



Faculty of Health Sciences  
Center for Public Health Practice



# Youth sexual and reproductive health and reproductive rights in the Arab region

## An overview

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# I. Acknowledgements

The United Nations Population Fund Arab States Regional Office (UNFPA ASRO) would like to extend its gratitude to the technical team of the Center for Public Health Practice (CPHP) at the Faculty of Health Sciences (FHS) at the American University of Beirut (AUB) led by Ms. Martine Najem for their dedication to this project; their hard work and input was instrumental to ensuring that the research process was as smooth and inclusive as possible. Appreciation goes to Dr. Dolly Basil, Mr. Farouk Abou Hassan and Ms. Nay Abdounour for their technical support, guidance and supervision of the whole process.

We would also like to thank colleagues in UNFPA ASRO, Samir Anouti, Regional Youth and HIV/AIDS Advisor, Chokri Ben Yahia, Regional Youth and HIV/Population and Development Programme Specialist, Theodora Castan, Regional Programme Specialist Gender, Human Rights and Culture, and Shadia Elshiw, Regional Programme Analyst Harmful Practices. And finally, we would like to thank colleagues at the UNFPA country offices in the countries covered by this review for their valuable feedback and advice throughout the project.

## Disclaimer

This document has been produced with financial support from UNFPA Arab States Regional Office. The views expressed herein can in no way be taken to reflect the official views of the United Nations, including UNFPA, or the UN member states.

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## II. List of acronyms

<b>AIDS</b>	Acquired immunity deficiency syndrome
<b>ANC</b>	Antenatal care
<b>ASRO</b>	Arab States Regional Office
<b>AUB</b>	American University of Beirut
<b>CEFMU</b>	Child, Early and Forced Marriages and Unions
<b>CMR</b>	Clinical Management of Rape
<b>CO</b>	Country Office
<b>CPHP</b>	Center for Public Health Practice
<b>CSE</b>	Comprehensive Sexuality Education
<b>EC</b>	Emergency Contraception
<b>ESCWA</b>	United Nations Economic and Social Commission for Western Asia
<b>FGM/C</b>	Female Genital Mutilation/Cutting
<b>FHS</b>	Faculty of Health Sciences
<b>FP</b>	Family Planning
<b>GBV</b>	Gender-based Violence
<b>GCC</b>	Gulf Cooperation Council
<b>HIV</b>	Human Immunodeficiency Virus
<b>HPV</b>	Human Papilloma Virus
<b>ICPD</b>	International Conference on Population and Development
<b>IPV</b>	Intimate Partner Violence
<b>LGBTQI+</b>	Lesbian, Gay, Bisexual, Pansexual, Transgender, Genderqueer, Queer, Intersexed, Agender, Asexual, and Ally community
<b>MCM</b>	Modern Contraceptive Methods
<b>MENA</b>	Middle East and North Africa

<b>MoH</b>	Ministry of Health
<b>NGOs</b>	Non Governmental Organizations
<b>NHRIs</b>	National Human Rights Institutions
<b>PHCC</b>	Primary Healthcare Centre
<b>PNC</b>	Postnatal Care
<b>PWDs</b>	Persons with Disabilities
<b>RH</b>	Reproductive Health
<b>SDG</b>	Sustainable Development Goals
<b>SGBV</b>	Sexual and Gender-based Violence
<b>SIGI</b>	Social Institutions and Gender Index
<b>SRH</b>	Sexual and Reproductive Health
<b>SRHRR</b>	Sexual and Reproductive Health and Reproductive Rights
<b>STIs</b>	Sexually transmitted infections
<b>SV</b>	Sexual violence
<b>UN</b>	United Nations
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations International Children's Emergency Fund
<b>VAW</b>	Violence Against Women
<b>VCT</b>	Voluntary Counselling Testing
<b>WHO</b>	World Health Organization

### III. Executive summary

The United Nations Population Fund Arab States Regional Office (UNFPA ASRO) collaborated with the American University of Beirut (AUB), the Faculty of Health Sciences (FHS), the Center for Public Health Practice (CPHP) to conduct an overview of youth sexual and reproductive health and reproductive rights (SRHRR) in the Arab Region. This overview aims at providing policymakers, civil societies and development practitioners in 15 Arab countries with a knowledge tool to advance the implementation of the Programme of Action of the International Conference on Population and Development (ICPD) as well as to ensure that issues pertaining to youth's needs are equitably addressed in this process. The 15 targeted countries are Algeria, Djibouti, Egypt, Iraq, Jordan, Lebanon, Libya, Morocco, the Sultanate of Oman, Palestine, Somalia, Sudan, Syria, Tunisia and Yemen. This overview also aims to provide a baseline for UNFPA ASRO and the 15 targeted country offices (COs) to support governmental and non-governmental actors at the national, regional and international levels to ensure the realization of UNFPA mandate in the area of youth and SRHRR in the Arab region.

Within this context, literature and desk reviews of relevance to the youth SRHRR situation in general and in the targeted countries in the region in particular were conducted. A particular focus was made on reviewing prevailing situations associated with seven SRHRR themes perceived to be critical to youth SRHRR wellbeing. These themes are as follows: (i) comprehensive sexuality education (CSE) provision; (ii) contraception counselling and provision; (iii) antenatal, intrapartum and postnatal care; (iv) safe abortion care; (v) sexually transmitted infections (STIs) prevention and care; (vi) gender-based violence (GBV) and harmful practices; (vii) bodily autonomy and integrity concerning youth.

It is important to note that in the Arab region, the official definition of "youth" varies from country to country. For the purpose of this study, the UN definition of youth was adopted. It considers youth as those individuals between the ages of 15 and 24 without prejudice to any other definitions by member states (UN, 2021a).

The main findings to highlight as deduced from the conducted overview/study are summarized as follows:

Youth in the Arab region, specifically young women, youth in rural areas and youth with disabilities still suffer from an inadequate health provision and a poor access to health facilities. Moreover, lack of easy access to health information is still a challenge to this young population in the region, particularly with regard to their SRHRR.

There are many factors affecting young individuals' SRHRR violation in the region. These factors include the following: (i) existing cultural norms; (ii) power dynamics among genders; (iii) local taboos associated with discussing any sex-related issues; (iv) inequalities in education; (v) belonging to marginalized communities including the LGBTQI+ community; (vi) conflict and disasters; (vii) national laws that do not ensure an adequate protection of youth SRHRR.

The high percentage of young populations in the Arab region with particular demographic profiles necessitates particular attention in what relates to addressing their particular SRHRR needs. This is more relevant in view of the prevailing socio-economic conditions, with a majority of the countries classified as low-income countries. These conditions are increasingly deteriorating as a result of growing political and socio-economic crises in different Arab countries as well as the prevalence of the COVID-19 pandemic. All this is worsening economic and social crises by increasing unemployment and decreasing economic opportunities, and thus the wellbeing of different groups of the population, particularly the youth, are affected accordingly.

In relation to the reviewed youth-related SRHRR themes, the following is deduced.

### **Comprehensive sexuality education (CSE)**

More than half of the 15 targeted Arab countries reported having set policies and/or strategies associated with school-based sexuality education. These include Djibouti, Egypt, Lebanon, Morocco, the Sultanate of Oman, Palestine, Syria and Tunisia. However, the extent to which these policies and/or strategies are being operationalised is yet to be investigated further, particularly in what relates to the following: (i) the adoption of CSE in schools and within local communities; (ii) targeting marginalised groups like refugees and hard-to-reach individuals; (iii) whether CSE providers, including teachers, are properly trained and provided with the needed technical support to provide quality youth-friendly CSE services.



## Contraception counselling and provision

Almost all 15 targeted Arab countries have set policies that facilitate access to effective contraception except for Libya. Also, in these countries, the knowledge level about family planning and modern contraceptive methods is, in general, high among both men and women, but the use of contraceptives is still low despite the noticeable increase in the last decades. This is due to a mix of social, cultural, financial and geographical barriers. The unmet need for FP in the Arab states is higher than the global average, reaching 15% compared to 10% globally (UNFPA ASRO, 2020). Unmet contraceptive needs among youth are greater than in any other age group putting them at risk of unintended pregnancies. Girls, in particular, who are aware of the benefits and wish to have access to contraception face numerous barriers. These include restrictive laws and policies regarding the provision of contraception based on age or marital status, health care provider bias or lack of willingness to acknowledge youth SRHRR needs and youth's own inability to access contraceptives because of knowledge, transportation and financial constraints. Even when youth are able to obtain and use contraceptives, they face challenges that include their families' pressure to have children, the stigma surrounding extramarital sexual activity or contraceptive use, their fear of the side effects, their lack of knowledge on correct usage and their lack of knowledge on where and how to obtain contraceptive information or services.

## Antenatal, intrapartum and postnatal Care

The provision of antenatal, intrapartum and postnatal care is essential to prevent maternal deaths through proper and adequate medical interventions. For the majority of Arab countries, more than 70% of pregnant women seek antenatal care. These are reported as follows: 92,5% in Mashreq countries, 93.1% in Maghreb countries and 75.6% for the least developed countries. the Sultanate of Oman which is a member in the Gulf Cooperation Council (GCC), has the highest percentage of women seeking ANC (99%) (UNFPA, 2019). However, young people may face barriers to accessing and using skilled care before, during and after pregnancy. The situation is direr for very young adolescents, unmarried adolescents, refugees and adolescents in humanitarian crises situations. Accessibility barriers include lack of information on the importance of using maternal health services, lack of confidentiality, stigma and the limited availability of youth-friendly services. Also, antenatal, intrapartum and postnatal health care providers are not always responsive to the needs of young people. They lack the proper knowledge, understanding and skills to provide high-quality adolescent-friendly antenatal, intrapartum and postnatal care based on the right of all people to health, confidentiality and non-discrimination.

