

**POPULATION STABILIZATION:
EFFORTS AND CHALLENGES:
CASE OF YEMEN**

**Prepared By:
Abdul-Malik Ali Sharafuddin
Director General
Planning and Resource Mobilization
National Population Council /
Technical Secretariat
Yemen**

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Introduction :

By the end of this year 2011, the world population will be seven billion. It is estimated to reach 9.3 billion in 2050. According to global projection of population, the world population increases by about 80 million every year. Since 1965 the world population has increased by more than a double. It is predicted that both China and India together may account for a third of the world population by the year 2050. It is also expected by that date the African countries will double to two billion which represents the largest rate of increase. Many developing countries are taking tough measures to control population growth and curb fertility rates in order to reach population stabilization or at least reaching more or less the level of replacement in fertility reduction. Other countries still facing many challenges and difficulties in attaining the national and international goals towards reaching the ultimate objective of population stabilization specially the Less Developed Countries, one of which is Yemen .

General Back Ground:

General Description:

The Republic of Yemen is suited in the south west corner of Arabia Peninsula, Bordering Saudi Arabia to the North, the Sultanate of Oman to the east, the Arabia Sea and Gulf of Aden to the south and the Red Sea to the west.

Topographically, the country is divided into five regions over: coastal, plateaus, mountainous, Empty Quarter, and Islands. Administratively, it is divided into 21 provinces (governorates) and 334 districts.

Politically, Yemen is a republican country that characterized by a multi-party system and democracy. In May 1990 the Republic of Yemen (ROY) emerged after the unification of the two former regimes the Yemen Arab

Republic in the north and the People Democratic Republic of Yemen in the south.

Economically, Yemen is a low income country adopting a market-based economic system as the private sector is being given the important role to play and to participate in the development process.

It depends heavily on declining oil revenue and international assistances. According to UNDP, the country is receiving limited aids and it is to be considered as below the international averages for least development countries.(Yemen report on millennium development goals 2010).

The Republic of Yemen is facing remarkable challenges and it is considered one of the 20th least developing countries in the world. A per capita domestic production remained very low. The population is estimated to be 23.8m in 2011 according to (2010 projections). Per capita of water is one of the least in the world (120m³ /year), and the country undergoes continuous and increased deficiency of water sources (3.075Billion m³ as of 2008). Despite improvements made over the last two decades, the Human Development Index (HDI) has shifted on from 0.402 in 1990 to 0.575 in 2009, thus ranking Yemen at 140 out of 182 countries. Yemen remains as one of the poorest countries in Arab region. The country will continue to be unable to achieve the national and international (ICPD& MDGS)goals due to a number of challenges and difficulties . On the top of challenges is the high annual population growth rate of 3%. Yemen still faces significant challenges.

This rapid population growth is one of long challenges that the country is facing. It is putting unprecedented pressure on basic social services infrastructures, mainly on water, health, education and other natural resources such oil. Unemployment is becoming as one of new challenges that the country faces as it is notably increasing among youth and women.

Population Stabilization :

Yemen is exerting huge efforts to achieve national and international population objectives in controlling population size and growth and other related factors such as fertility rate. The intent from these efforts is also to reach more or less the level of replacement in fertility rate reduction. But

these efforts have met with a number of challenges. Thus it seems to be that the country is very far from attaining this objective in the coming years and it has to go along way till reaching it.

