YEMEN
Access to reproductive health for women and girls

ACAPS ANALYSIS HUB MIDDLE EAST

Thematic Report
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INTRODUCTION

Yemen's continuing conflict has had devastating consequences on the country's severely underfunded, overstretched, and damaged healthcare system. The conflict has disrupted healthcare services, causing limited access, with women bearing a disproportionate share of the burden (ICRC 07/07/2022).

Across the country, healthcare needs are rising, primarily as a result of difficulties accessing medical services and medications (ACAPS 30/08/2023). Needs are especially rising among women and girls of childbearing age, who face a plethora of barriers impeding their access to timely sexual and reproductive health (SRH) services. At least 5.5 million women and girls of childbearing age require SRH services across the country, their lives at risk from pregnancy, childbirth, and postpartum-related complications (UNFPA 27/02/2023). Maternal mortality rates in Yemen remain alarmingly high, at 43.3 per 1,000 lives births in 2021, with a woman dying in childbirth every two hours, predominantly from entirely preventable causes (UNFPA 26/03/2024; WHO 26/04/2024).

As Yemen is one of the poorest countries in the world, accessing basic needs – such as medicine – is increasingly out of reach for many, further aggravating health risks for women and girls in need of essential SRH services (WB 01/03/2024 and 25/10/2024; KII 13/11/2024; UNHCR 28/08/2024). This situation is worsened by cultural and logistical barriers, which further impede access to SRH services.

This report explores the availability of SRH services in Yemen and the multidimensional challenges faced by women and girls in accessing available services, highlighting the intersection of cultural, economic, and structural barriers. This report also explores the availability of and access to three key areas of SRH services: gender-based violence (GBV) health responses, family planning services, and maternal healthcare.

METHODOLOGY

This report employs a mixed method methodology, integrating and building on existing data on women and girls' access to SRH services in Yemen and triangulating with primary data from key informant interviews (KIIs). Seven KIIs were conducted with humanitarian responders, health practitioners, and key responders providing and coordinating SRH services in Yemen: two with experts responsible for coordinating services across Yemen, including in areas controlled by the Internationally Recognized Government of Yemen (IRG) and the de-facto authority (DFA) in the north of Yemen (also known as the Houthis); four with experts covering IRG-controlled areas; and one with an expert working in DFA-controlled areas.

Scope

This report covers the whole of Yemen, including areas under either IRG or DFA control, taking into account data availability, control area differences, data biases, and other relevant challenges.

Limitations

Certain SRH topics are more culturally sensitive than others in Yemen, including but not limited to safe abortion care, sexual relations outside marriage, sexually transmitted diseases, and sexual violence, including marital rape. These topics are less frequently mentioned in the secondary data and, although discussed in KIIs, information is more limited, likely as a result of cultural taboos. The sensitive nature of these more culturally sensitive SRH topics meant that we also could not directly consult with women and girls, instead relying on KIIs for such information.

This report is also limited by the lack of publicly available, up-to-date statistics on some key SRH indicators in Yemen. In some cases, key informants also provided conflicting information on the restriction of contraceptives in DFA-controlled areas, highlighting that policies on accessing contraception are fluid and vary depending on the governing authority in each area.

Although SRH response covers a very wide range of services, this report focuses on a handful of key services for which information was available.