## Safe abortion care

As per the International Conference on Population and Development's Brief Draft Report (2020), the majority of countries in the region have restrictive abortion laws. They allow for abortion only under certain circumstances whether through penal codes, fatwa\*, ministerial regulations or presidential decrees. These circumstances include rape or incest, the mental or physical health of pregnant women, fetal impairments and, in the case of Djibouti, undefined "therapeutic" reasons. Despite evidence that restrictive abortion laws are associated with higher levels of maternal mortality, access to safe abortion services is highly restricted in many countries. Countries often further restrict adolescent access to legal safe abortions through policy interventions related to consent (parental, spousal or health care provider), age and marital status, in addition to restrictions on information provided to the public.

Unsafe abortions among adolescents constitute a significant problem and have major health consequences. Compared to older women, adolescents are "more likely to seek abortions on the hands of untrained providers, to have self-induced abortions, to terminate their pregnancies after the first trimester when the procedure is more dangerous and to delay seeking medical care for complications following unsafe abortions; they are less likely to know about their rights concerning abortion and post-abortion care and to report having had an abortion". Where safe abortion care is available to youth, it is often not youth-friendly. In many contexts, health care providers lack the proper training whereby they can inform, counsel and provide services to concerned youth as well as be responsive to the particular needs of different groups of young people.

## Sexually transmitted infections prevention and care

Sexually transmitted infections (STIs) among adolescents are a significant problem to address. Available data sources on STIs among adolescents and youth in most low- and middle-income countries are limited. Nevertheless, where age-disaggregated surveillance systems exist, a substantial proportion of STIs incidence occurs among youth.

Because of the immaturity of the cervical mucosa and of increased cervical ectopy, adolescent girls may have greater biological susceptibility than adult women to some STIs. In the Arab region, boys who are more prone to have multiple partners could be at a higher risk of contracting STIs. Also, the risk of contracting STIs is often higher for particular groups of youth, including adolescent sex workers and their clients and boys who have sex with men or other boys.

STIs among youth have major health consequences that could be beyond the immediate impact of the infection itself. Comprehensive sexuality education (CSE) and contraception counselling and provision have been shown to offer prevention against STIs. However, many young populations in the region do not have access to integrated STI prevention and management services, and even when these services are available, youth often face barriers related to stigma, shame, cost and the lack of confidentiality or friendliness. Mandatory parental and guardian authorisation or notification is also frequently requested. In many Arab countries, health care providers have limited training and are poorly supported to inform, counsel and care for youth based on their evolving capacities to understand the treatment and care options being offered.

## Gender-based violence and harmful practices

Gender-based violence (GBV) takes many forms. Besides child marriage, physical and sexual violence, primarily against women and girls, includes psychological and emotional harm and abuse, sexual harassment, female genital mutilation (FGM), the so-called honour killings of women and girls, trafficking of women and girls, female infanticide and other harmful practices. Intimate partner violence (IPV) and non-partner sexual violence are among the most pervasive and insidious forms of violence against women and girls. In the Arab region, despite having laws against child marriage (except for Lebanon and Yemen), the practice remains widespread, in part because of persistent poverty and gender inequality.

Palestinian laws provide protection from early marriage in the Gaza Strip, however, exceptions are also permitted there. Early marriage is allowed in the West Bank, and girls coerced into child marriage often become pregnant while still adolescents,



increasing the risk of complications in pregnancy or childbirth. These complications are a leading cause of death among older adolescents in developing countries.

While some of the Arab countries also have laws in place to hold any perpetrator of GBV to account, their enforcement is often limited. Also, laws that prohibit FGM exist in Djibouti, Egypt, Iraq, Palestine, Somalia, Sudan, Tunisia and Yemen. However, in some countries like Djibouti, a high practice is noted despite the existence of such laws. Also, practices of FGM in Somalia and Sudan are extremely high. In Iraq, FGM is not prohibited by a separate law; yet, it is stated under the Domestic Violence Law and criminalised.

National plans and policies for addressing GBV are not adequately resourced and financed, and intersectoral coordination for properly addressing different forms of GBV is often lacking in most Arab countries. These challenges are prevailing mostly in countries where political instability and wars occur such as in Palestine, Somalia, Syria and Yemen. This is compounded by the restricted access to services due to stigma and/or cultural taboos and social norms.

### **Bodily autonomy and integrity concerning youth**

In the Arab region, the most present barriers to bodily autonomy include patriarchal views, stereotypes, assumptions and misconceptions about bodily autonomy and ensuring the rights of youth in general and women and girls in particular to be fully informed of their different options in health care. The right to autonomy in making health decisions in general, and sexual and reproductive decisions in particular, derives from the right to liberty, dignity, privacy, security and bodily integrity. These rights constitute the basis for ensuring the rights to informed consent and confidentiality in relation to health services and health care. Despite such rights and the existence of protective laws in many countries in the region, a variety of legal, cultural, social, gender and other obstacles still prevent many people — mainly women, adolescents, youth, persons with disabilities, refugees and migrants in addition to lesbian, gay, bisexual, transgender, queer, intersex and other sexuality, sex and gender diverse community (LGBTQI+) — from seeking and obtaining appropriate SRHRR information, counselling and services. Although youth participation and engagement in the development of national strategies associated with their health is pursued in Algeria, Egypt, Morocco, Sudan and Syria, parental consent is required by law for adolescents to access SRHRR services in Algeria, Morocco, the Sultanate of Oman and Syria. In these countries, when youth in general and women and girls in particular can make the most essential choices about their bodies, they not only gain in terms of autonomy but also in terms of enhancements in their health, education, income and safety.



Based on the overview/study results and deduced information, recommendations are suggested for each of the youth-related SRHRR themes tackled within the context of this study. Cross-cutting recommendations valid to all explored themes are also provided. These recommendations are classified based on a socioecological model which highlights the different elements that should be ensured and that should work in synergy to guarantee a proper SRHRR response to all concerned parties with particular attention to youth.

Related elements are associated with ensuring the availability of the following: (i) an enabling environment through relevant and supportive laws, policies and programming, in addition to coordinating between all concerned parties and procuring the needed human and material resources; (ii) a proper supply of high-quality, youth-friendly integrated SRHRR services; (iii) awareness about existing SRHRR services and about the increased demand for those services through social and behavioural change programmes and interventions; (iv) evidence-based data and information that inform decision-making for a proper SRHRR response with particular attention to the particular groups of youth and their needs. Establishing accountability mechanisms to monitor, evaluate and learn from conducted youth SRHRR services is also suggested.



## IV. Background information

Twenty-five years ago, the landmark International Conference on Population and Development (ICPD) put people's rights at the heart of development and emphasised that empowering people is key to ensuring the wellbeing of individuals, families, nations and the world at large. It called to ensure availability of resources for the full implementation of laws and policies furthering the progressive achievement of the right to sexual and reproductive health (SRH) of adolescents and youth.

Within this context, UNFPA ASRO collaborated with the American University of Beirut (AUB), the Faculty of Health Sciences (FHS), the Center for Public Health Practice (CPHP), to conduct an overview of youth sexual and reproductive health (SRH) in the Arab Region. This overview aims at providing policymakers, civil societies and development practitioners in all countries in the region with a knowledge tool to advance the implementation of the ICPD Programme of Action and to ensure that issues related to youth's needs are equitably addressed in this process. This also comes in line with the Arab region's commitments at the Nairobi Summit on ICPD25 and with the Summit's top commitment categories.

This overview is also linked to the **Sexual and Reproductive Health and Reproductive Rights Regulatory Frameworks across the Arab States Region: Current Status and Future Outlook** project conducted in 2019. This project aimed at conducting a regional review to map laws, policies and practices related to UNFPA's mandate across the Arab states region. The overall objective of the exercise is to support UNFPA ASRO and the country offices' work in meeting the three transformative goals through policy-related interventions. These goals relate to (i) ending unmet needs for family planning, (ii) ending preventable maternal deaths and (iii) ending gender-based violence and harmful practices. They also aim to (i) strategically position UNFPA as the lead agency on SRHRR, (ii) inform programmes and create demand for more substantive work in the areas of UNFPA's mandate related to the legal framework, (iii) produce knowledge to enhance UNFPA's ability to provide information to the Universal Periodic Review, Common Country Analysis, Treaty Bodies, etc., and (iv) strengthen UNFPA's partnership with SRHRR actors, including national human rights institutions. Accordingly, a regional report that mapped all existing laws and policies related to UNFPA's mandate across the Arab states region was developed. Specifically, this report presented a situation analysis, highlighted the existing laws and policies and identified gaps, challenges and opportunities in order for the UNFPA to engage with national institutions and propose recommendations for improving the work of national institutions with SRHRR.

## V. Project context

This overview aims to provide an in-depth understanding about youth SRHRR and at proposing recommendations that shall inform youth SRHRR policies and programme development in the Arab region. It also aims to provide a baseline for UNFPA Arab States Regional Office and country offices to support governmental and non-governmental actors at the national, regional and international levels so as to ensure the realisation of UNFPA mandate in the area of youth and SRHRR in the Arab states region.

### A. Approach and methodology

The following methods were adopted to develop the regional youth SRHRR overview report.

#### 1. Literature and desk Reviews

Literature and desk reviews of relevance to the youth SRHRR situation in general and in the targeted countries in the region in particular were conducted. The 15 targeted countries are Algeria, Djibouti, Egypt, Iraq, Jordan, Lebanon, Libya, Morocco, the Sultanate of Oman Palestine, Somalia, Sudan, Syria, Tunisia and Yemen.