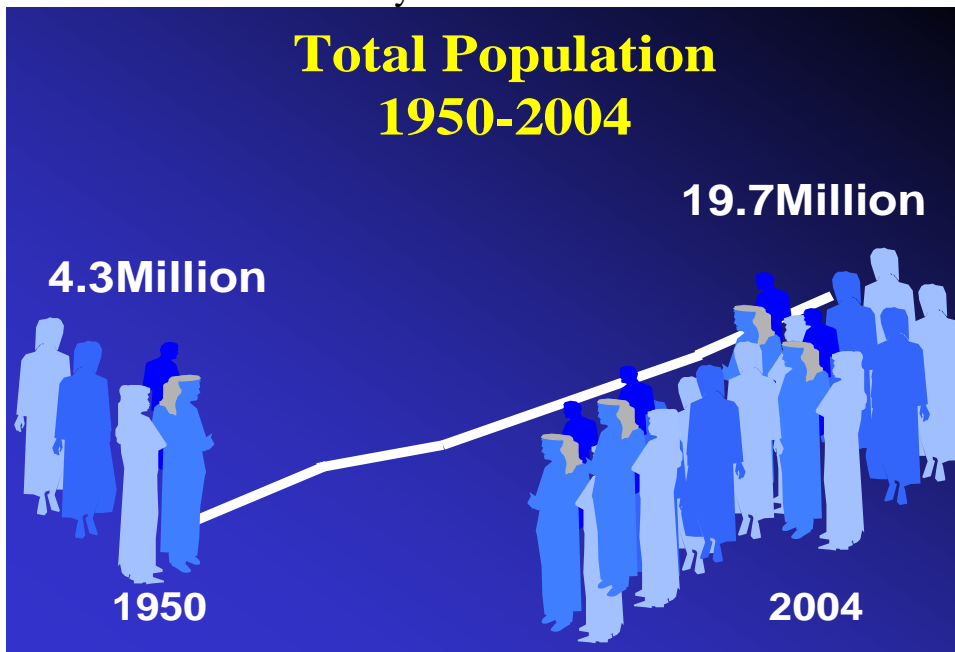
This paper is divided in two sections. The first is to describe the current situation of population and related issues. The second is to highlight the efforts and challenges towards the attainment of population stabilization.

Part one :Current situation and analysis

I. Population dynamics:

Development of Population size:(1995-2004)

Yemen is classified as one of LDCs . The population size of Yemen was 4.3 million in 1950 and has increased up within 54 years specially during the seventies and nineties. The since 1954 has increased more than 3 times to an estimated 15.4 million. By 2005 it had reached 19.7 million.



The reasons behind that are :

1. Imbalance between crude birth and crude death rates during the period 1975-2004, which resulted in an increase in population growth rate

- from 1.8% in 1975 to reach 3.7% in 1994 and to decline to 3.0% in 2004.
2. The birth rate was very high at 47 live births per 1000 in 1975 and continued at the same rate until the beginning of 1990s, while the death rates witnessed a tangible decline from 29 deaths per 1000 in 1995 to 11 deaths in 1994. (1994 census).
 3. From this period the trends of increase in population size went to normal direction due to slight decline in birth rates from 74 live births per 1000 in early 1990s to reach 37.7 in the year 2004.(2004 census).
 4. Despite all positive improvement in birth rates , but the country remains among of high population growth in the world.

The high total fertility rate (TFR) is the main reason behind the rapid population growth. TFR reached its peak in the eighties at 8.1 live births per woman. However, this indicator declined to 7.4 in 1994, and to 6.5 in 1997 and then to 6.1 live births per woman in 2004. Almost 76% of population lives in scattered population settlements (over 110,000 small villages) in rural areas, while less than 30 % counts for the urban ones. About half of the population concentrated in five provinces namely Taiz, Ibb, Al-Hodeidah, Sana'a City and Hajja.

The under -15 age group represents almost 50% of total population. This means huge demands for basic services (mainly health services) and infrastructure requirements which are beyond the government's ability to provide.

Population growth:

The population growth in Yemen has increased at an unprecedented rate since the mid 1970s. The population growth rate was never less than 3% annually. According to the 1994 census, the population growth rate had reached 3.7 %. This rate has declined to 3.0% and has continued at the same rate. However the population continues to increase despite this decline in overall population growth.

The rapid population growth can be attributed to diseases set back since the establishment of modern state of Yemen in 1962 and the independence of

the southern part of Yemen in 1967. The morbidity rate and diseases prevalence have decreased due to the gradual improvement in living standards as well as relative expansion in preventive and curative medical services. These development were reflected in the remarkable reduction of infant mortality rate from 170 deaths per 1000 live birth in the seventies to 130 deaths by the end of eighties, then to 81 by the mid nineties, and to 75.3 by the end of nineties (1997). Under five years child mortality rate had decreased from 121 deaths per 1000 live births in 1994 to 105 in 1997, and then to 99.8 in 2003.