KEY MESSAGES

- **There are severe gaps in SRH service availability:** over 5.5 million women and girls of childbearing age lack sufficient access to timely reproductive healthcare in Yemen. Of the functioning health facilities across the country, only about 20% provide complete maternal or neonatal care, leaving women and girls vulnerable to pregnancy complications and maternal mortality and newborns with heightened health needs at risk of worsening health outcomes. Only 5% of health facilities offer clinical management of rape (CMR) services.
- **SRH services are insufficient in rural areas:** women and girls in rural areas of Yemen face disproportionately high maternal mortality rates as a result of more limited access to maternal healthcare services, poverty, high transportation costs, and delays reaching facilities. Access to other forms of SRH services are also typically more limited compared to urban areas.
- **Gender norms perpetuate practices with potentially harmful effects:** including female genital mutilation (FGM) and child marriage, which are deeply rooted in cultural traditions and often normalised by communities, increasing girls' risks of negative reproductive health outcomes.
- **Gender norms and associated mobility restrictions impede women and girls' access to SRH services:** gender norms typically require women to be treated by female doctors, but these are scarce, especially in rural areas, because of cultural restrictions and a lack of financial incentives for staff to consider working in remote locations. Mobility restrictions on women and girls, such as the Mahram requirement, further inhibit their ability to independently access SRH services, particularly in areas under DFA control, if travel to a different governorate is required to access services.
- **Poverty severely limits economically vulnerable women and girls' access to SRH services:** as financial constraints force reliance on costly private clinics amid a deteriorating public healthcare system, impoverished women and girls, particularly in rural areas, face higher maternal mortality rates as a result of unaffordable services, transportation barriers, and widespread humanitarian needs.
- **Declining funding poses challenges to SRH service continuity:** Yemen's healthcare system remains heavily reliant on international support, but recent funding reductions have posed significant challenges. Drops in funding of key SRH responders have led to the suspension of critical programmes, including maternal and child health services, resulting in the potential closure of over 1,000 facilities in 2024 and affecting access to essential care for women and girls of childbearing age.

AVAILABILITY OF SRH SERVICES IN YEMEN

The continuing crisis in Yemen has had a devastating impact on the already fragile public health system, with a significant portion of Yemen's infrastructure and healthcare system severely damaged or destroyed (Alsabri et al. 28/02/2022). According to the 2025 Humanitarian Needs and Response Plan (HNRP), approximately 35% of the 5,345 health facilities assessed are only partially functional, while around 5% are non-functional (OCHA 15/01/2025). Among the limited health facilities that are operational, few have comprehensive SRH services. Reflecting this, the 2025 HNRP notes that only 22% of primary healthcare centres and 50% of district hospitals provide comprehensive maternal and newborn health service packages (OCHA 15/01/2025). The limited availability of functioning healthcare facilities is further aggravated by a lack of essential resources, including medical supplies, a stable power supply, adequate equipment, and specialised medical staff. While these challenges are widespread across the country, they are especially pronounced in rural regions where access to healthcare is most limited (MSF 16/08/2023; USAID 04/2024; ACAPS 11/04/2023; KII 04/12/2024).

Functioning healthcare facilities tend to be concentrated in urban areas, resulting in a significant lack of both medical facilities and physicians in rural areas (ACAPS 26/10/2023; KII 06/11/2024 a; KII 06/11/2024 b; KII 04/12/2024). Governorates further away from central cities also face greater shortages of maternity beds, which – as more than 70% of Yemen's population reside in rural areas and approximately 42% reside over an hour's travel from the nearest fully or partially operational public hospital – is a significant factor (MEE 05/05/2017; UNFPA 01/2023).

Funding cuts

The insufficient and depleted funding of Yemen's healthcare system is a key factor underpinning challenges linked to SRH service availability. The healthcare system relies heavily on external funding as part of international aid, and health services are predominantly funded by external responders, including INGOs (WB 14/09/2021; KII 04/12/2024). This situation is primarily the result of poverty and economic stagnation, which have further strained the country's fragile infrastructure, including health services. As a result, medical staff in Yemen often go unpaid, only partial paid, or receive inconsistent salaries (MSF 22/07/2024; KII 04/12/2024). Financial support for Yemen's healthcare system has rapidly decreased, especially in the past five years, with key health responders – including the WHO and UNFPA – seeing a significant reduction in funding (ACAPS 26/10/2023; KII 06/11/2024).