This regional study was guided by a desk review framework which included the following seven SRHRR themes that are critical to youth SRHRR wellbeing:

- Comprehensive Sexuality Education (CSE) Provision.
- Contraception Counselling and Provision.
- Antenatal, Intrapartum and Postnatal Care.
- Safe Abortion Care.
- Sexually Transmitted Infections (STIs) Prevention and Care.
- Gender-based violence and harmful practices (child marriage, female genital mutilation and Sexual Violence).
- Bodily Autonomy and Integrity Concerning Youth.

#### 2. Data and information compilation and analysis

Youth-related data and information, generated from the previously conducted assignments mentioned above, were compiled and cross checked to deduce a relevant understanding about Youth SRHRR in the region, allowing to provide related recommendations.

## VI. Youth sexual and reproductive health and reproductive rights

### A. An overview

Adolescence and youth are phases of transition from childhood to adulthood during which a person biologically and psychologically develops and moves towards autonomy. Despite the assumption that adolescents and youth are a healthy group, many die prematurely as a result of accidents, suicide, violence and pregnancy-related complications. Some of the serious conditions of adulthood have their roots in adolescent behavior. Examples include sexually transmitted infections, such as HIV, drug addiction and tobacco use.

Although constituting a substantial percentage of the population of many countries, adolescents and youth have not been considered a health priority in many countries, including Arab countries. While Arab countries have been investing efforts in implementing substantial interventions aiming to reduce child mortality and morbidity, interventions addressing the health needs of young people have been limited in scope and perspective, more so in what relates to their SRHRR needs. Accordingly, young people grow up and become sexually active without a proper access to quality, gender-responsive information, education or services regarding their SRHRR. Health services are seldomly designed to particularly meet youth's needs, while health service providers receive targeted trainings on issues relevant to adolescent sexual health only occasionally. This justifies the low levels of health-seeking behaviors among young people, more so in what relates to SRHRR services.

Studies show that young people are not affected similarly by sexual and reproductive health problems. Orphans, young girls in rural areas, young people who are physically/mentally impaired/abused or have been abused as



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children, refugees and those who are displaced are more likely to have SRHRR problems.

The negative health and SRHRR consequences of adolescents and youth can pass from one generation to the next. Babies born to young mothers have a high risk of being underweight or stillborn. Those babies are also likely to suffer from the same social and economic disadvantages faced by their mothers (UNFPA, 2020a).

## **B. Youth SRHRR violations**

- Approximately, 16 million adolescent girls aged 15 to 19 and 2.5 million girls aged 12 to 15 give birth each year (WHO, 2018d).
- Every day, an average of 33,000 girls are forced into child marriage (UNICEF, 2019b).
- Complications during pregnancy and childbirth are the leading causes of death for girls aging from 15 to 19 years globally (WHO, 2018e), and three in five of all maternal deaths take place in humanitarian and fragile contexts (UNFPA, 2015a).
- 3.2 million adolescent girls aged 15 to 19 in low-income countries undergo unsafe abortions each year (UNFPA, 2013c).
- Globally, about 120 million girls have been raped or subjected to other forced sexual acts during their lives (UNICEF, 2014), and many occur at the hands of their partners.
- At least 200 million girls and women alive today have been subjected to female genital mutilation/cutting (UNICEF, 2016).
- Three in every five new HIV infections among young people occur among young women (UNAIDS, 2019).
- More than 220 million women and girls, most of whom live in the poorest countries and wish to use contraception, still do not have access to modern contraceptive methods (Inter-Agency Working Group, 2018). Unmet needs for contraception are highest among adolescents and youth (UNFPA, 2015b).

## C. Factors contributing to SRHRR violations

The main factors that contribute to SRHRR violations relate to the following:

- **Cultural norms** greatly influence how people experience their sexuality. Adolescent girls' sexuality is controlled through an emphasis on virginity, chastity, submission and practices like female genital mutilation/cutting (FGM/C) as well as child, early and forced marriages and unions (CEFMU). In married life, their sexuality is often controlled by parents, husbands, in-laws and religious and community leaders.
- **Power dynamics between genders** lead to unequal decision-making in sexual partnerships among boys and girls. It also leads to sexual oppression and violence.
- **Talking about sex is considered as a taboo** in many countries. This situation can prevent young people from seeking SRHRR services.
- Children, adolescents and youth are often considered **too young for accurate information and access to SRHRR services**.
- **Disadvantaged youth, including those with disabilities**, are often disempowered regarding their sexuality.
- **Girls and young women with less education** are more likely to experience adolescent pregnancy, which raises their disadvantage by disrupting school attendance and limiting future livelihood opportunities.
- **Conflict and disasters** aggravate poor SRHRR outcomes for youth, particularly girls and young women. Such crises increase the risks of GBV (including CEFMU), STIs (including HIV), unintended pregnancies, maternal morbidity and maternal mortality.
- **Lesbian, gay, bisexual, transgender, intersex and questioning (LGBTIQ+)** adolescents and youth are prevented from expressing their sexuality and accessing SRHRR services by discriminatory laws and due to a lack of the know-how among service providers.
- **National laws** often reflect harmful practices prevalent in society and among decision makers instead of protecting young people's SRHRR. Laws may actively discriminate based on age, marital status or gender identity; they may also cause harm by expressly permitting or being silent on harmful practices such as CEFMU or FGM/C and other forms of GBV, by criminalising consensual adolescent sexual behaviour or by restricting access to SRHRR services, information and education.

## VII. Youth in the Arab region

### A. Youth definition

There is no single definition of adolescence and youth commonly adopted by all countries. The United Nations (UN) defines youth, for statistical purposes, as those persons between the ages of 15 to 24 years without prejudice to any other definitions by member states (UN, 2021a). The Middle East Youth Initiative, on the other hand, defines youth as people between the ages of 15 and 29 years (UN, 2021b). For the purpose of this study, we will adopt the UN definition of youth.

In the Arab region, the official definition of “youth” varies from country to country, as illustrated in Table 1 below.

**Table 1: Youth definition by country**

Country	Youth definition (Individuals in the Following Age Ranges per Country)
Algeria	15-29
Djibouti	15-24
Egypt	18-30
Iraq	10-30
Jordan	12-30
Lebanon	15-29
Libya	No specific age range for youth
Morocco	15-29
Sultanate of Oman	No specific age range for youth
Palestine	13-29
Somalia	No specific age range for youth
Sudan	15-24
Syria	15-25
Tunisia	15-29
Yemen	15-24

## B. Youth population in the Arab region

Out of a total population of 436 million in the Arab region, over 84 million are youth aged 15–24 years (UNFPA, 2020b). Youth aging 15–24 years account for approximately 20% of the total population of the 15 countries under review. Table 2 below provides information about the total population in millions and the percentage of total youth population in each of the 15 countries, in addition to information associated with some youth-related demographic indicators that are perceived to have some association with their SRHRR situation.

The same data sources were used for each of the investigated indicators. This was important to ensure the validity of data comparison among the different countries under review.



**Table 2: Countries' profiles / youth-related demographic indicators**

Country	Total Population in millions (UNFPA, 2020 c)	Income Group Classification (World Bank, 2020)	Age Structure: Percent of Population Aged 15-24 (Index Mundi, 2020)	Literacy Rate, Youth Males: Percent of Males Aged 15-24 (World Bank a)	Literacy Rate, Youth Females: Percent of Females Aged 15-24 (World Bank b)	Employment to Population Ratio: Percent of Males Aged 15-24, (World Bank, 2019 c)	Employment to Population Ratio: Percent of Females Aged 15-24, (World Bank, 2019 d)
<b>Algeria</b>	43.8	Lower middle income	13.93	98 (2018)	97 (2018)	32	5
<b>Djibouti</b>	1	Lower middle income	20.32	No data	No data	31	31
<b>Egypt</b>	102.3	Lower middle income	18.01	89 (2017)	87 (2017)	30	6
<b>Iraq</b>	40.2	Lower middle income	19.83	95 (2018)	92 (2018)	38	2
<b>Jordan</b>	10.2	Lower middle income	19.77	99 (2018)	99 (2018)	25	4
<b>Lebanon</b>	6.8	Lower middle income	14.98	100 (2018)	100 (2018)	36	14
<b>Libya</b>	6.8	Lower middle income	15.21	100 (2004)	99 (2004)	13	3
<b>Morocco</b>	36.9	Lower middle income	16.55	98 (2018)	97 (2018)	31	10
<b>Sultanate of Oman</b>	51	High income	17.35	98 (2018)	99 (2018)	52	7
<b>Palestine</b>	51	Lower middle income	21.67	99 (2018)	99 (2018)	32	3
<b>Somalia</b>	15.8	Low income	19.81	No data	No data	42	13
<b>Sudan</b>	43.8	Low income	20.94	73 (2018)	73 (2018)	26	11
<b>Syria</b>	17.5	Low income	19.34	95 (2004)	90 (2004)	42	4
<b>Tunisia</b>	11.8	Lower middle income	12.9	97 (2014)	96 (2014)	25	11
<b>Yemen</b>	29.8	Low income	21.26	93 (2004)	61 (2004)	37	3

The population size varies tremendously among the 15 Middle East and North Africa (MENA) countries. It ranges from 1 million (Djibouti) to more than 100 million (Egypt). The majority of the countries (n=10) are classified as either low-income (Somalia, Sudan, Syria and Yemen) or low-middle income countries (Algeria, Djibouti, Egypt, Morocco, Palestine and Tunisia), whereas only the Sultanate of Oman is classified as a high-income country. With regard to the percentage of the youth population (15–24 years), UN Economic and Social Commission for Western Asia (ESCWA) estimated it to account for 17% of the total population in the Arab region and it is projected to increase to 17.5% by 2030 (ESCWA, 2019). In all the Arab countries represented in table 2, the percentage of youth accounts for >10% of the population with the lowest percentage reported in Tunisia (12.9%) and highest percentage reported in Palestine (21.67%). Despite the relatively high percentage of youth in the Arab region, the youth unemployment rate is the highest worldwide and the fastest growing, increasing from 19.5 to 23 per cent between 2012 and 2020 with the highest percentage among females (42.1%) (ESCWA, 2020b). Similar to those results, the MENA country-by-country employment rates remain significantly low especially among females. Except for Djibouti, the employment rate among females ranges from as low as 2% in Iraq to as high as 14% in Lebanon compared to 38% and 36% among males in the same countries, respectively. This comes in contrast to literacy rates among youth which are high and comparable between males and females in most countries except for Yemen (93% among males compared to 61% among females).