The Yemen Demographic Survey conducted in 1997 (DHS) has indicated various economic, cultural and social factors that influence the child and infant mortality. There are differences in the mortality rates during the previous ten years preceding the survey in accordance to the mother education level. The infant mortality rate among illiterate mothers reaches 93 deaths comparing to 52 for the secondary education level mothers. These deaths are also affected by the medical care received by mothers. The death rate reaches 79 deaths among mothers deprived of maternal care comparing to 61 deaths for mothers receiving maternity health care (pre, delivery and postnatal care). The infant mortality rate is also affected by the place of living as the under-five child mortality rate reaches 128 deaths in rural areas, which this figure drops to 96 deaths in urban areas according to 1992 DHS. This figure decreased to 80 deaths in urban areas comparing with 112 deaths per 1000 live birth in rural areas (DHS1997) then to 79 deaths in urban areas in contrast to 105 deaths in rural areas (2003).

Fertility Rate:

The high total fertility rate is the main reason behind the rapid population growth. The TFR has reached its peak in the eighties decade 8.1 live births per woman. This figure declined to 7.4 in 1994, and to 6.5 in 1997 and then to 6.2 live births per woman in 2003.

All results derived from the conducted surveys and censuses indicated that the fertility trends are moving towards descending rates. This is indicated by the fact that the mediating factors affecting directly the fertility level have changed due to economic and social change in the community. The impact of Family Planning in bringing about fertility reduction is increasing, as it is a long-term determinant, while the other determinants are limited impact.

Based on the age composition of the population; the Yemen population is considered to be young as the less than 15 years age group represents the highest portion and reaching 42.9% of the total population. The age group 15-64 years represents 54.5%, and 3.1% are the portion of the age group exceeding 64 years.

This slight change in age composition as the age group (15-65 years) rate increased will result in the increase of the number of childbearing women. Consequently the population will continue to grow rapidly in spite of lowering the fertility level. This phenomenon is known as population momentum.

The sex composition of the population has witnessed a slight change. The sex ratio (the number of male for every 100 females) was within the range of (101.5 – 102.1) before the nineties and change to 100.4 by the mid nineties (Population census 1994).

The population distribution indicates that there are gaps between rural and urban areas as well as among geographical and administrative regions due to the population mobility, which is inconsistent with required population stability.

Urban population increases by 7% annually in average. As this emigration trend from rural to cities is going to continue, 36% of the population will live in urban areas in the next two decades.

Population characteristics and qualities have been under the acceptable level. The Poverty level is 42% of population (30% in Urban and 45% in rural areas), while food poverty is reaching 17.6%, 19.9% in rural and 10% in urban areas. About half of the population is not covered by primary health care; as well as about 64% have no access to safe drinking water. Illiteracy is widespread and the reaching rate of 47.2% of population, with 67.5% among women. The gap between governorates is wide as well as between rural and urban areas. The elimination of illiteracy can be achieved though the expansion of basic education. The enrolment rate in the basic education reaching 64.4% only by the year 2000, and this limited level has not up to the immediate ambitions. The rural areas have undergone of low level of basic education, the enrolment has not exceeded 57.4%.

Population development (2004-2010):

The result of 2004 census and other related surveys conducted during 2004-2010 including 2010 population projections indicate that population size has continued to increase .It is increased from 19.7 million in 2004 to reach 23.1 in 2010.During the period of last national development plan

for social , economic and poverty alleviation 2005-2010, the population size has increased by 3.4M while the population growth remains unchanged during this period(3.0%)comparing to 3.5% in 1994.

Table 1. below shows the increase in population size during 2004-2010

Year	population size
2004	19.685
2005	19.983
2006	20.590
2007	21.209
2008	21.844
2009	22.492
2010	23.154

This increase in population size is attributed to high fertility rate even though there were decline in its levels as it declined from 6.1 in 2004 to 5.5 by the end of 2010(according to 2010 population projections). These declines have effects on differences occurred between birth and death rates. It is noted that both death and birth rates have declined during this period due to tangible improvement in health services.

Population growth :

The population growth rate has witnessed regression from 3.5% in 1994 to 3.0% in 2004 ,but it did not decline below this rate (3.0 %) which indicates that the population size for productive age has increased during the last three decades to reach 23.154 in 2010 comparing to 6.0 in 1975.The following indicators (2005-2010)show how the population problem remains very vital and serious as it was during the last decades and will continue to be so in the coming years.