In 2024, funding cuts led the IRG to declare the potential closing of more than 1,000 health facilities, likely to further reduce SRH service coverage (MEM 05/08/2024). Funding limitations have also led to the discontinuation of several essential SRH-related programmes in recent years, including mother and child health support initiatives, the provision of mobile clinics

in remote areas (which include SRH services), and services focused on the social and psychological protection of mothers and children (Euro-Med Human Rights Monitor 27/09/2022; KII 04/12/2024). Even where services have not been fully cut, they risk being down-scaled. One such example is the Health Cluster's decision to limit funding for financial incentives for doctors who agree to work in remote rural areas (see below) (KII 06/11/2024; KII 04/12/2024).

Shortage of skilled healthcare professionals

The shortage of skilled healthcare professionals is another factor affecting SRH service availability. Following years of conflict, Yemen is experiencing a severe shortage of healthcare professionals (WHO 11/04/2024). In 2011, according to official documents from the Ministry of Health, some governorates were already facing physician shortages and inadequate healthcare capacity (IPI 01/2018). Prior to the current conflict, Yemen was heavily reliant on foreign healthcare professionals, especially surgeons. Since the start of the conflict in 2014, the majority of the 1,200 foreign health practitioners have left the country, creating a significant gap in the workforce. Many of these professionals had been working in remote areas; their departure has severely affected healthcare access for rural populations. Those who remain in the country prefer to work in big cities and areas less affected by the conflict, such as Hadramawt (MEE 29/03/2022).

Brain drain has also been a significant factor, as conflict and economic deterioration has led many locally trained and qualified medical professionals to leave the country (KII 08/12/2024). To overcome the shortage, financial incentives have been provided to doctors working in remote rural areas, although funding for this initiative has been reduced (KII 06/11/2024; KII 04/12/2024). One key informant argued that these financial incentives were essential to encouraging doctors, including women doctors, to take positions in remote and rural areas. As these incentives have been scaled down significantly, in some cases by more than half, it is becoming more challenging to employ doctors in remote locations (KII 06/11/2024). Another key informant noted that most medical staff who relocate to remote locations rely on these incentives for housing, as health facilities typically lack accommodation. This makes it even more difficult for health personnel to relocate, unless supported by adequate financial incentives (KII 04/12/2024).

OVERARCHING BARRIERS IMPEDING WOMEN AND GIRLS' ACCESS TO SRH SERVICES

Alongside challenges relating to the availability of SRH services, women and girls also face overarching barriers impeding their access to these potentially life-saving services.

Shortage of female medical professionals

Not only is the shortage of healthcare professionals, in general, a critical barrier to women and girls' access to SRH services, but specifically the shortage of female healthcare professionals. Strong cultural taboos exist around women and girls being treated by male doctors, especially when it comes to pregnancy-related and other SRH issues (ACAPS 11/04/2023; Première Urgence Internationale 05/01/2023). Female doctors or health professionals, such as midwives, are crucial to enabling women and girls' access SRH services. In rural areas, female doctors are particularly scarce for several reasons, including: worsening security and living conditions, lack of financial incentives to work in remote areas, and the declining availability of medical education for women (Première Urgence Internationale 05/01/2023; KII 06/11/2024). The insufficient number of female doctors in remote areas has led some organisations to deploy foreign female medical professionals to address this gap, although this is not a long-term, sustainable solution (IRC 29/01/2020).

Instances in which there are shortages of female doctors, midwives step in, if available, to provide essential maternal healthcare services, including assisting with childbirth, conducting antenatal and postnatal checks, and addressing basic reproductive health needs. One key informant argued that midwives often play a pivotal role in filling SRH service gaps in remote areas, offering culturally acceptable care to women and girl patients (KII 16/12/2024). Midwives are trained to refer patients in more complex or emergency cases, however, they are not equipped to handle complications requiring intervention by skilled and trained doctors (KII 16/12/2024; KII 13/11/2024). If female doctors are not available, even in areas where midwives offer services, barriers still remain for women and girls in need of more specialised care. ACAPS was unable to access accurate data on midwife coverage across the country, or their level of training.