The high percentage of youth population with particular demographic profiles in the Arab region necessitates particular attention in regard to addressing their particular needs including health and SRHRR needs. This is more relevant in view of the prevailing socio-economic conditions in the region, with a majority of the countries classified as low-income countries. These conditions are increasingly deteriorating as a result of the growing political and socio-economic crises in the region as well as the prevalence of the COVID-19 pandemic. All this is worsening economic and social crises by increasing unemployment and decreasing economic opportunities, and thus the wellbeing of different groups of the population, particularly the youth, are affected accordingly.

### **C. Youth health and SRHRR in the Arab region**

The youth population in the Arab region is exposed to several challenges including structural violence and political conflict, which in turn exacerbates the uncertainties of an already tumultuous stage in life (Alaouie, Ali, and Afifi, 2017).

Youth in the region, specifically young women, youth in rural areas and youth with disabilities still suffer from inadequate health provision and poor access to health

facilities (UN, nondefined). Moreover, the lack of easy access to health information is still a challenge to this young population in the region, particularly with regard to SRHRR. Almost 50% of the Arab youth lack knowledge about STIs, while other issues concerning sexual health, such as unwanted pregnancies, HIV/AIDS infections and FGM, remain to be taboo topics not to be discussed openly (UN, nondefined). In 2021, a study was conducted in Lebanon to assess SRH knowledge and awareness among single unmarried women. Findings of the study show that only 8.8% of all the participants had adequate SRH knowledge. The highest level of SRH-related knowledge was about pregnancy (88.0%), and the least was about contraception (13.5%) (Hamdanieh et al., 2021).

Cultural, economic and social factors, including religion and tradition, play an important role in shaping sexual health in a society (Zahlan et al., 2020; Roudi-Fahimi and El-Feki, 2011). In Arab countries, sexual and reproductive health among youth is often a sensitive topic surrounded by political and cultural barriers. In some of these countries, young people engage in pre-marital sexual relations, particularly in countries with a higher mean age of marriage (Ghandour et al., 2014; Roudi-Fahimi and El-Feki, 2011). Sex outside marriage, particularly in predominantly Muslim Arab countries, is considered fornication (i.e. zina in Arabic) by religious and social standards and represents a punishable offence (Zahlan et al., 2020). Consequently,

virginity is a very important part of women's identity in the region and reflects family honour. Due to the cultural pressure on women to remain virgins until marriage, hymen repair procedures are widely practiced in the region (Zahlan et al., 2020).

More importantly, pregnancies among unmarried women have deleterious consequences including unsafe abortions as access to safe abortions is often lacking in most Arab countries.



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In addition, child marriage is still prevalent in the region with almost 20% of women aged 20–24 years get married before the age of 18. Ending child marriage is a priority for policy makers, with a focus on the rights and wellbeing of girls as the former increases the risks of adverse reproductive health outcomes (Obermeyer, 2015). Female genital mutilation is also still prevalent in some countries (i.e. Egypt and Sudan) (UNDP, 2019).

Addressing the SRHRR needs of young people through youth-friendly services and facilities in the Arab region is also limited despite the importance and value of youth-friendly entities in attracting youth to seek SRHRR needed services (Thoméé et al., 2016; Roudi-Fahimi & El-Feki, 2011). The comprehensive integration of SRHR services into primary health care is being emphasized as an important element to ensure service equity, accessibility and acceptability. However, the integration of services faces several challenges in the region. These challenges include the lack of financial, human and technological resources, the lack of political commitment, the presence of complex health care systems (i.e. a mix between public and private providers) and the existence of fragmented primary health care centres (PHCs) with weak infrastructures and donor-driven agendas (Kabakian-Khasholian et al., 2020).

What makes the situation for the youth even worse is the COVID-19 pandemic that hit this population which had already been suffering from pre-existing structural inequalities harder than other populations in the region (ESCWA, 2020b). The series of measures adopted by the Arab States in response to the COVID-19 pandemic, including lockdowns, curfews and other restrictions on movement, have resulted in the disruption of basic services for the most vulnerable populations (UNFPA, 2021c). Accessibility to SRHRR and GBV services have been highly affected. There has been a decrease in the provision of services for survivors of domestic violence and, in some countries, the numbers of calls to hotlines have largely increased (ESCWA, 2020c).

It is important to note that efforts are being invested globally and regionally to address youth SRHRR needs. In 1994, the ICPD marked a global movement towards the provision of comprehensive and integrated SRH services through universally accessible health care (Kabakian-Khasholian et al., 2020). The movement is currently being promoted under sustainable development goal (SDG) 3 target 3.7 of the Sustainable Development Goals to ensure universal access to sexual and reproductive health care services by 2030.

## VIII. Particular youth-related SRHRR themes

### A. Comprehensive sexuality education provision

**Comprehensive sexuality education (CSE)** “is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and adolescents with knowledge, skills, attitudes and values that will empower them to realize their health, well-being and dignity, to develop respectful social and sexual relationships, to consider how their choices affect their own well-being and that of others and to understand and ensure the protection of their rights throughout their lives” (WHO, 2018a).

Young people undergo a number of physical, emotional and social changes as they transition from childhood to adulthood. Studies demonstrate that they are often unprepared for these changes. Accordingly, they need knowledge and skills to make well-informed choices about their health in general and their SRHRR in particular (UNESCO, 2018).

There is strong evidence on the positive effects of CSE on increasing youth knowledge and improving their attitudes towards their sexual and reproductive health (UNESCO, 2018). Studies have also shown that curriculum-based CSE programmes can contribute to a delayed initiation of sexual intercourse, a decreased frequency of sexual intercourse, a decreased number of sexual partners, a reduced risk taking, an increased use of condoms and an increased use of contraception (UNESCO, 2018).

Despite the fact that there is no evidence suggesting that CSE increases sexual activity, sexual risk-taking behaviors or infection rates by HIV and other STIs (UNESCO, 2018; Fonner et al., 2014; Shepherd et al., 2010), there is a widespread misconception that providing CSE will encourage youth to engage in early or risky sexual behaviors. As a result, the content of CSE curricula in many countries is often more limited than recommended by international guidelines.

Also, accessing CSE is often school-based. However, the most marginalized youth, including refugees who are often most at risk for adverse SRH outcomes, are often the least likely to be in school (UNESCO, 2017). Furthermore, teachers often lack quality training and technical support on CSE content and on strategies for participatory facilitation and non-judgmental positive approaches.

Recommendations emerging as an output of the ICPD Cairo Declaration in 2013 stressed on the importance of having policies and programmes in place which recognize the promotion and protection of SRHRR as a means towards the achievement of national and global commitments for sustainable development. More specifically, the recommendations highlighted the need to “make available cultural and age-appropriate sexuality education” in an effort to promote and protect sexual and reproductive health (UNFPA, 2013a, p.23). A number of countries have policies or strategies that support CSE, but a few have implemented and sustained large-scale CSE programmes (UNESCO, 2018; UNESCO, 2015).

Among the 15 reviewed Arab countries, data and information from the gathered literature on existing policies related to school-based sexuality education revealed that only six out of the 15 reviewed countries have set policies at this level, and these are Djibouti, Egypt, Lebanon, Morocco, the Sultanate of Oman and Palestine. On the other hand, data collected from the targeted countries revealed that only Lebanon, Palestine, Syria and Tunisia reported having set policies and/or strategies/plans on school-based sexuality education. This supports what is recommended in the ICPD brief (refer to the *Sexual and Reproductive Health and Reproductive Rights Regulatory Frameworks across the Arab States Region: Current Status and Future Outlook* report, 2019).

Furthermore, the ICPD recommends that countries should provide scientifically accurate and comprehensive sexuality education programmes both within and outside of schools. Such programmes must include information on contraceptive use and acquisition. Although this recommendation is not properly adopted by all countries, several countries in the region have invested efforts to scale up sexuality education. For example, the Ministry of Education and Higher Education and the Ministry of Public Health in Lebanon approved a decree in 2010 to introduce a school-based reproductive health education and gender curriculum. However, this decree has yet to be widely implemented in schools. Furthermore, The Ministry of Health in Palestine has also started conducting comprehensive sexuality education programmes within and outside of schools which, based on the ICPD recommendation, include information on contraceptive acquisition and use (ICPD, 2019, unpublished draft report).

The above reflects the need to design and implement community and school-based comprehensive sexuality education programmes that promote human rights and gender equality in the Arab region. The right of access to accurate SRH services and information including CSE is grounded in fundamental human rights, in Sustainable Development Goals, in the ICPD Programme of Action, in the Beijing Platform for Action, in the Convention on the Elimination of all Forms of Discrimination against Women and in the Nairobi Summit.