Indicators	Unit of measurement	2005	2010
Population growth	%	3.0	3.0
Total fatality rate	birth per woman	6.1	5.5
Crude birth rate	per 1000	37.9	35.9
Crude death rate	per 1000	8.9	8.1
Life expectancy	year	62.0	63.0

Age composition of the population:

Yemen society is considered as a very young as less than 15 years age group young age (0-14) represents the highest portion and reaching 42.% of total population .while active population at age group of (14-64) represents 54.5% of total population .

Table below highlights the changes taken place in age composition of the population (according to 2010 population projections):

Age group	2004	2005	2010
Less than 15 Yrs	45.0%	45.0%	42.4%
15-64 yrs	49.9%	51.3%	54.5%
65+	5.1%	3.7%	3.1%

These indicators reflect population age structure as a result of declining in fertility rate during this period (2004-2010) as it was 6.2 in 2004 and it became 5.5 in 2010. But these indicators show how big is the segment of population at working age.

II. Health services:

The total health services coverage is still very low and estimated currently by 58% of the population comparing to 54 % in 1994. The total number of health facilities reach 3820 in 2010, around 80% of them are in rural areas where as the remaining 20% are located in urban ones. Only 40 % of these facilities provide reproductive services.

As for human resources , only 20% are working in rural areas while 80% in urban ones. Despite the important progress in increasing the number of facilities and expansion of services, but the distribution of facilities and services provided for population is inconstant with actual distribution of population and their needs at both urban and rural areas.

Table below reflects the availability of services to population and distribution.

Services/facilities		No. of population
1 hospital	for	100,000
0.7 beds	for	1,000
1 physician	for	3,536
1 nurse	for	1,810
1 dentist	for	50,000

In reviewing the current situation of health facilities, Ministry of Health indicated that many of health facilities are lacking equipment (24%) ,staff (7%), and operational budget(17%) as well as medical drugs(26%).

Reproductive Health and Rights:

Reproductive health is an indispensable part of the broad health care concepts, and directly engaged to childbearing and fertility as well as prevention and health care elements and problem associated with them. It has been defined by the government as a high priority to improve of population status. Reproductive health services include provision of safe motherhood, child, youth and adolescents' health and reproductive care, married men RH services, prevention of STDs, treatment of infertility, in addition to family planning (FP) as well as awareness raising and education about FP concepts and healthy reproductive behavior.

Current Situation :

Maternal and newborn care:

The indicators reflect deplorable maternal status, which confirm the need for tremendous efforts for approaching acceptable level. The maternal mortality rate is one of the highest in the world, as estimated by 351deaths per 100,000 live births in 1997 DHS. WHO and UNFPA estimate the mortality rate at 580 deaths per 100,000 which accounts for 42% of all deaths among women of reproductive age. The maternal mortality and morbidity can be perceived through two angles; the first links to the reproductive behavior, and the second is the access and utilization of maternal health services. In the Republic of Yemen, childbearing behavior is considered risky caused by; too early, too many, too close and too late pregnancies. The results of the 1997 survey indicated that 12% of the women at the age of (15-19) are either

pregnant or have already delivered a child, and this also not much lower than the results of 1992 survey at 14%. Also in 1997, 11% of births are for mothers at the age of 40 years and above comparing to 17% in 1992 survey. 19% of births occurred within 18 months spacing in 1997 survey comparing to 23% according to 1992 survey. 39% of the women at age (40-44 years) and 46% at the age of (45-49 years) have delivered 10 children or more in 1997.

As the health development is put among the priorities for social and economic development, the development efforts made in the past decades resulted in a considerable improvement of the health situation. Consequently, this led to reduction in the mortality level. The crude mortality rate has declined from 21 deaths per 1000 in the year 1990 to 11.2 deaths by the year 2000, as estimated. Infant mortality has also decreased from 130 to 75.3 deaths per 1000 live births by the year 1997. The under five-year mortality has decreased from 122 deaths per 1000 live birth in the year 1994 to 99.8 by the year 2003. Life expectancy at birth ascended from 46 years to 60.7 years by the year 2000. These reductions have not been parallel between rural and urban areas, as a reflection of development gap and discrepancy of access to basic services between rural and urban areas, such as education and health, which is very low in rural areas. That influenced the pattern of families' awareness mainly the mothers and their reproductive choices, accordingly that have an effect on mortality level.