A factor further compounding the shortage of female healthcare workers is their need, in many cases, to have a male guardian accompany them when working in conservative and remote areas, adding to the expense. This reduces the availability of female medical professionals in such areas (KII 06/11/2024; KII 04/12/2024). These restrictions also apply to female aid workers, obstructing the humanitarian community's ability to respond to SRH needs, especially when female staff mobility is required (UNFPA 01/2023).

Movement restrictions for women and girls

Restrictions on movement also affect female patients' access to SRH services. Culturally, it is common for women and girls to be accompanied by a male guardian when accessing healthcare services, deepening women's dependence on male family members when accessing SRH services and increasing the associated transport costs (ACAPS 11/04/2023; KII 13/11/2024). In DFA-controlled areas, women and girls must be physically accompanied by a Mahram (a male relative or husband) or have written approval to travel between governorates (HRW 11/01/2024; ACAPS 11/04/2023). While more prevalent in DFA-controlled areas, women and girls in the south and IRG-controlled areas also experience movement restrictions impeding their timely access to SRH services (HRW 11/01/2024; ACAPS 11/04/2023).

Household spending power

Even when SRH services are available, they may be unaffordable for women and girls from more economically vulnerable households. In 2024, the World Bank ranked Yemen as "one of the most food insecure, and possibly poorest countries in the world", with worsening rates of poverty as a result of continuing conflict (WB 02/2024 and 25/10/2024). The lack of reliable statistical data makes it challenging to accurately estimate poverty levels in Yemen, but available information indicates that poverty may have more than doubled since the conflict began in 2014(WB 02/2024). Growing poverty has impeded many households' ability to afford healthcare services and medicine, including SRH services. For example, with rising poverty, only a small portion of Yemen's population can afford to travel for medical care (ACAPS 26/10/2023). Mindful of these economic barriers, one key informant noted that, in some rural areas, humanitarian organisations provide transportation vouchers to support access to healthcare facilities that would otherwise be inaccessible. Not all rural and remote areas are covered by such initiatives, however (KII 04/12/2024).

One key informant noted that dissatisfaction with the level of public SRH services, coupled with an inability to afford private healthcare, can lead women and girls to avoid seeking professional SRH services, especially if they require money for travel (KII 13/11/2024).

GBV health response

As of 2025, it is estimated that around 6.2 million women and girls in Yemen are in need of GBV services (HNRP Yemen 2025), including GBV health response. GBV in Yemen takes various forms, many of which have direct SRH outcomes. These include rape, sexual assault, and other forms of conflict-related sexual violence, child marriage, intimate partner violence, and harmful traditional practices, like female genital mutilation (see box) (ACAPS 17/11/2023; OXFAM 04/02/2021).

A critical element of a well-functioning SRH system is the provision of widely accessible and survivor-centred GBV health response services. Access to comprehensive GBV services remains severely limited, however, with fewer than 5% of health facilities across Yemen offering CMR services (OCHA 15/01/2025). As such, the majority of healthcare facilities do not offer potentially life-saving medical care for rape survivors. Even when medical staff are trained to recognise and support GBV cases, key informants noted that significant training gaps persist, as SRH service providers are not always equipped to handle GBV cases using survivor-centred approaches or accurately identify survivors (KII 04/12/2024; KII 06/11/2024). Training gaps create critical access barriers, as survivors are less likely to seek services if they have no confidence that service providers will protect their safety, dignity, or treat them with respect. Key informants familiar with the GBV health response in their local areas noted that, when GBV cases requiring either medical attention or referral are identified, staff are typically able to refer these cases to relevant responders – such as NGOs and local organisations providing GBV response services – or, if the survivor wishes, the police or lawyers providing free legal services (KII 13/11/2024; KII 04/12/2024).