## B. Contraception counselling and provision

**Contraception** is the intentional prevention of pregnancy by artificial or natural means (WHO, 2018a). Contraception allows people to attain their desired number of children and to determine the spacing of pregnancies by delaying or preventing childbearing. Numerous contraceptive options, designated by duration and context of use (long-acting, permanent, short-term or emergency) and by method of operation (hormonal, non-hormonal, barrier or fertility awareness-based), exist (Festin et al., 2016).

Estimates suggest that 2.5 million girls aged under 16 years in low-resource countries give birth every year (Neal et al., 2012). For some youth, pregnancy and childbirth are planned and wanted; whereas for others, they are not. About half of pregnancies to girls aged 15–19 years in developing regions are unintended (Darroch et al., 2016). Primary reasons for youth pregnancies include child marriage, poverty, lack of opportunity and social or cultural values related to motherhood (UNFPA, 2015a).

It is important to note that early pregnancies among young people have major health and social consequences. For what relates to health consequences, pregnancy and childbirth complications are the leading cause of death among girls aged 15–19 years globally, with low- and middle-income countries accounting for 99% of global maternal deaths of women aged 15–49 years (WHO, 2016a; WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division, 2015). Moreover, some 3.9 million unsafe abortions among girls aged 15–19 years occur each year, contributing to maternal mortality, morbidity and lasting health problems (Darroch et al., 2016). Early childbearing can increase risks for newborns too. Babies born to mothers under 20 years of age face higher risks of low birth weight, preterm delivery and/or severe neonatal conditions (Ganchimeg et al., 2014). As for what relates to social consequences, girls who become pregnant before the age of 18 years are more likely to experience violence within a marriage or partnership (UNFPA, 2013b). Adolescent pregnancy may also threaten girls' education and employment opportunities (UNFPA, 2015a; Merrick, 2015).

Promotion of contraceptive use can prevent early and unintended pregnancies and can help reduce maternal and newborn mortality and morbidity as well as decrease the need for unsafe abortion (Darroch et al., 2016). In addition, the use of condoms provides dual protection against pregnancies and STIs, including HIV (WHO, 2018b).

Twenty-three million adolescents aged 15–19 years have an unmet need for modern contraception and are at risk of unintended pregnancy (Darroch et al., 2016). Girls in particular who are aware of the benefits and wish to have access to contraception face numerous barriers. These include restrictive laws and policies regarding provision of contraception based on age or marital status, health care provider bias or lack of willingness to acknowledge youth SRH needs and youth's own inability to access contraceptives because of knowledge, transportation or financial constraints (Chandra-Mouli et al., 2017). Even when youth are able to obtain and use contraceptives, they face challenges that include the family's pressure to have children, the stigma surrounding marital sexual activity or contraceptive use, their fear of the side effects, their lack of knowledge on correct use and their lack of knowledge on where and how to obtain contraceptive information or services (Chandra-Mouli et al., 2017). As a result, unmet contraceptive needs among youth are greater than in any other age group (Darroch et al., 2016).

Also, it is important to mention that contraceptive services and health care providers are often not youth friendly (Chandra-Mouli et al., 2017). In many situations, even when there are no legal or policy restrictions to providing youth with contraceptive information and services, there is a need to overcome health care provider biases and misconceptions regarding contraceptive use by youth (WHO, 2011).

The contraceptive needs of youth vary. Accordingly, complementary strategies must be used to respond to the differing needs of different young populations (WHO, 2011). Furthermore, programmes must address the needs of special populations of youth, including those with disabilities or chronic diseases, migrants and refugees (WHO, 2014).

In Arab countries, the level of knowledge about family planning and modern contraceptive methods (MCM) is, in general, high among both men and women, but the use of contraceptives is still low despite the noticeable increase in the last decades. This is due to a mix of social, cultural, financial and geographical barriers (UNFPA ASRO,



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2020). The unmet need for family planning in the Arab states is higher than the global average, 15% compared to 10% globally (UNFPA ASRO, 2020). For instance, the rate of MCM use among women aged 15–49 ranges from as low as 12.75% in the least developed countries to as high as 28% in the Mashreq, with Egypt at 42%. The average of contraceptive prevalence in Maghreb countries is 27%, with Libya only at 16%. A relatively low uptake in the Sultanate of Oman (14%) is noted. The proportion of the same group of women who have satisfied their needs for modern contraceptives also varies among countries. Satisfaction is highly expressed in Egypt (82%) and Morocco (79%) and to a much lesser extent in the Sultanate of Oman (41%) and Sudan (36%), while the proportion of the same group of women who have unmet needs for family planning ranges from as high as 16% in the least developed countries to as low as 8% in the Mashreq. The unmet need for family planning in Maghreb countries is estimated at 9.5% with Libya at 17%. A similarly high unmet need in the Sultanate of Oman (15%) is noted.

In 2019, of the 91 million women in reproductive age (15–49 years) in the Arab region, 13.6 million women had an unmet need for family planning as they wanted to avoid pregnancy but were not using a contraceptive method (UNFPA, ASRO 2020). More specifically, young married women in their twenties account for a significant portion of unintended pregnancies in the region, and this is because they make up a large share of all married women in childbearing age and because young married women are generally more sexually active and likely to become pregnant than older married women (UNFPA, 2018b).

The various underlying factors influencing this unmet need in contraception use are complex, ranging from lack of access to information, services and commodities to lack of support from partners and communities. As with other aspects of women's lives, the desire and ability to practice family planning are affected by women's socioeconomic characteristics (UNFPA, 2018b). Additionally, meeting the family planning needs of women affected by war and conflict is even more challenging. Health care services in these contexts are limited, and reproductive health care in particular is not adequately prioritized in humanitarian settings where girls and young women are particularly vulnerable and need special attention (UNFPA, 2018b). In general, poorer people, less educated people and people in rural areas often have less access to family planning services. For instance, certain groups such as adolescents, unmarried women, women of low socio-economic status in urban and rural areas, refugees, migrants, internally displaced individuals, persons with disabilities and people living with HIV also face a variety of barriers to reproductive health care and family planning. This can lead to higher rates of unintended pregnancy, increased risk of HIV and other STIs, limited choice of contraceptive methods and higher levels of unmet needs for family planning (UNFPA ASRO, 2020).

In fact, while there is a relatively clear understanding of the impact of unmet needs for family planning among married women in the Arab world, there is very little on the status of unmet contraceptive needs among unmarried sexually active women. Evidence from the region suggests that contraceptive use, including emergency contraception, among unmarried women is in fact infrequent and irregular. One national survey conducted in Morocco shows that only 3 percent of unmarried sexually active women in the ages of 15 to 24 used MCM (Axetudes, MoH of Morocco, 2007). Surveys of unmarried youth are likely to underestimate both sexual activity and contraceptive use because young women are reluctant to admit to premarital sex or to contraceptive use. Single men and women may avoid family planning and reproductive health services because of lack of confidentiality as well as moral judgments by providers (UNFPA, 2018b).

As for emergency contraception, it is often referred to as the morning-after pill and is equally important to consider when addressing safe abortion. The World Health Organization (WHO) recommends several forms of emergency contraception to prevent an unwanted pregnancy within three days of intercourse. Emergency contraception has been available in the MENA region since 2001 when it was first registered in Tunisia. It is now available in Algeria, Egypt, Iran, Lebanon, Libya and Yemen. But neither young women nor health care providers are well informed about how to use the method (Foster et al., 2005). In contrast, in several countries, such as Jordan, emergency contraception medication is not approved and is not available on the market with the few exceptions in which the UN and NGOs provide emergency contraceptives to rape survivors, but these are mostly limited to refugee communities (Amnesty international, 2019).

According to a mapping exercise implemented in 2019, the findings revealed that almost all 15 countries that were included in the study had set policies that facilitate access to effective contraception except for Libya. However, the findings did not reveal if these countries have laws regulating access to effective contraception or not. The existence of related policies could explain the somewhat low contraceptive prevalence (34%) among women aged 15–49 in Libya in comparison to some of the reviewed countries. The findings of the conducted desk review also revealed the existence of related strategies/plans only in Jordan. This might explain why Jordan is positioned among the countries that have good SRHRR-related indicators (refer to the *Sexual and Reproductive Health and Reproductive Rights Regulatory Frameworks across the Arab States Region: Current Status and Future Outlook* report, 2019).

### C. Antenatal, intrapartum and postnatal care

**Antenatal care** “is care provided by skilled health care professionals to pregnant women and adolescent girls in order to ensure the best health conditions for both mother and baby during pregnancy” (WHO, 2016a).

**Intrapartum care** “is care provided by skilled health care professionals to women and adolescent girls during childbirth in order to ensure the best health conditions for both mother and baby” (WHO, 2015).

**Postnatal care** “is care provided by skilled health care professionals to women and adolescent girls and their babies up to six weeks following childbirth in order to ensure the best health conditions for both mother and baby” (WHO, 2015).

In many settings, adolescent pregnancy is common. Estimates suggest that 2.5 million girls aged under 16 years in low-income countries give birth every year (Neal et al., 2012). As stated above, early pregnancies among young people have major health and social consequences on mothers themselves and their newborns.

The provision of antenatal, intrapartum and postnatal care is essential to prevent maternal deaths through proper and adequate medical interventions (Every Woman Every Child, 2015). However, young people may face barriers to accessing and using skilled care before, during and after pregnancy (Banke-Thomas et al., 2017). The situation is direr for very young adolescents, unmarried adolescents, refugees and adolescents in humanitarian crises situations (Chynoweth, 2015). Accessibility barriers include lack of information on the importance of using maternal health services, lack of confidentiality and stigma (WHO, 2011).