Regarding the use of safe motherhood services, it is found that services for prenatal care has improved from 26% in the beginning of the nineties to 34% by the mid nineties and then to 45% in 2003 survey. Delivery under skilled supervision rose from 16% to 22% mid nineties and to 25% in 2003. It is noticeable that access and utilization of such services may make remarkable change in maternal mortality and morbidity.

Family Planning:

The use of family planning (FP) depends on awareness, access to services and reproductive attitudes. During the last decade of the twentieth century, contraceptive use and tendency has increased but still far less than the demand and the encountered challenges.

The use of FP methods has increased among middle –aged individuals particularly at the age of 30. It is also affected by women educational level,

as 19.3% illiterate women using FP comparing to 36% among women with basic education and 45% with secondary education and higher according to 2003 survey. The use of FP methods for postponing or delaying the first pregnancy is very rare, but the use is rising to 25% among mothers with 3 children. The rural population has low access to FP methods, as the use does not exceed 15.8% comparing to 36% for urban population. The following table highlights the use.

Use of family planning methods

Source	Knowledge of modern methods	Knowledge of the method source	Total demand	Total use	Modern method use	Unmet need
Demographic survey 1992	53	27	27	10	6	17
Demographic survey 1997	79	53	56	21	10	35
PAPFAM 2003				23.1	13.3	
Population Action Programme 2005	100	100		28	23	

According to a survey contacted by Ministry of Health jointly with UNICEF and GTZ in 10 governments (provinces) in 2005, the contraceptive prevalence rate is at 23% with only 13% for modern ones and unmet need is high reaching up to 51%.

Sexual Transmitted Diseases/Infections including HIV/AIDs:

Although there are clear signs illustrate that the infection with STDs is raising , taking concrete integrated steps for containing STDs is still in the preliminary stage . STDs are estimated by the National AIDS Control Program (NAP) at the Ministry of Health at 15,000 cases of which 874cases of HIV/AID in the year 2000.HIV/AID cases have increased from 1 in 1990 up to the total cumulative number of 3017 cases in Mid2010.WHO believes that there are about 50 Hidden cases behind each case .Therefore, and according to this assumption, The UNAIDS , and WHO and NAP estimate that around 12000 to 24000 people live with HIV/AIDS in the country. NAP indicated that there is in increase in the percentage of HIV positive cases among blood donors from 0.04% to 0.19% during the period 1998-2008.The

prevalence of HIV has increased in the total population from 0.14-0.2% in the 2007 compared to 0.01% in 1999. As for services concern, NAP has developed a standard guideline on STIs and HIV/AIDS case management for doctors as for health assistance personnel. Moreover, guidelines for provision of voluntary counseling and testing services have developed and distributed to all services sites. Till now about 14 health services sites were initiated in selected important governorates (provinces) providing voluntary counseling and testing services. The Prevention of Mother to Child Transmission (PMTCT) services are provided within integrated antenatal care package in 2 services sites mainly Sana'a and Aden.

Harmful Practices of RH: (Female Genital Mutilation (FGM))

Female circumcisions wide spread in some governorates particularly the coastal areas. It is rooted to strong biased cultural believes of certain population of coastal societies. The latest data reveal that 23% of interviewed mothers have undergone the circumcision process and 20% of their daughters have been circumcised. This rate reaches 63% in coastal areas of Yemen, 15% in the mountainous regions and 2% in the plateau and desert area. The latest study conducted shows that any one who has undergone the circumcisions does not necessarily prefer the practice as 71.2% of circumcised women support the continuation of the circumcisions while 21.7% of them support elimination of the practice. Regarding men, it was found that 48% of men and 76.9% of religious leaders are in support of continuation for female circumcision. The FGM /C many cause maternal and neonatal death due to uncontrolled bleeding or infection after the procedure. The newborn of girls are considered be victims of genital mutilation in the country as their lives are jeopardized of the consequences of infection and pain of this practice. As for the prevalence of FGM practices in the country, the results of 1997 DHA reveal that it is 97.3% in Hodeidah, 96.6% in Hadramout, 96.5% in Al-Mahara, 82.2% in Aden and only 45.5% in Sana'a the capital city. It is indicated that FGM is most commonly practicing by traditional birth attendance, barbers. While about 20% of health professionals are practicing it. It is indicated also that most common type of FGM is type II; clitoridectomy.