Compounding the extremely limited CMR service coverage, social stigma and harmful social norms that lead to the underreporting or concealment of sexual violence can also impede survivors' access to potentially life-saving GBV health response services. For survivors, the potentially detrimental consequences of reporting – such as violence linked to family honour, threats of or actual violence from perpetrators and their families, and the risk of being stigmatised or blamed by families and the wider community – leads to this underreporting. Yemen's legal framework also reinforces some of these harmful social norms. For instance, marital rape is not legally recognised in Yemen, as the Yemeni Personal Status Law mandates that women and girls 'submit' to their husbands, including in matters of sexual intercourse (ACAPS 17/11/2023). In such cases and instances of other forms of GBV normalised by communities, survivors may not recognise that they are experiencing GBV and eligible for response services (ACAPS 17/11/2023).

In the case of sexual violence involving minors, barriers to disclosure or accessing health services include stigma associated with sexual victimisation, fear of retaliation, and ineffective reporting mechanisms (Justice for Yemen Pact 06/2024; STC 18/02/2021). It has been found that, globally, girls married in childhood face an increased risk of IPV and, as such, are in need of GBV health response services (Hayes et al. 03/09/2021). Given cultural norms requiring women and girls to be accompanied by a male relative, such as their husband, when accessing healthcare, both women and girls are at increased risk of being unable to access services if their guardian is their perpetrator.

In an attempt to increase access to GBV and SRH services, including GBV health responses, the integration of SRH and GBV services has been tested in Yemen and is demonstrating promising results, with a notable improvement in both the uptake of GBV and SRH services

and overall wellbeing of GBV survivors. The 2025 HNRP outlines this integration as a priority, reflecting a strategic shift toward addressing survivors' interconnected needs, and recognises the importance of a comprehensive approach that combines healthcare, protection, and psychosocial support to enhance the overall wellbeing of women and girls in conflict-affected areas such as Yemen (Deem 01/08/2022; OCHA 15/01/2025).

FGM and SRH outcomes

In Yemen, the practice of FGM is the result of deeply held cultural and gender norms passed down through families and communities (UNICEF 2023; KII 16/12/2024; ACAPS 17/11/2023). Yemen lacks national legislation specifically criminalising and punishing FGM. In 2001, however, a ministerial decree was issued prohibiting the practice of FGM in both private and public medical facilities (UNICEF 2023). As a result, FGM is usually conducted at home, by a person with no medical training, exposing girls to harmful health outcomes. In some cases, FGM can lead to a child's death (KII 16/12/2024).

FGM is also associated with potentially long-term negative SRH outcomes, including uncontrollable pain, excessive bleeding, infection, urinary and vaginal problems, sexual problems (such as pain during intercourse), painful menstruation, scar tissue, childbirth complications, cysts, and possible infertility. Psychological issues also arise from the practice, including post-traumatic stress disorder, depression, and anxiety (WHO 05/02/2024; Klein et al. 10/07/2018).

FAMILY PLANNING SERVICES

Access to family planning services is critical for women and girls, as such services support their right to control their own bodies and make decisions about their future. Although there are no current statistics on women and girls' access to family planning services and methods, Yemen's Ministry of Public Health and Population published data, in 2015, on women and girls' access to modern contraceptive methods, which showed that only 20% of women and girls across the country had access at the time (STC 01/2020).

Family planning services can be accessed via state healthcare facilities and private health sector locations, such as private clinics and pharmacies, although availability differs between IRG and DFA-controlled areas. For instance, by 2019, the DFA had increasingly restricted access to contraceptives in areas under its control, framing family planning as an "ideological tool of the West" (IRC 29/01/2020; KII 04/12/2024). By mid-2020, restrictions had been tightened further in DFA-controlled areas, where the sale of contraceptives – such as birth control pills and condoms – had been prohibited at public and private health facilities. Intrauterine devices were also banned, leaving residents to obtain contraceptives in secret and at great risk to their personal safety (Mwatana 08/03/2022).

In 2021, the DFA issued several more orders preventing women and girls from obtaining contraceptives from health centres and pharmacies, unless accompanied by their husband or with his written consent and upon showing their marriage certificate (Mwatana 08/03/2022). Even with a husband's approval and physical presence, however, there have been reported cases of women and girls being denied access to contraceptives in areas under DFA control, even with evidence that pregnancy could pose a health risk (Asharq Al-Awsat 18/05/2023).