Also, antenatal, intrapartum and postnatal health care providers are not always responsive to the needs of young people. They lack the proper knowledge, understanding and skills to provide high-quality and adolescent-friendly antenatal, intrapartum and postnatal care based on the right of all people to health, confidentiality and non-discrimination (WHO, 2011).

In the Arab region, similar reported challenges are faced. However, studies have shown that there has been an adequate increase in the establishment and use of private health care centres and facilities for childbirth procedures in the region even in the least developed countries (Khachfe et al., 2019). For the majority of countries in the MENA region, more than 70% of pregnant women seek ANC. These are reported as follows: 92.5% in Mashreq countries, 93.1% in Maghreb countries and 75.6% in the least developed countries. The Sultanate of Oman (member of the GCC) has the highest percentage of women seeking ANC (99%) (UNFPA 2019).

Also, a recent study that assessed the integration of SRH into primary health care (PHC) in 11 countries (Egypt, Jordan, Lebanon, Libya, Morocco, the Sultanate of Oman Palestine, Saudi Arabia, Sudan Tunisia and the United Arab Emirates) between 2017 and 2018 showed that all 11 countries provide antenatal and postnatal care as well as neonatal and child health care within PHC (Kabakian-Khasholian et al., 2020).

However, it is important to highlight the following situation for particular Arab countries. In Sudan, over 40% of currently married women (15–49 years) do not receive regular ANC and are not vaccinated against tetanus during pregnancy. Furthermore, 71% of women deliver at home and 22.5% deliver by the hands of unskilled providers. Also, in Morocco, at least one quarter of currently married women (15–49 years) do not receive ANC, do not receive tetanus vaccines during pregnancy and deliver at home by the hands of unskilled providers. Furthermore, Egypt and Jordan suffer from high proportions of C-section deliveries (51.8% and 28.0%, respectively) and insufficient tetanus vaccination during pregnancy (25.6% and 69.1%, respectively) (UNFPA and the American University in Cairo, 2019).

Another level of inconsistency is seen in relation to the continuum of care. For example, in Lebanon, Syria, Iraq, Palestine and Jordan, while ANC is quite prevalent, there is limited use of and little importance given to the impact of postnatal care (PNC), with a significant lack of organized PNC delivery systems and low usage of PNC services by women (Kabakian-Kasholian, El-Kak, and Shayboub, 2012) (Also refer to Iraq, Palestine and Jordan SRHRR policy guidelines reports, 2021).

## D. Safe abortion care

**Induced abortion** refers to “the intentional loss of an intrauterine pregnancy due to medical or surgical means” (WHO, 2018c).

**Safe abortion** refers to “abortion that is done with a method recommended by WHO (medical abortion, vacuum aspiration, dilatation and evacuation), is appropriate to the pregnancy duration and is provided by a trained health care provider” (Ganatra et al., 2017).

**Less safe abortion** refers to “abortion that meets only one of two criteria — either the abortion is done by a trained health care provider but with an outdated method (e.g. sharp curettage), or a safe method of abortion (e.g. misoprostol) is used but without adequate information or support from a trained individual” (Ganatra et al., 2017).

**Least safe abortion** refers to “abortion provided by untrained individuals using dangerous methods (e.g. ingestion of caustic substances, insertion of foreign bodies, use of traditional concoctions)” (Ganatra et al., 2017).

Unsafe abortions among adolescents constitute a significant problem. An estimated 3.9 million girls aged 15–19 years undergo unsafe abortions every year in developing countries (Darroch et al., 2016). Unsafe abortions among youth have major health consequences. Approximately 8% of maternal mortality among all women between 2003 and 2012 was attributable to unsafe abortion (Say et al., 2014). Compared to older women, adolescents are “more likely to seek abortions from untrained providers, to have a self-induced abortions, to terminate their pregnancies after the first trimester when the procedure is more dangerous, and to delay seeking medical care for complications following unsafe abortions; they are less likely to know about their rights concerning abortion and post-abortion care and to report having had an abortion” (Guttmacher Institute, 2016).

Despite evidence that restrictive abortion laws are associated with higher levels of maternal mortality, access to safe abortion services is highly restricted in many countries (Chae et al., 2017; UN DESA, 2014). Countries often further restrict adolescent access to safe legal abortion through policy interventions related to consent (parental, spousal, health care provider), age, marital status and restrictions on information provided to the public (Guttmacher Institute, 2016; Bayer et al., 2011). Where safe abortion care is available to youth, it is often not youth friendly (Guttmacher Institute, 2016; Bayer et al., 2011). In many contexts, health care providers lack proper training and support to inform, counsel and provide services to concerned youth and to be responsive to the particular needs of different groups of young people (WHO, 2011).

In the Arab region, unintended pregnancy and unsafe abortion are serious public health issues that often go ignored, jeopardizing the health of women and families and placing a burden on society as a whole. On average, two in five pregnancies are unplanned, and half of these unintended pregnancies result in abortions which, due to restrictive laws, are largely unsafe, putting women's lives and health at risk (UNFPA, 2018b). Also, according to the WHO, around 3.2 million abortions in the Eastern Mediterranean region in 2008 were performed in unsanitary settings, by unskilled providers or both. Complications from those unsafe abortions accounted for 10 percent of maternal deaths in the region (UNFPA, 2018a).

As per the *ICPD Brief Draft Report (2020)*, "the majority of the countries in the region allow for abortion under certain circumstances, whether through the penal code, fatwa, ministerial regulation or presidential decree. These include rape or incest, mental or physical health of the pregnant woman, foetal impairments, and, in the case of Djibouti, undefined "therapeutic" reasons". In Bahrain and Tunisia, a broad range of reasons for acquiring a legal abortion exist. In Bahrain, penal code of March 20, 1976 (sections 321-323) allows for abortion to save the mother's life or to protect her physical and mental health, and it also allows it in the case of rape, incest, foetal malformations and socio-economic problems. In Tunisia, under penal code of 2012, article 214, women are freely permitted to seek an abortion; however, the procedure must be carried out during the first three months by a legally licensed medical doctor in a hospital, health facility or licensed clinic. After the first three months of pregnancy, an abortion may be performed if there is a risk to the mother's health (including if mental wellbeing would be impaired by continuing the pregnancy) or a risk that the unborn child will suffer from a disability or serious illness. More restrictive environments are present in Iraq, Lebanon, Libya, the Sultanate of Oman Somalia, Syria and Yemen where abortion is only legal if the life of the mother is at risk/to save the mother's life" (Social Institutions & Gender Index/SIGI, 2019).

Data from Tunisia, where abortion is legal, suggest that abortions have not only become safer as a result of legalization, but that abortion rates have also declined as their family planning programmes have expanded (UNFPA, 2018b). In contrast, in the majority of Arab counties with restrictive laws, women risk injury or even death as they resort to clandestine operations to terminate their pregnancies, placing a large burden on health care systems (UNFPA, 2018b).

Post-abortion care is particularly important in countries with restrictive laws, making it an essential element of reproductive health services. Several Arab countries, including Egypt, Iran and Yemen, have introduced post-abortion care programmes that allow for the training of health care providers in handling the complications of unsafe abortion (Dabash et al., 2008); however, additional efforts are still needed to ensure a proper response.

Also, the study that assessed the integration of SRH into PHC in 11 Arab countries (Egypt, Jordan, Lebanon, Libya, Morocco, the Sultanate of Oman Palestine, Saudi Arabia, Sudan, Tunisia and the United Arab Emirates) between 2017 and 2018 showed that the prevention of unsafe abortions and post-abortion care services are provided in only 5 countries (Morocco, the Sultanate of Oman, Sudan, Tunisia and UAE) (Kabakian-Khasholian et al., 2020).

As mentioned in section B above, it is being recognised that the most effective intervention to reduce unintended pregnancy and abortion is improving access to effective contraceptive methods.

As such, in determining the size of the problem in Arab countries and understanding its underlying factors, it is essential to look at contraceptive access and use as well as the legal and social ecosystem that often constitute a barrier to safe abortion.

## E. Sexually transmitted infections prevention and care

**Sexually transmitted infections (STIs)** are “infections caused by bacteria, viruses or parasites transmitted through sexual contact, including vaginal, anal and oral sex. Some STIs may also be spread by skin-to-skin sexual contact or through non-sexual means, such as from mother to child during pregnancy and childbirth. There are more than 30 known bacteria, viruses and parasites that cause STIs” (WHO, 2016b).

STIs among adolescents are a significant problem to address. Available data sources on STIs among adolescents and youth in most low- and middle-income countries are limited. Nevertheless, where age-disaggregated surveillance systems exist, a substantial proportion of STIs incidence occurs among youth.

Because of the immaturity of the cervical mucosa and increased cervical ectopy, adolescent girls may have greater biological susceptibility than adult women to some STIs (Kleppa et al., 2015; CDC, 2017). In the Arab region, boys who are more prone to have multiple partners could be at a higher risk of contracting STIs. Also, the risk of contracting STIs is often higher for particular groups of youth, including adolescent sex workers and their clients as well as boys who have sex with men or with other boys (WHO, 2016c; WHO, 2012a).

STIs among youth have major health consequences that could go beyond the immediate impact of the infection itself (WHO, 2016c). Herpes, ulcerative (syphilis) and inflammatory (chlamydia, gonorrhoea, trichomoniasis) curable STIs are associated with a two to threefold increased risk of acquiring HIV (Freeman et al., 2006; Sexton, Garnett & Rottingen, 2005). All curable STIs have been associated with severe pregnancy complications for the newborn, including preterm birth, low

birth weight and death (Gottlieb et al., 2014; Johnson et al., 2011). Also, STIs such as gonorrhoea and chlamydia are major causes of infertility (Gottlieb et al., 2014). Human papillomavirus caused an estimated 528,000 cases of cervical cancer and 266,000 deaths from cervical cancer in 2012 (WHO, 2012b).

