-228.
[31] Fargues P. "Terminating marriage" in Hopkins N, ed., *The New Arab Family*, Cairo Papers in Social Science, Vol. 24, Nos. 1-2 (Cairo: The American University in Cairo Press, 2003), 247–273.
[32] Two exceptions are Singerman and Ibrahim 2003 and Amin and Al-Bassusi 2003. Singerman and Ibrahim, "The Costs of Marriage in Egypt : A Hidden Dimension in the New Arab Demography" in Hopkins, N., ed., *The New Arab Family*, Cairo Papers in Social Science, Vol. 24, Nos. 1-2 (Cairo: The American University in Cairo Press, 2003), 80 – 116. Amin, Sajeda and N. Al-Bassusi, "Wage work and marriage: Perspectives of Egyptian Working Women," Policy Research Division Working Paper No. 171 (New York: Population Council, 2003).
[33] Singerman and Ibrahim 2003.
[33] Rashad and Osman 2003.
[34] Rashad 2000.
[35] The figure for Sudan needs to take into account that most recent population-based surveys in Sudan have only been conducted in the northern part of the country because of the civil war in the South.
[36] Rashad and Osman 2003; their analysis covers only 13 countries of the region, however.
[37] Rashad 2000.
[38] Rashad and Osman 2003.
[39] Rashad 2000.
[40] UNICEF Innocenti Research Centre, *Early Marriage: Child Spouses*. *Innocenti Digest* (7), March 2001. Available in a PDF file from: http://www.unicef-icdc.org/research/
[41] World Bank, *Reproductive Health in the Middle East and North Africa: Well-Being for All,* Author*:* Atsuko Aoyama. Human Development Network, Health, Nutrition and Population Series, (Washington, D.C., 2001).
[42] World Bank 2001
[43] El-Tawila et al. 1999
[44] Hamamsy, L. El. *Early marriage and Reproduction in Two Egyptian Villages*, Occasional Paper. (Cairo: Population Council/UNFPA, 1994).
[45] Hamamsy, 1994: 8.
[46] Sajan, Fatima and Fariyal Fikree, "Does Early Age at Marriage Influence Gynaecological Morbidities Among Pakistani Women?" *Journal of Biosocial Science* 34(3) (2002): 407-417.
[47] Information on the Egyptian initiative is from UNICEF 2001, and is drawn from Assad, M. and Bruce, J. "Empowering the Next Generation: Girls of the Maqattam Garbage Settlement." Seeds, No. 19, New York, 1997. http://www.popcouncil.org/publications/seeds/seeds19.html#m
The publication does not show clear evaluation results, partly because the numbers involved were small, but there is no information, for example, on what percentage of those involved in the programme successfully delayed marriage. One interesting but discouraging finding was that many girls who successfully postponed marriage until age 18 found that once married, they faced strong family opposition to continuing their income-generation activities.
[48] UNIFEM 2004.

[49] Hardee, Karen, Pamela Pine, and Lauren Taggart Wasson, *Adolescent and Youth Reproductive Health in the Asia and Near East Region,* (Washington, DC: Policy Project, Futures Group, 2003). http://www.policyproject.com/pubs/generalreport/ARH_ANE.

[50] Hardee et. al 2003.

[51] Rashad and Osman 2003: 39.

[52] In Egypt, until very recently it was not possible for a woman to convey citizenship to her child. This issue has been a main point for advocacy of the Arab feminist movement.

[53] NOTE: A television programme on the Al Jazeera channel of October 13, 2003 featured discussion of three forms of non-conventional marriage: temporary marriage, *'urfi* marriage and *jawaz al misyar*, or business-related marriage that was reported to be practiced increasingly in the Gulf countries.

[54] Tremlett, Giles, "Morocco Boosts Women's Rights," *Guardian*, 13 October 2003, p. 15.

[55] See Singerman and Ibrahim 2003 regarding revisions to marriage legislation in Egypt

[56] World Bank 2001.

[57] Al Riyami, A., M. Afifi, and R. Mabry, "Women's autonomy, education and employment in Oman and their influence on contraceptive use (Issues in Current Service Delivery)" Reproductive Health Matters 12(23) (2004):144 -155.

[58] El-Zanaty, F. and A. Way, *Egypt Demographic and Health Survey* (Calverton MD: Ministry of Health and Population Egypt, National Population Council and ORC Macro, 2001); Azelmat M., M. Ayad, and E.A. Housni, *Enquete de Panel sur la Population et la Sante, 1995.* Rabat, Morocco: Ministere de la Sante Publique (Calverton, MD: Macro International, 1996); Yemen Central Statistical Organization, Macro International, *Yemen Demographic, Maternal and Child Health Survey 1997* (Calverton, MD: Central Statistical Organization and Macro International, 1998); Jordan Department of Statistics Jordan and ORC Macro *Jordan Population and Family Health Survey 2002* (Calverton, MD: Dept. of Statistics and ORC Macro, 2003); Department of Statistics Sudan and Macro International 1991, Sudan Demographic and Health Survey (Columbia, MD: Macro International, 1991).

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[60] Rahman, A., L. Katzive, and S.K. Henshaw, "A global review of laws on induced abortion, 1985–97." *International Family Planning Perspectives 24*(2) (1998):56–64.

[61] Egyptian Fertility Care Society (EFCS), Study of the Prevalence and Perception of Maternal Morbidity in Menoufeiya Governorate, Egypt: Final Report (Cairo: EFCS, 1995).

[62] World Bank 2001.

[63] Egyptian Ministry of Health and Population, *Egypt National Maternal Mortality Study 2000: Report of Findings and Conclusions* (Cairo: Egyptian Ministry of Health and Population, 2000).

[64] Khattab, H., N. Younis, and H. Zurayk, *Women, Reproduction and Health in Rural Egypt: the Giza Study* (Cairo: American University in Cairo Press, 1999.)

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

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

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

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[92] See Association Tunisienne du Planning Familial, *Evaluation du Projet "La Double Protection pour les Jeunes" : Résultats d'une enquête qualitative*, 2003

[93] See Foster 2002 FN 30

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