The DFA's policies on family planning have impeded not only women and girls' personal access to family planning methods but also the humanitarian response's ability to provide comprehensive family planning services. According to one key informant, the DFA initially refused to allow entry of emergency reproductive health kits that contained contraceptives (KII 08/12/2024). Another key informant noted, however, that there have been some improvements: after focused advocacy, certain contraceptives have now been allowed, including injectable contraceptives, intrauterine devices, and implants (KII 16/01/2025). Another key informant noted that, while the DFA's longstanding policy has put limitations on access to contraceptives, there does appear to be a shift under the new Minister of Health and Environment, who has shown greater openness to the use of contraceptives. It remains unclear, however, whether this shift in attitude will translate into tangible policy changes, and if so, when and how these new policies would be implemented (KII 16/12/2024). Current information about the availability of contraceptives at private health facilities in DFA-controlled areas is contradictory, with some sources reporting no restrictions and others reporting the opposite (KII 06/11/2024; Mwatana 08/03/2022).

In IRG-controlled areas, family planning services and methods appear to be more freely available. For example, one key informant noted that if contraceptives are not available at public health facilities, they are available at private facilities (KII 22/12/2024). Another key informant noted that, in November 2024, a maternal and newborn health and family planning campaign had been successfully completed in the south, which included the provision of antenatal care, postnatal care, contraceptives, and awareness materials. The same key informant noted that a needs assessment for youth had also been recently undertaken to better understand how to meet this group's needs (KII 16/01/2025).

Across both IRG and DFA-controlled areas, however, economic costs remain a critical barrier to family planning services. Rising poverty levels make it increasingly difficult for women and girls from more economically vulnerable households to afford private healthcare and contraceptives. The most affordable option, the contraceptive pill, costs YER 100 (USD 0.40) for a one-month supply, while a T-loop costs approximately USD 24. This is while Yemen's average wage is around USD 50 per month (MEE 05/05/2017).

A significant barrier to women and girls' access to essential sexual and reproductive healthcare lies in their limited control over family finances. Women and girls often have less means of accessing and controlling their family's expenditure and financial resources; it is common for men to take the lead on decisions related to healthcare expenditures (IRC 29/01/2020; ACAPS 11/04/2023; Première Urgence Internationale 05/01/2023). In cases when the husband is physically absent, as one key informant noted, decision-making around family expenses is often transferred to the extended family, particularly if the woman resides with her in-laws or other members of her husband's extended family, who may not prioritise her SRH needs (KII 13/11/2024).

MATERNAL HEALTH SERVICES

Women and girls of childbearing age face significant challenges accessing essential maternal health services, as there is limited availability of antenatal care, safe delivery, postnatal care, and emergency obstetric and neonatal care (UNFPA 01/2023). It is estimated that 19 of Yemen's 22 governorates face critical shortages in maternity beds, with fewer than six beds available per 10,000 people – only half the standard set by the WHO (UNFPA 01/2023). It is believed that six out of ten births are not attended by a skilled birth professional, only one-third occur in healthcare facilities, and only four out of ten women and girls receive appropriate antenatal care from a trained healthcare provider (OCHA 15/01/2025; UNFPA 01/2023). Women in rural and remote areas face specific challenges accessing maternal healthcare services. In some remote villages in Yemen, the lack of midwives and health centres has resulted in traditional birth attendants delivering babies without proper sterilisation or adequate knowledge of antenatal and postnatal care (UNICEF 01/12/2023; KII 04/12/2024).