Comprehensive sexuality education and contraception counselling and provision have been shown to offer prevention against STIs (WHO, 2016c; Kalamar, Bayer & Hindin, 2016). But as previously noted, many young populations do not have access to integrated STI prevention and management services (WHO, 2016c). Even when STI prevention and management services are available, youth often face barriers related to stigma, shame, cost and lack of confidentiality and friendliness (Newton-Levinson, Leichter and Chandra-Mouli, 2016). In many countries, health care providers have limited training and are poorly supported to inform, counsel and care for youth based on their evolving capacities to understand the treatment and care options being offered. Also, STI prevention and management services should be provided for youth without mandatory parental and guardian authorization or notification (WHO, 2016c).

At the level of the Arab region, UNAIDS (2018) noted that “despite having one of the lowest HIV rates in the world, however, stigmas associated with AIDS could be contributing to its rise in several countries in the region” (UNAIDS, 2018, p.243). Particular information was also highlighted by UNAIDS as “special efforts are needed to expand and improve the HIV testing and treatment programmes in the Islamic Republic of Iran and Sudan, which accounted for more than 60% of the region’s deaths from AIDS-related illness in 2017.” (UNAIDS, 2018, p.240). In addition, and based on the United Nations SDG database, it is noted that Djibouti has the highest rate of new infection cases in the region, with 0.64 new cases being reported per every 1000 in the uninfected population (UN SDG, 2018). It is also important to note that the population groups that are most at risk in the region include people who inject drugs, sex workers, clients of sex workers and other sexual partners (UNICEF, 2019a).



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Limited data and information are available in the literature for the existing STI-related regulatory frameworks available in relation to the reviewed Arab countries. For those with available data, it is noted that Syria has no set policies for STI prevention, screening and treatment, nor for screening pregnant women for syphilis or for mother-to-child transmission of syphilis. However, Algeria, Egypt, Morocco and Sudan have set policies for mother-to-child transmission of syphilis and for screening pregnant women for syphilis. The Sultanate of Oman has policies on screening pregnant women for syphilis. It is also important to mention that Libya, Somalia, Sudan and Tunisia reported not having any related set policies. Absence of related strategies/plans is also noted in Egypt and Somalia. It is also important to highlight that Algeria, Iraq, Jordan, Lebanon, Morocco, the Sultanate of Oman, Palestine and Yemen have set HIV-related policies and/or plans.

As for the provision of STIs services within the region, the study that assessed the integration of SRH into PHC in 11 countries (Egypt, Jordan, Lebanon, Libya, Morocco, the Sultanate of Oman, Palestine, Saudi Arabia, Sudan, Tunisia and UAE) between 2017 and 2018 showed that services related to STIs screening, diagnosis and treatment are provided in Jordan, Lebanon, Morocco, the Sultanate of Oman, Palestine, Sudan and Tunisia (Kabakian-Khasholian et al., 2020). Voluntary counselling testing (VCT) services related to HIV and STIs, such as anonymous telephone hotlines for information about HIV and SRH, anonymous testing services and free treatment services to AIDS patients, are present in 12 countries (Algeria, Bahrain, Djibouti, Egypt, Jordan, Lebanon, Morocco, occupied territory of Palestine, Tunisia, Sudan and Syria) (Zahlan et al., 2020). However, access to such needed services is often limited, and even when there is access, persons including youth are reluctant to seek those services due to issues related to confidentiality, stigma and discrimination.

Based on the above and in light of the existing burden of STIs, more effective responses from global and national health sectors to STIs are promptly needed. Also, having access to services conducting prevention and management of STIs, including HIV and AIDS, is a human right associated with the rights to education and information, health and effective remedy and response.

## **F. Gender-based violence and harmful practices (child marriage, female genital mutilation and sexual Violence)**

**Gender-based violence (GBV)** refers to “violence directed against a woman because she is a woman or violence that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty” (CEDAW, 1992).

**Violence against women (VAW)** refers to “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life” (UN, 1993).

**Intimate partner violence (IPV)** refers to “behavior by a current or former intimate partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviors” (WHO, 2017).

**Sexual violence (SV)** refers to “any sexual act, attempt to obtain a sexual act or other act directed against a person’s sexuality using coercion, by any person, regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object” (WHO, 2017).

**Traditional cultural practices** reflect values and beliefs held by members of a community through generations. Every social context possesses specific cultural beliefs and practices, and some of these beliefs and practices can be harmful to a specific group, particularly women. These harmful cultural practices include FGM, child and early marriage, female infanticide, menstrual stigma and nutritional practices (UN OHCHR, 1995).

**Female genital mutilation (FGM)** refers to “any procedure that involves the partial or total removal of external genitalia or other injury to the female genital organs (such as stitching of the labia majora or pricking of the clitoris) for non-medical reasons” (WHO, 2016d).

**Child marriage** refers to “a formal marriage or informal union before the age of 18 years” (UN OHCHR, 1990).

As stated in the definitions above, GBV takes many forms. In addition to physical and sexual violence, violence practiced primarily against women and girls includes psychological and emotional harm and abuse, sexual harassment, FGM, so-called honour killings of women and girls, trafficking of women and girls, female infanticide and other harmful practices. Intimate partner violence (IPV) and non-partner sexual violence are among the most pervasive and insidious forms of violence against women and girls. The lifetime prevalence of IPV is 29% among ever-partnered girls aged 15–19 years, (WHO, 2013). It is also estimated that about 200 million girls and women have been exposed to FGM, an intensely harmful practice coupled with serious short- and long-term health risks and even leading to death (WHO, 2020; UNFPA, 2019). Worldwide, the prevalence of child sexual abuse is estimated at 18% for girls and 8% for boys (Stoltenborgh et al., 2011).

GBV is deeply rooted in discriminatory cultural beliefs and attitudes that perpetuate inequality and powerlessness, particularly of women and girls. Attitudes justifying violence against women and girls are often held by women and men, and sexual harassment could be present even in institutions assumed to be safe such as schools and social welfare institutions (WHO, 2012c; UNICEF, 2017). Various other factors such as poverty, lack of education and livelihood opportunities and impunity for crime and abuse also tend to contribute to and reinforce a culture of violence and discrimination based on gender.

GBV among youth has major health and social consequences. IPV can increase girls' risks for unintended pregnancies and induced abortions, often in unsafe conditions (WHO, 2013). It can also increase girls' and women's risk of acquiring HIV and STIs in some contexts (WHO, 2013). As for the unfavourable mental health outcomes, child and adolescent sexual abuse and IPV are associated with an increased risk of depression, post-traumatic stress disorder and suicidal ideation and attempt (WHO, 2013; Sumner et al., 2015). Also, child and adolescent sexual abuse is a risk factor for a range of behavioural risks during adolescence and in adulthood. These include unsafe sex, alcohol misuse and substance use (Maniglio, 2009).

Women and girls who experience GBV face major obstacles in disclosing it, including those related to stigma, blame and shame. A limited number of survivors (10–40%) seek any type of medical or legal help from concerned service providers (Sumner et al., 2015; Namy et al., 2017). Although health care service providers are supposed to be the first professional contacts for women and girls who experience IPV or any kind of sexual violence, there is a limited availability of trained health care personnel who are properly supported to identify and respond to GBV (WHO, 2015; WHO,



2016e). Coverage and quality of services, especially mental health services, needed by survivors are limited, often fragmented and concentrated in urban places (WHO, 2016e).

In the Arab region, despite having laws against child marriage, the practice remains widespread, in part because of persistent poverty and gender inequality. Girls coerced into child marriage often become pregnant while still adolescents, increasing the risk of complications in pregnancy or childbirth. These complications are a leading cause of death among older adolescents in developing countries (UNFPA, 2021b).

Within the same context, and as detailed in the mapping studies conducted on SRHRR legal frameworks in the 15 Arab countries (2019), the following points should be noted.

While some of these countries have laws in place to hold perpetrators of GBV to account, their enforcement is often limited. Furthermore, laws that prohibit Female Genital Mutilation (FGM) exist in Djibouti, Egypt, Iraq, Palestine, Somalia, Sudan, Tunisia and Yemen. However, in some countries like Djibouti, despite the existence of such laws, a high practice is noted. Also, practices of FGM in Somalia and Sudan are extremely high. In Iraq, FGM is not prohibited by a separate law; yet, it is stated under the Domestic Violence Law and criminalized.

As for laws on the minimum age for marriage, they exist in the 15 reviewed countries except for Lebanon and Yemen. However, exceptions for early marriage are permitted in almost all countries. Palestinian laws provide protection from early marriage in the Gaza Strip; however, exceptions for early marriage are also permitted there. It is also notable that early marriage is allowed in the West Bank. In Lebanon and Syria, two countries that include different confessional groups, the personal status laws of different religious sects regulate the legal age of marriage. In Somalia, sharia and customary laws are adopted to address family matters and affairs.

National plans and policies for addressing GBV are not adequately resourced and financed, and intersectoral coordination for properly addressing different forms of GBV is often lacking in most Arab countries. These challenges are prevailing mostly in countries where political instability and wars prevail such as in Palestine, Somalia, Syria and Yemen. This is compounded by the restricted access to services due to stigma and/or cultural taboos/social norms.

As for existing GBV-related services within the region, the study that assessed the integration of SRH into PHC in 11 countries (Egypt, Jordan, Lebanon, Libya, Morocco, the Sultanate of Oman, Palestine, Saudi Arabia, Sudan, Tunisia and UAE)

between 2017 and 2018 showed that prevention and management of GBV services are provided in the aforementioned countries except for the Sultanate of Oman (Kabakian-Khasholian et al., 2020).