However, the danger and harm of female circumcisions issue is addressed by the Information and Education and Communication (IEC) and health education within RH services. NGOs are playing great roles and efforts in

cooperation with communities and religious leaders to address the harmful practice of FGM and raising awareness about it. A decree was issued by the Ministry of Health banning the exercise of these harmful practices in all health facilities in the Republic of Yemen.

III. Education:

education is one of the most important factors in socio-economic development and the main element in transforming the human resources into an effective force serving the progress of the comprehensive development .

current situation:

Yemeni education system has witnessed qualitative and quantitative expansion in the last decades. The expansion has been observable in basic education . Enrolment in basic education has increased from 22% in 1972 to 55% in 1975 and then rose to 67.9% by the year 2000 with annual growth of 2.9% . The net basic education enrolment rate for girls has increased from 37.3% of total student in the basic education.

According to Demographic and Housing Survey (DHS) of 1997, the enrolment of boys and girls in basic education at ages 6-15 years is about 71% while 50% of children of basic education are still out of school. In rural areas, the enrollment of female is 30%. Where as 50% of the girls enrolled in primary drop out before they reach grade 6. Indicators show that only 17% of the population at age 10 and above have completed 6 years of basic education. In general The percentage of children enrolled in basic education remains low which is 50% at age of 4-6 years. while for net enrollment rate (NER), indicators show that it is 80% in rural areas where more than 70% of population reside . Within this NER , gender gap is clear which indicates that 28% for girls and 67% for boys. Distance is to considered as one of major barriers against sending girls to school particularly in rural areas as parents are reluctant to send their daughters to school far from their residences. Another obstacle is that most school don't have toilets and only 6% of basic schools do have toilets. Deficit in teachers is to be considered among other factors of weakness in basic education, as one teacher has been provided for every 40 children. In addition , there are remarkable deficit in spaces as many schools lack enough class rooms for large number of children enrolled . These factors keep Yemen far away from achieving 100% enrollment in basic education , the goal of "Universal Access to Education "

Illiteracy is the highest among Arab and other developing countries. Illiteracy rate among males at age 10 years and over is 37% while it is 76% among female.

The illiteracy rate among the population 10 years and above has reduced during 1990s from 62.7% in 1994 to 47.2% in 1999. It has been noted that the reduction of illiteracy among women is comparatively lower. The gap between the rural and urban areas is still wide as the rate is 55% and 27.3% respectively.

IV. Gender Equity and Equality :

Women are still facing some difficulties in acquiring their status and opportunities in education and participation in labor forces and political activities due to deep culture factors. Gender issues remain very weak and improperly addressed.

Despite those factors, many legislative, institutional and political regulation come forward emphasizing the gender equality, equity and women empowerment.

The gender gap is still very wide as the illiteracy rate among women reaches 67.5% comparing to 27.7% of the men. Female enrolment in basic education is 48.9% while it is 78.5% for males. This gap is reflected on the other forms of education such as, secondary, high, technical and vocational education where the presence of females is limited.

The women participation in workforce has not adequate, their participation estimated to be 23% comparing to 70% for men. The majority of women workforce participation is in the agriculture sector. Even though the importance of this productive role of woman, it considers a prolongation of her reproductive role and originally aims to meet basic family needs. Often woman has not received any fees of her work in agriculture. In addition, women are working in public service such as education and health services. Women access to resources and services are very weak, and this doubled women suffering of poverty. Poverty rate among women heading households is 12.3%. Women participation in decision-making position is

very low. There is one woman in the parliament, two in the Consultative Council and one member of the Cabinet.

Women role in family decision also is very frail, even in the issues of marriage, reproduction and access to health and education and other services.

Part two : Efforts and Challenges Towards the Attainment of Population Stabilization

Population projections :

The government of Yemen is recognizing the population challenges resulted from the rapid population growth as it constitutes a key challenge facing the development process. It is expected that the population size would be doubled within the next twenty years.