Insufficient availability of and access to maternal healthcare services has significant implications. Maternal mortality rates in Yemen are alarmingly high, ranking the highest in the Middle East and North Africa region (UNICEF 03/2024). In Yemen, a woman dies during childbirth every two hours, primarily from preventable causes often linked to lack of access to qualified professionals and adequately equipped services. Certain groups of women and girls are at heightened risk of maternal mortality, including girls who give birth in childhood (see box), those from impoverished households, and those living in rural areas (ACAPS 08/12/2023; UNICEF 03/2024; Alsharif et al. 27/06/2023). For example, in an observational case study conducted between 2011–2017, 86.5% of maternal deaths occurred among referred cases, with most referrals coming from rural hospitals or community health centres (Alsharif et al. 27/06/2023). While this study dates from 2011–2017, enduring access challenges to maternal healthcare services in rural areas mean the findings likely still apply.

Pregnant and lactating women and girls who are also malnourished are at increased risk of worse maternal health outcomes. By January 2025, 1.3 million pregnant and lactating women and girls were malnourished in Yemen (OCHA 15/01/2025). Increasing food insecurity – 49% of Yemen's population is classified as food insecure – means that women and girls risk giving birth to infants with severe developmental delays and nursing malnourished babies while also facing difficulties breastfeeding (OCHA 15/01/2025). Pregnant and malnourished women and girls face a higher risk of complications during pregnancy and childbirth, with iron deficiency and anaemia being most common (MSF 19/03/2024; UNFPA 26/03/2024). This situation is further aggravated by critical shortages of essential medicines, medical supplies, and specialised staff (UNFPA 26/03/2024).

To address some of the barriers impeding timely access to maternal healthcare and improve service availability, particularly in remote and rural areas, midwives are also being trained – in coordination with the Ministry of Health in both IRG and DFA-controlled areas – to provide critical services, including antenatal care, safe delivery, and postnatal care, referring complicated cases to urban centres only when necessary (KII 16/12/2024; KII 08/12/2024; UNFPA 26/03/2024). These services are supported by international humanitarian responders and coordinated through the Ministry of Health with local service providers (KII 08/12/2024; KII 16/12/2024). Mobile clinics offer general consultations and basic services, including antenatal and postnatal care, coupled with integrated healthcare services such as immunisation for women and children and nutrition services. When complications arise or more advanced care is needed, patients are referred to better-equipped primary healthcare facilities nearby (KII 04/12/2024; KII 08/12/2024; KII 16/12/2024; UNFPA 26/03/2024).

Although mobile clinics increase SRH service accessibility, they face greater challenges gaining community acceptance and trust. Unlike static clinics, which allow community members to develop familiarity and establish relationships with service providers embedded in their communities over time, mobile clinics lack the continuity needed to foster such connections (ACAPS 08/12/2023).

Adolescent girls who give birth

Pregnancy and childbirth complications are among the leading causes of death for girls aged 15–19 globally (Girls Not Brides accessed 22/12/2024). Early marriage and early childbirth increase the risk of health complications and maternal mortality (Hunersen et al. 02/02/2021). Giving birth at a young age places immense strain on a girl's body, increasing the risk of severe conditions such as obstetric fistula and, in some cases, even death (UNFPA 26/03/2024). In Yemen in 2022, 52 out of every 1,000 girls aged 15–19 gave birth, likely linked to the high rate of child marriage in the country, which affects over 30% of girls (WB accessed 15/01/2025; UNFPA 26/03/2024).

Pregnancy-related complications are a leading cause of death for girls aged 15–19, as reported by the Yemen Multiple Indicator Cluster Survey 2022–2023 (UNICEF 07/12/2023 and 29/05/2024). Child mortality rates are also higher among infants whose mothers give birth at an early age, showing a link between early childbirth and poor newborn health outcomes. The highest child mortality rates for children under five are found among mothers under 20 years of age, with 54 deaths per 1,000 live births (UNFPA 26/03/2024).

As child marriage and early births are normalised social practices, key informants noted that health facilities in Yemen lack specific protocols or dedicated services for treating, admitting, or providing specialised care to girls facing early childbirth and/or marriage. While some medical attention is offered for complications or medical conditions arising from early pregnancy, there is no comprehensive system in place to address these girls' broader health and psychosocial needs (KII 04/12/2024; KII 13/11/2024; KII 22/12/2024).