Ensuring the availability of a proper GBV response, including harmful practices, is a national and regional responsibility. Having access to GBV and harmful practices services is a human right directly associated with the right of every person, including youth, to be free from any kind of violence that harms them and affects their wellbeing.

## G. Bodily autonomy and integrity concerning youth

**Bodily autonomy** means “having the power and agency to make choices over our bodies and futures, without violence or coercion. This includes when, whether or with whom to have sex. It includes when, whether or with whom you want to become pregnant. It means the freedom to go to a doctor whenever you need one” (UNFPA, 2021).

Nearly half of all women are denied their bodily autonomy according to data from 57 countries that measured women’s ability to make their own decisions on issues relating to health care, contraception and whether to have sex (UNFPA, 2021). UNFPA emphasises that the situation for many women and young girls is even worse in crises like the current Covid-19 pandemic. When schools are closed, girls are at a greater risk of sexual violence. Because of lockdown restrictions and severe measures in countries, many sexual and reproductive health services are not delivered. In countries such as Ethiopia, Kenya, Nigeria and Sudan where marriage is seen as a way of protecting girls from the negative economic impact of the pandemic, FGM is being performed increasingly to ensure premarital virginity (UNFPA, 2021).

Some of the most present barriers to bodily autonomy include patriarchal views, stereotypes, assumptions and misconceptions about bodily autonomy and the rights of youth in general and of women and girls in particular. The right to autonomy in making health decisions in general, and sexual and reproductive decisions in particular, derives from the right to liberty, dignity, privacy, security and bodily integrity. These rights constitute the basis for the rights to informed consent and confidentiality in relation to health services and health care. Also, youth, particularly women and girls, have the right to be fully informed of their different options in health care, including potential benefits and adverse effects of proposed methods of treatment and available alternatives, and including the option of refusing care.

Despite such rights and the existence of protective laws in many countries, a variety of legal, cultural, social, gender and other obstacles still prevent many people — mainly women, adolescents, youth, persons with disabilities, refugees and migrants in addition to lesbian, gay, bisexual, transgender, intersex and other sexuality, sex and gender diverse community (LGBTI+) — from seeking and obtaining appropriate SRHR information, counselling and services. As noted, these obstacles invade the right to health whereby essential services must be available, accessible, acceptable, of good quality and provided by trained professionals without any coercion, discrimination or violence (UNFPA, 2021).

Within the context of the reviewed 15 Arab countries, desk review findings showed that in Algeria, Morocco, the Sultanate of Oman and Syria, parental consent is required by law for adolescents to access SRH services. Also, in Algeria, Egypt, Morocco, Sudan and Syria, youth participation and engagement in national strategies associated with their health is pursued.

Securing bodily autonomy and equality for women and youth requires changes in norms and behaviours, and the engagement of men needs to be brought on board. Local communities and countries can flourish only when every person has the power to make decisions about their bodies and to chart their own futures. When youth in general, and women and girls in particular, can make the most essential choices about their bodies, they not only gain in terms of autonomy but also in terms of enhancements in their health, education, income and safety (UNFPA, 2021).

## IX. Recommendations

Recommendations are suggested for each of the youth-related SRHRR themes detailed above. Cross-cutting recommendations valid to all tackled themes are also provided.

More detailed policy guidelines and recommendations associated with each of the tackled SRHRR themes are provided within the previously developed “Regional SRHRR Policy Guidelines – 2020 - 2021)”. These were classified based on the socioecological model which highlights the different elements that should be ensured and that should work in synergy to guarantee a proper SRHRR response to all concerned parties with particular attention to youth.

Related elements are associated with the availability of the following: (i) an enabling environment through relevant and supportive laws, policies and programming, in addition to coordination among all concerned parties in procuring the required resources; (ii) quality services; (iii) awareness about existing services and the increasing demand for those services; (iv) evidence-based data and information that inform decision-making for a proper SRHRR response.

### A. SRHRR themes recommendations

#### 1. Comprehensive sexuality education provision

- Advocate for CSE provision among all concerned stakeholders to promote the wellbeing of youth and to particularly prevent adolescent and youth pregnancy. This could be achieved through interventions aiming at information provision, sexuality and health education, life-skills building, contraceptive counselling, service provision and the creation of supportive environments.
- Support planning and implementation of scientifically accurate CSE programmes within and outside schools that include accurate SRHRR information and education.

#### 2. Contraception counselling and provision

- Pitch to political leaders and planners to formulate laws and policies to increase youth’s access to contraceptive information and services, including emergency contraceptives.
- Support interventions that would influence community members to support access to contraception counselling for youth.
- Support interventions that would provide accurate information and

education about contraception within curricular and extra-curricular programmes.

- Improve access to comprehensive contraceptive information and services for youth who have difficulties with accessing services (e.g. rural residents, poor urban people and others).
- Advocate for the provision of SRH services, including contraceptive information and services, for youth without mandatory parental and guardian authorization or notification with the aim of meeting their educational and service needs.
- Ensure that emergency contraception is offered to girls who have been raped within 120 hours (5 days) of the incident.

### **3. Antenatal, intrapartum and postnatal care**

- Promote birth and emergency preparedness in antenatal care strategies for pregnant youth in community and health facility settings.
- Expand the availability of and access to basic and comprehensive emergency obstetric care to all populations, including youth.
- Provide information to all pregnant youth and other stakeholders about the importance of using quality antenatal and postnatal care.
- Provide information to all pregnant youth and other stakeholders about the importance of using quality childbirth care.

### **4. Safe abortion care**

- Ensure that laws and policies enable adolescents to obtain safe post-abortion care.
- Identify and overcome barriers to the provision of safe post-abortion care for adolescent girls.
- Enable youth to obtain safe post-abortion care by increasing their awareness and that of other stakeholders about the dangers of unsafe methods of interrupting a pregnancy, about safe abortion services that are legally available and about where and under what conditions abortion services can be legally obtained.

### **5. Sexually transmitted infections prevention and care**

- Consider introducing HPV vaccination to girls aged 9–14 years as per national guiding strategies and as part of a coordinated comprehensive strategy to prevent cervical cancer and other HPV-related diseases. Such consideration is suggested when (i) cervical cancer or other human papillomavirus HPV-related diseases constitute a public health priority, (ii) vaccine introduction is programmatically feasible, (iii) sustainable financing can be secured and (iv) the cost-effectiveness of vaccination strategies in the country or region has been considered.

- Promote screening for cervical pre-cancer and cancer in women and young girls who have initiated sexual activity.
- Support the provision of STIs testing and counselling services, with linkages to prevention, treatment and care for youth who are at risk in all settings.
- Ensure that STIs testing and counselling services, with linkages to prevention, treatment and care, are accessible to all youth.
- Support initiatives that empower and encourage youth to seek STIs prevention, treatment and care.
- Ensure the availability of prophylactic treatment for gonorrhoea, chlamydia and syphilis for children and youth who have been sexually abused, particularly in settings where laboratory testing is not feasible.
- Increase the capacities of health care workers to provide STIs youth-friendly services.

## **6. Gender-based violence and harmful practices (child marriage, female genital mutilation, and sexual violence)**

- Support initiatives seeking to review and amend relevant laws and policies to protect youth from GBV and harmful practices.
- Encourage political leaders, planners and community leaders to formulate and enforce laws and policies that prohibit harmful practices, including the marriage of girls before the age of 18, and to increase family awareness, including young girls, and community awareness about the hazards of harmful practices such as early marriage.
- Increase educational opportunities for girls through formal and non-formal channels in order to delay marriage until the age of 18.
- Create supportive social norms that do not ignore GBV, including harmful practices and forced sex.
- Promote interventions that aim to engage men and boys in critically assessing gender norms and normative behaviors that relate to sexual violence.
- Support interventions for adolescent girls to resist forced sex and obtain support if they experience forced sex by building their self-esteem, by developing their life skills in areas such as communication and negotiation and by improving their links to social networks and their ability to obtain support.
- Ensure the availability and accessibility of clinical management of rape services to sexual violence survivors, with emphasis on the hard to reach.
- Ensure the availability and accessibility of case management services, including psychosocial services for victims of GBV.

## 7. Bodily autonomy and integrity concerning youth

- Deliberate with all parties concerned about the right of all people to bodily autonomy and integrity, free of discrimination and coercive practices.
- Support initiatives aiming to increase the understanding and acceptance of all concerned parties of the fact that human rights apply to all people, that no one's right is above another's and that no one should be denied their right to health in general and to SRHRR in particular.
- Support initiatives aiming to prevent and manage violence and discrimination based on sexual orientation or gender identity among youth.

### B. Cross-cutting recommendations

Deliberate with key actors on the following:

- Reviewing and amending youth-related SRHRR laws and policies with the aim of promoting the SRHRR rights of this target group.
- Supporting the availability of resources essential for ensuring a proper SRHRR response targeting youth.
- Inducing social and behavioral change at the community, family and personal levels, which would lead to the promotion of youth SRHRR wellbeing in the region.
- Establishing youth-friendly spaces for SRHRR service provision
- Investing in the capacity building of SRHRR service providers to be better equipped to provide youth-friendly SRHRR services .
- Establishing mechanisms to increase the availability and accessibility of SRHRR services targeting youth who are considered marginalized and hard to reach.
- Promoting the availability of integrated youth SRHRR-related services within existing health systems and services, particularly at the community level.
- Collaborating with research entities to generate evidence-based data and information informing decision-making and planning for Youth SRHRR-relevant programmes.
- Establishing accountability mechanisms to monitor, evaluate and learn from conducted youth SRHRR services.



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