It is estimated that the population of Yemen will continue to increase as both rates of population and fertility remain at high levels.

According to latest study conducted in 2010, three assumptions were made for population projection till the year 2035 based on three alternatives for fertility control.

The first (high alternative for fertility rate) is to suggest stability of fertility rate at 6 birth for woman in average during the coming years .The population will increase to reach 61 M by the end of the period (2035).

The second (medium alternative for fertility rate) is to suggest the fertility rate to be improved as to decline to 3.3. According to this assumption the population will increase to reach 46 M. The UNDP in its estimation for the population of Yemen considers this assumption .

The third (low alternative for fertility rate) is to propose the fertility Rate will decline from the current rate 6.0 birth for women to reach 3.3 in 2025 and continue to decline till it reaches the rate of stabilization 2.1 by the year 2035.

As we looked at these three alternatives , we will find out that the country will face challenges in many development arena cause huge pressures on natural resources of the country which are very limited. Here below we will focus on efforts and interventions that the country is making to help in

solving these issues towards achieving the ultimate goal of reaching stabilization of population..

Opportunities and Challenges:

The population issues are interlinked with economic challenges which led to structural imbalance between the high increase in population growth and limited resources.

Since early nineties efforts have been exerted to reduce population growth ,but the results are very limited.

1. At policy level :

- A national Population Policy was adopted in 1991 and revised in 2000 for long term to cover the period ending in 2025.It includes within its objectives and framework other population related issues such as RH and Gender taking in consideration the international objectives stated by ICPD and MDGs. This policy is very ambitious in its goals and the intention now to review it and update to be more realistic in scope and objective and be reliable for achievement.
- Incorporate of population policy , RH and Gender objectives within integrated policy frame work of national mid term comprehensive economic and social development and poverty alleviation plans (2006-2010 and 2011-2015).
- Integrate population issues including RH and Gender in the curricula of education.
- A national Strategy for Population Information , Education , and Communication (IEC) was approved and adopted for raising awareness on population issues in coordination with concerned parties involved in population issues.

As for health sector:

- A National Health Policy were adopted in early 2000.
- A National Reproductive Health Strategy for the period (2006-2010) was embarked in order to improve the RH situation. This strategy was reviewed updated in 2010 for the period 2011-2015

the purpose of enhancing the RH status of women , men and young people. Two priorities among other components of RH to be focused on in the strategy.

- The reduction of maternal and newborn health (MNH).
- The reduction of Total Fertility Rate among married women in reproductive age.
- A National Strategy for HIV/AIDS Control was endorsed and adopted in 2002. This strategy was updated in 2010.

As for education:

- A Basic Education Development Strategy (BEDS) was prepared and endorsed based NPP and MDGs requirements to attain 100% enrollment and education for all by 2015.
- Based on this strategy a group of eight donors (4 bilateral and 4 multilateral including World Bank support an initiative of Education for all Track (Fast Track) to help in attaining the MDGs in education by 2015.

As for gender equity and equality :

- A National Women Strategy was ratified in 1997, and a new National Strategy for Gender was adopted 2002 and updated for the period 2003-2005.
- A new Strategy for Women Development for the period 2006-2015 was approved and adopted which represent in its context an expansion of the previous strategy for 2003-2005 with taking in consideration the new development in Gender issues emerged since then in Beijing Platform and other forms regarding woman empowerment and gender equality and equity .

2. Institutional set up :

1. Establishment of the National Population Council (NPC) in 1992 to be involved deeply within population issues ,policies, and programs in population and development. It is attached with a Technical Secretariat (TS) as a technical body for the NPC. This council is under the leadership of the Prime Minister and composed from 10 Key line ministries and representatives of relevant NGOs , and private sector.

2. Establishment of Population Coordination Committees (PCC) at Governorates (provinces) level. It covers now 16 governorates out of total of 21. The representation of this PCC is from the same authorities composing the NPC.
3. Establishment of Population Sector in the Ministry of Health responsible for the implantation population issues in respect to RH and FP.
4. creation of Supreme Council for Women Affairs in 2003 headed by the Prime Minister and attached by Women National Committee Body in 2004.(as technical body).
5. establishment of Yemen Women Union and branches in most of the provinces.(as NGOs dealing with gender issues and women empowerment.
6. establishment of Population and Health Committee at both the Parliament and Al-Shoura Council . (to facilitate the discussions and legislation endorsement in these to houses.

3. At programming level:

- Plans of action were prepared and implement for the National Population Policy and its objectives during the periods 2001-2005 and 2006-2010.A new plan of action for the years 2011-2015 is under preparation which will reflect measures to undertaken to overcome the new challenges emerged.
- A health sector reform program has been developed aiming to fill the gap in health services at central and local levels taking in consideration the health policy and RH and HIV/AIDS strategies.
- Carry out many activities in population advocacy and raising awareness at both national and districts levels.

Challenges:

- Weak coordination; More coordination is required between implementing agencies of population issues and with NPC/TS. In the same time , this weakness is clear among donors that are involved in population and population related problems and with concern authorities. In this respect , there is a need for development of strategy and mechanisms and support for strengthening coordination at all levels.
- Capacity building: it is the bottleneck for making any achievement in all development process including population and development. The

- country is suffer from continuous lack of qualified staff at central sectoral and local levels. This problem will persist in the coming years. More attentions are required and urgently needed to improve the human resources with huge support from international communities in all areas of concerns and at different levels.
- **Advocacy and Awareness :** The country has launched many programs and activities in IEC on population issues and raising awareness towards supporting these issues. But making behavior changes and attitudes towards population issues including RH,FP and HIV/AIDS require more efforts and new thinking programs and methodologies which the country is lacking. New experiences to learn from are needed as well as support and capacity building in the field.
 - **Monitoring and Evaluation System :** To enhance policy making and programs and activities implementations requires monitoring and evaluation systems. This is one of major dilemma that the country in facing in controlling its development process. The country is in need for a revolution in this area with support of international communities in order enable it fellow up and evaluated all programs and activities of population and development at all levels.
 - **Financial and Technical resources:** As the country is one of the poorest countries in the world and classified as one of LDCs , has very limited resources coming from small oil revenues and taxes. It is still heavily reliant on foreign assistance and low – interest loans provided by donors and continues to depend on technical aids provided by external resources. Mobilization of resources is need and continue to be in the future in order finance the programs and activities in different arena including population and development.
 - **Data base for population variables and indicators:** The country is lacking such kind of data base on population and development to produce , analysis and disseminate population indicators at central and local levels.

An Emerging Challenges:

- The recent political crisis resulted from the "Arab Spring " movement in the Arab countries including Yemen. This crisis created new and huge burden pressures on the limited resources which caused to decline in local revenues and sharp decrease and in many cases halt of international support for the development process including

population and development programs and activities. What makes it worse is the development of political crisis to military confrontations. Most of available resources have been exhausted and directed to cover the emergency cases emerging from this crisis.

Conclusion :

The high population growth is to be considered as a real threat to development process in Yemen .The government is recognized this challenge and therefore giving at the top of its priorities and agenda. In this respect , the National Population Council and its Technical Secretariat (NPC /TS) play major role and leading the public efforts in policy making ,planning , implementation of programs and activities of population issues and awareness raising among population and decision makers. It is clear that country has made some progress in specific sectors and service which resulted in descending of fertility rate . However, even though of the scenarios of continuation of reduction in fertility rate , the population size will increase . Challenges are huge and remain difficult to be solved in the coming future particularly in rural areas where more than 70% resides. The reason behind that are many among of them are;

- The scattered population in very small groups at remote and mountainous areas.
- Access of services are difficult to reach.

In order to make tangible changes and progress towards achieving the objectives of reaching population stabilization more efforts and huge resources are needed from the government and its partners in development process. Priorities and focus should be given to:

- curbing the fertility rate which will bring about controlling of population growth.
- Reduction of maternal and newborn mortality and morbidity.
- Eliminate the effects of emerging challenges.

As a matter of fact , the supporting environment that facilitates achieving the above goals are necessary to be overcome before and within the process of the interventions. To sum up , the country is still need to go along way till it reach the stage of curbing the fertility rate to level of replacement and halt

the population growth. By doing so , the country could be able to achieve stabilization of the population.

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